5/18/23

FY23-24 COA Alternative Payment Model – PCMP Administrative Payments

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Agenda

1. COA Administrative Payment Model: Goals
2. Utilizer Payment Model Elements
3. 2023 Measurement Period Metric & Spec Changes
4. Pediatric Complex Member Definition
5. Complex & ECP Payment Model Elements
6. PCMP+ & ECP Ascension
7. Vulnerable Populations Provider Support Payment
8. APM 2 Early Adoption Incentive
9. Q&A

Goals of the Program

1. Improve health outcomes for our shared members/patients by incentivizing services associated with
   - Prevention
   - Chronic condition control

2. Use performance results to identify and reward providers with demonstrated ability to increase member/patient uptake of these high-value services

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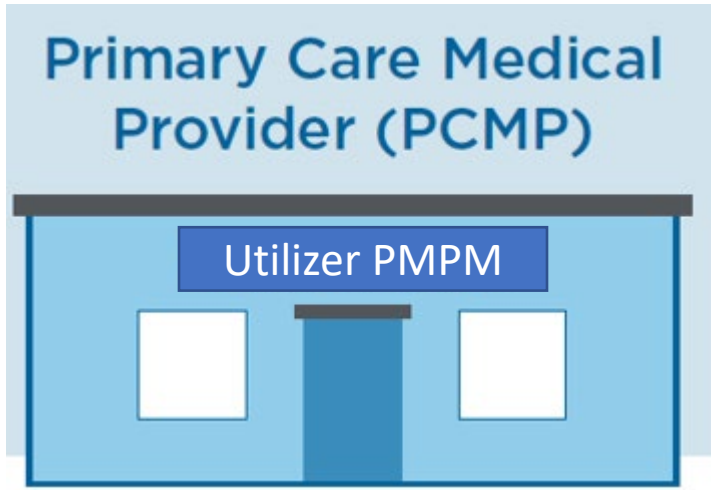
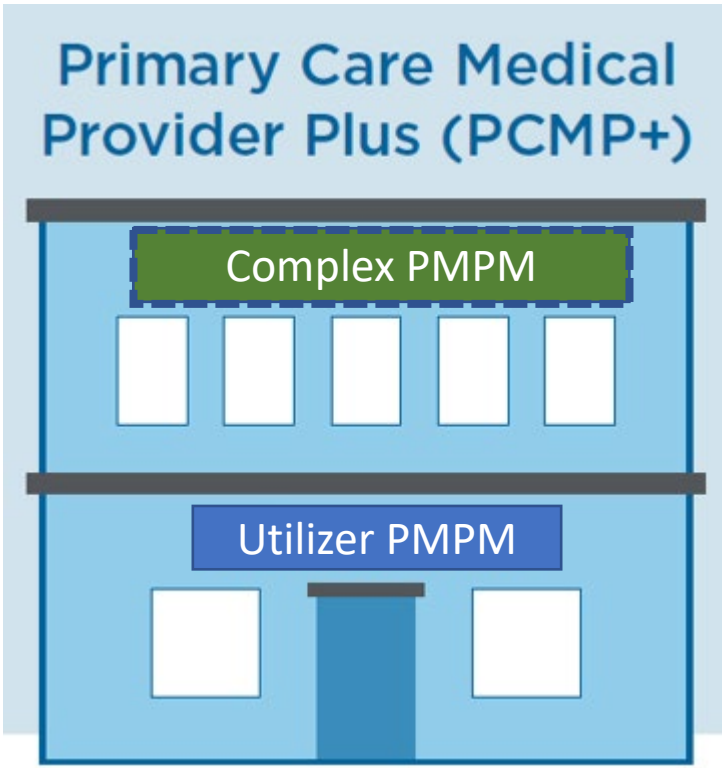
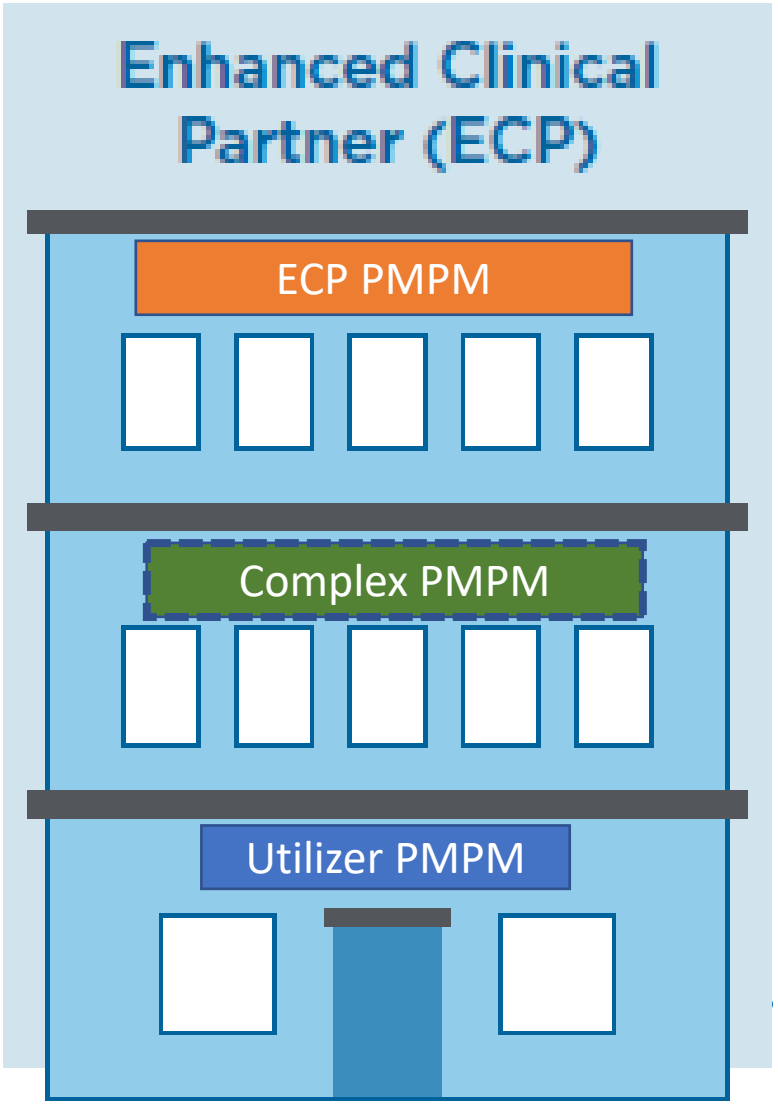
COA PCMP Network: 3 Types of Providers & Payments

