FY23-24 Colorado Access Administrative Payment Models -Frequently Asked Questions

General Questions:

1. When will I receive my new contract?
Contracts were sent out beginning May 4, 2023. If you have specific questions about your contract, please contact provider.contracting@coaccess.com.

2. When will contracts and these new payment models be effective? Contracts and new payment models will be effective July 1, 2023.

3. Where can I find model program and measure specification documents?
Current and prior model program and measure specification documents can be found on our Provider Resource page under Value Based Payments:
coaccess.com/providers/resources/vbp/

4. What is the performance measurement period?
The performance measurement period is calendar year 2022. Claims data for December 2022 was pulled mid-March 2023 to allow for claims runout. Membership numbers are based upon March 2023 attribution.

5. Why are there NAs listed for some measures on Exhibit 1-A?
If an NA is listed for the measure, the measure was either not applicable to the practice type, or there not being a large enough population to measure meaningful performance.

6. What are the implications of the public health emergency (PHE) ending on attribution?
We anticipate that there will be a decrease in Health First Colorado (Colorado's Medicaid program) membership. It is unclear what the member mix will look like after redetermination. If you have questions about your site's attribution, email practice_support@coaccess.com.

7. Who do I contact if I have more questions?
a. For specific questions about your contract, email provider.contracting@coaccess.com
b. For questions about your site's performance, email practice_support@coaccess.com
c. For questions on the vulnerable populations provider support payment, email sarrah.knause@coaccess.com
d. For general inquiries, email providerrelations@coaccess.com

Utilizer Payment

1. Why are sites participating in the Family Medicine model being paid less per metric than other models?

There are more opportunities for sites participating in the Family Medicine model to earn dollars due to there being more measures on the table. If you add up the max level across all measures in the Family Medicine model, there is more earning potential.

2. What modifiers are being implemented for depression screening codes?

Beginning July 1, 2023, a billing modifier on ALL depression screens delivered to members using G8431 or G8510 will be required. Modifiers are intended to track when a screen is done for the individual whose Health First Colorado ID the screen is billed under, for the parent who gave birth to the member, or for a caregiver to the member.

Relationship to Member ID on Claim	Unique Modifier
Self	U1
Parent who gave birth to member	U2
Other primary caregiver to member	U3

3. What metrics are changing for the calendar yaer 2024 performance period?

The Family Medicine model will transition to well visits 15 to 30 months of life and A1c <8% (good control). Well visits zero to 15 months of life and A1c testing will be retired at the end of the calendar year 2023 performance period.

The Adult Internal Medicine model will transition to A1c <8% (good control). A1c testing will be retired at the end of the calendar year 2023 performance period.

4. Why did Colorado Access chose HbA1c Control (<8.0%) and not HbA1c Poor Control (>9.0%)?

We chose to not include HbA1c Poor Control (>9.0%) in the Family Medicine and Adult Internal Medicine models due to no result reported included in the numerator.

The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was modified by NCQA into a combined measure that has two rates: HbA1C Control (<8%) and HbA1C Poor Control (>9%). The combined measure is called Hemoglobin A1c Control for Patients With Diabetes.

5. What is a CPT II code?

CPT Category II codes are supplemental tracking codes used for performance measurement and data collection related to quality and performance measurement.

Complex Member Payment

1. What is the regional Complex Member definition?

The **Adult Complex Member** definition is members with ≥4 of 8 priority health conditions:

- Asthma
- Cardiovascular disease
- Chronic pain
- Chronic obstructive pulmonary disease (COPD)
- Depression or anxiety
- Diabetes
- Hypertension
- Substance use disorder (SUD)

The **Pediatric Complex Member** definition is members with ≥3 of 8 priority health conditions:

- Asthma
- Depression or anxiety
- Diabetes
- Obesity
- Pervasive developmental disorder
- Pregnancy
- Social needs (Z-code diagnosis)
- SUD

2. Why aren't social determinants of health included in the Adult Complex Member definition?

In the short term we are monitoring the use of social needs (Z-code diagnosis) for adults and children through the Pediatric Complex Member definition to understand the prevalence of social needs in our population. We will evaluate the impact of including social needs codes in the adult population and modify the definition as needed.

3. Under the Pediatric Complex Member definition, what are the parameters around pregnancy and postpartum, i.e., how long is a "young mother" considered complex?

Complexity will last 27 months from the last pregnancy diagnosis code on any claim.

4. What codes are used to determine pregnancy if prenatal/postpartum care is done by a specialist under the maternity bundle?

Any O code and encounter codes related to pregnancy in the Z30s are included.

5. What codes are used to determine foster care?

Z622.2 is used to identify members in the foster care system.

Primary Care Medical Provider Plus (PCMP+)/Enhanced Clinical Partner (ECP) Ascension

1. How would I know if met the 80th percentile for a metric?

We are working on adding these data to the provider score card so providers may monitor their performance.

2. Do we anticipate ECP descension in the future?

Possibly, but not soon. We want to give providers the opportunity to improve, and not penalize. It is also possible that this model will change in ACC 3.0, as requirements to align value based payments across Colorado payers progress.

Provider Support Payments

1. Where can I find the RFP and application?
The RFP and application can be found on our Provider Resource page under Value Based Payments: coaccess.com/providers/resources/vbp/

2. Are there examples of vulnerable populations?
- People experiencing homelessness
- People with a severe persistent mental illness
- People living with HIV
- Children and adolescents experiencing medical complexity and/or fragility
- Refugees
- American Indians and Alaskan Natives
- Other marginalized groups

3. Are there examples of enhanced care projects?
- Onsite housing and employment supports
- Onsite access to a food pantry
- Integrated pharmacy
- Integrated dental
- Chronic condition education and medication adherence programs
- Street outreach and street medicine programs

4. What happens if I turn my application in after 5:00 p.m. on July 31, 2023?
Applications received after 5:00 p.m. on July 31, 2023 will not be considered.

5. When would I be notified if my proposal was awarded?
Awardees will be notified in September 2023.

6. If my proposal is funded when would we receive funds?
Funds will be distributed in October 2023.

7. Are there reporting requirements associated with these funds?
Yes, awardees will be required to submit a written report with a description of how the project was implemented and if the objectives were met, two to three member experience vignettes based upon the enhanced care project implemented, and outcome reporting.