3 Member Types:
1. Utilizer
2. Non-Utilizer
3. Complex







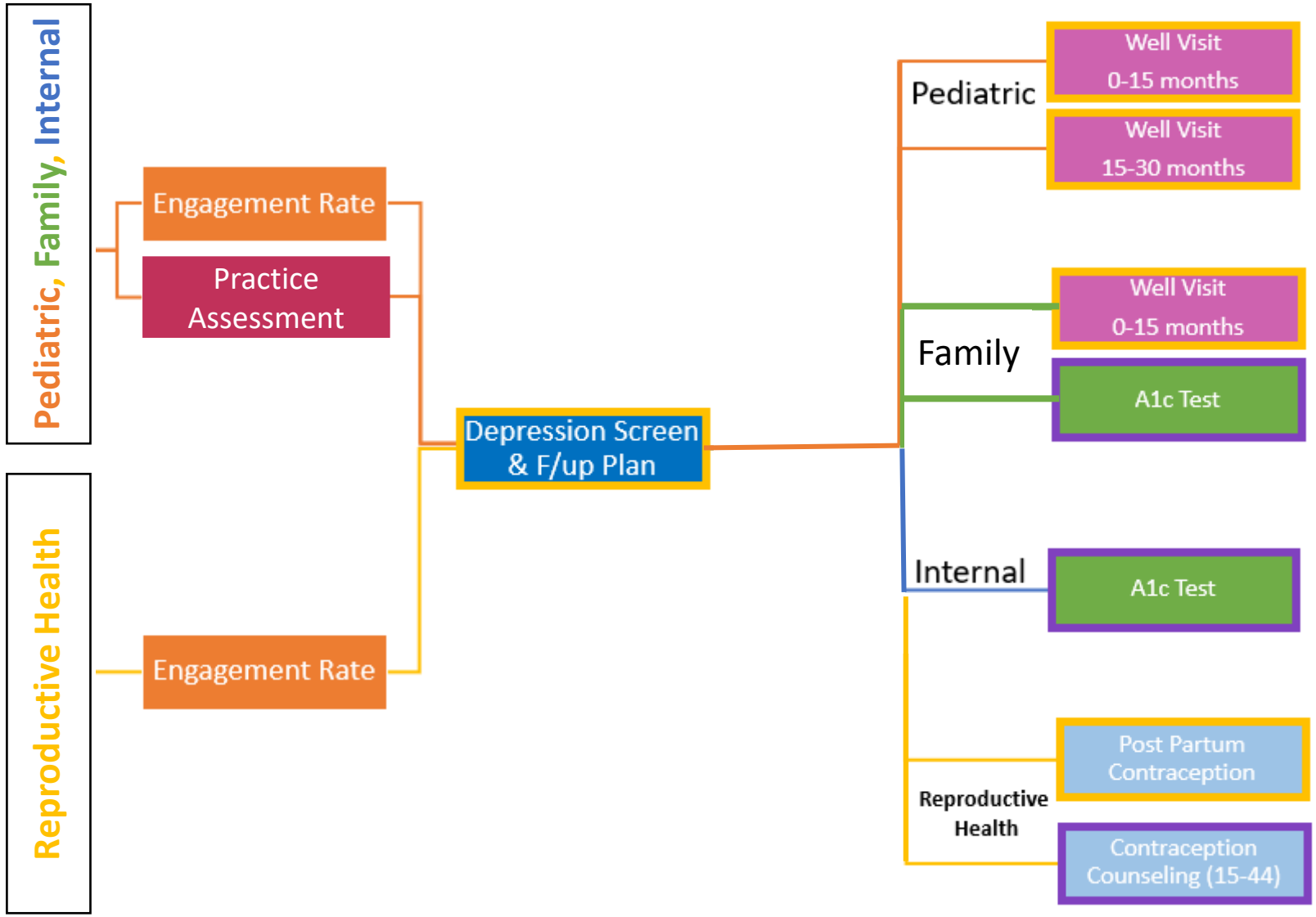
July, 2023

Elements of the Utilizer PMPM

Summary of Changes to the Model

- Eliminated C3EDR program – redistributed $0.50 PMPM
- Increased relative value of most metrics
- Eliminated points to the extent possible
- Simplified performance ranges into none/min-mid-max
- Performed full QA vetting process to standardize coding and align with updated measure specifications

Utilizer PMPM Model: 4 Configurations



CMS Core Measure

Lead Measure to CMS Core

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Utilizer PMPM Payment Model

Family Medicine: FY 23-24 Performance Standards

Practice Assessment Score

None = 0-90%
Mid = 91-96%
Max = 97-100%

Engagement Rate

None = 0-16%
Mid = 17-53%
Max = 54-100%

Depression Screen

Min = 0-2%
Mid = 3-30%
Max = 31-100%

Well-Visits 0-15 Months of Life

Min = 0-39%
Mid = 40-67%
Max = 68-100%

Hemoglobin A1c Testing

Min = 0-64%
Mid = 65-85%
Max = 86-100%

FY23-24 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	Well Visit 0-15 Mos	HbA1c Testing
None/Min	$0.00	$0.00	$0.50	$0.25	$0.25
Mid	$0.25	$0.25	$1.00	$1.00	$1.00
Max	$0.50	$0.50	$1.25	$1.50	$1.50

FY22-23 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	Well Visit 0-15 Mos	HbA1c Testing
None	$0				
Min	$0.50		$0.25	$0.25	$0.25
Mid	$0.75		$0.75	$0.75	$0.75
Max	$1.00		$1.00	$1.00	$1.00

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Pediatric Medicine: FY 23-24 Performance Standards

Practice Assessment Score

None = 0-90%
Mid = 91-96%
Max = 97-100%

Engagement Rate

None = 0-29%
Mid = 30-66%
Max = 67-100%

Depression Screen

Min = 0-30%
Mid = 31-69%
Max = 70-100%

Well-Visits 0-15 Months of Life

1 = 0-39%
2 = 40-67%
3 = 68-100%

+

Well-Visits 15-30 Months of Life

1 = 0-60%
2 = 61-75%
3 = 76-100%

Payment Level	Well-Visit Points
Min	1-2
Mid	3-4
Max	5-6

FY23-24 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	Well Visit 0-30 Mos
None/Min	$0.00	$0.00	$0.50	$0.50
Mid	$0.25	$0.50	$1.25	$1.25
Max	$0.50	$0.75	$1.75	$2.00

FY22-23 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	Well Visit 0-30 Mos
None	$0.00			
Min	$0.50		$0.25	$0.25
Mid	$0.75		$0.75	$0.75
Max	$1.25		$1.25	$1.25

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Peds/Fam Med Models

*Well-Visits for Children and Adolescents

Child & Adolescent Well-Visits Age 3-21
Family Medicine/Pediatrics

Min = 0-19%
Mid = 20-45%
Max = 46-100%

Payment Level	Peds PMPM	Fam Med PMPM
Min	$0.25	$0.25
Mid	$1.25	$1.00
Max	$2.00	$1.50

*If a Peds or Family Med site has fewer than 10 attributed Members eligible for the ***Well-Visits Within 0-15 (fam/peds) and/or 15-30 (peds only) Months of Life*** measure, the practice site will be evaluated on the ***Child & Adolescent Well Care Visits*** metric.

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Internal Medicine: FY 23-24 Performance Standards

Practice Assessment Score

None = 0-90%
Mid = 91-96%
Max = 97-100%

Engagement Rate

None = 0-16%
Mid = 17-53%
Max = 54-100%

Depression Screen

Min = 0-2%
Mid = 3-30%
Max = 31-100%

Hemoglobin A1c Testing

Min = 0-64%
Mid = 65-85%
Max = 86-100%

FY23-24 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	HbA1c Testing
None/Min	$0.00	$0.00	$0.50	$0.50
Mid	$0.25	$0.50	$1.25	$1.25
Max	$0.50	$0.75	$1.50	$2.00

FY22-23 Rates

Payment Level	Practice Assessment	Engagement Rate	Depression Screen	HbA1c Testing
None	$0.00			
Min	$0.50		$0.25	$0.25
Mid	$0.75		$0.75	$0.75
Max	$1.25		$1.25	$1.25

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Reproductive Medicine: FY 23-24 Performance Standards

Engagement Rate

None = 0-16%
Mid = 17-53%
Max = 54-100%

Depression Screen

Min = 0-2%
Mid = 3-30%
Max = 31-100%

Contraceptive Counseling Women Age 15-44

1 = 0-10%
2 = 11-32%
3 = 33-100%

+

Contraceptive Care - Postpartum

1 = 0-28%
2 = 29-33%
3 = 34-100%

Payment Level	Contraceptive Points
Min	1-2
Mid	3-5
Max	6

FY23-24 Rates

Payment Level	Engagement Rate	Depression Screen	Contraceptive
None	$0.00	$0.50	$0.50
Mid	$0.75	$1.25	$1.25
Max	$1.25	$1.50	$2.00

FY22-23 Rates

Payment Level	Engagement Rate	Depression Screen	Contraceptive
None	$0.00		
Min	$0.50	$0.25	$0.25
Mid	$0.75	$0.75	$0.75
Max	$1.25	$1.25	$1.25

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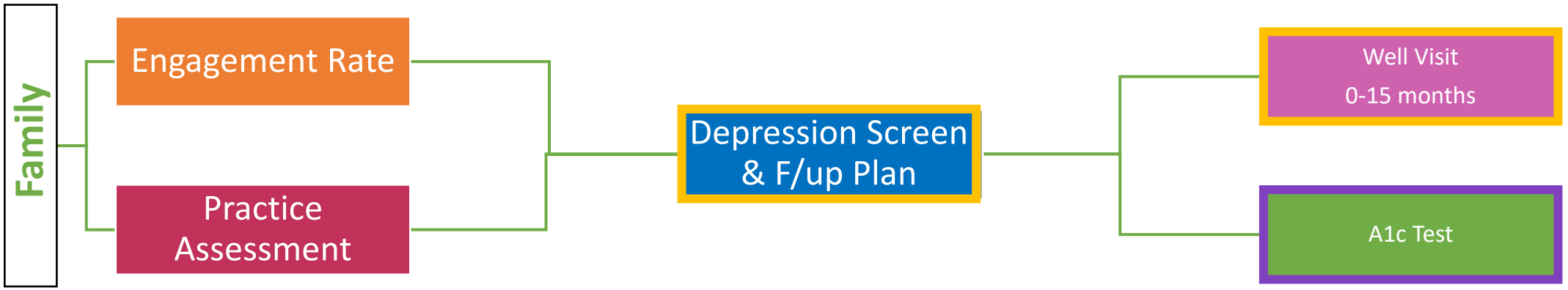
Utilizer PMPM Calculation: Family Medicine Example



Engagement Rate	**Practice Assessment Score**	**Depression Screen Rate**	***Well-Visits Age 3-21**	**Hemoglobin A1c Testing Rate**
None = 0-16% Mid = 17-53% Max = 54%+	None = 0-90% Mid = 91-96% Max = 97-100%	Min = 0-2% Mid = 3-30% Max = 31+%	Min = 0-19% Mid = 20-45% Max = 46-100%	Min = 0-64% Mid = 65-85% Max = 86-100%
None $0 / Mid $0.25 / Max $0.50	None $0 / Mid $0.25 / Max $0.50	Min $0.50 / Mid $1.00 / Max $1.25	Min $0.25 / Mid $1.00 / Max $1.50	Min $0.25 / Mid $1.00 / Max $1.50
37% = $0.25	**100% = $0.50**	**7% = $1.00**	**30% = $1.00**	**80% = $1.00**

Clinic A Utilizer Rate = $3.75 PMPM

Utilizer Payment = 680 x $3.75 = $2550

Non-Utilizer Payment = 150 x $.50 = $75.00

Clinic A Monthly Utilizer Payment = $2,625

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2023 Measurement Period Metric & Spec Changes

FY23-24 Metric Spec Change Summary

All Models

Depression Screening

Modifier U1 has been added to inclusion criteria.

See slide 53.

Fam/Internal Med Models

A1c Testing

Members with diabetes are identified via claims and pharmacy data. No longer based on COA diabetes registry.

See slide 54.

Reproductive Health Model

Contraceptive Care – Postpartum Women

Revised the 60-day postpartum rate to be a **90-day postpartum rate.**

See slide 55.

FY24-25 Metric Change Summary

Fam Med Model

Well-visits 15-30 months

Switching from well-visits in the first 15 months of life to **well-visits 15-30 months**.

See slide 56.

Fam/Internal Med Models

HbA1c Control (<8.0%)

Switching from A1c testing to **A1c control (<8.0%)***.

See slide 57.

***The member is not numerator compliant if the testing claim is missing a CPT II result code**

Complex Member Definition Changes

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The Adult Complex definition will stay the same

Regional Adult Definition: ≥4 of 8 Chronic Conditions

- Hypertension
- Diabetes
- Heart Failure – refined to be CVD
- COPD
- Asthma
- Chronic Pain – CP Diagnosis only
- SUD – F code diagnosis captured in regional behavioral health benefit
- Anxiety or Depression

Current Pediatric Complex Member Definition: ≥3 of 11 Chronic Conditions

- Hypertension
- Diabetes
- Heart Failure – aka CVD
- COPD
- Asthma
- Chronic Pain – Diagnosis only
- SUD – F code diagnosis captured in regional behavioral health benefit
- Anxiety or Depression
- Obesity – based on provider feedback
- Pervasive Developmental Disorder - based on significance in data
- Social Determinants of Health Diagnosis – Z codes

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FY23-24 Pediatric Complex Member Definition: Summary of Changes

Adult Conditions

Remove chronic conditions which primarily affect older adults

Pregnancy

Add in pregnancy to Pediatric Definition only

Overweight

Remove overweight diagnosis as a sign of obesity

Mental Health

Shorten lookback period for anxiety and depression

SDoH

Add in alternative data sources or situations which reflect a complexity to the member's living situation

NEW: FY23-24 Pediatric Complex Member Definition

Regional Pediatric Definition: ≥3 of 8 Chronic Conditions

- Pregnancy
- Diabetes
- Asthma
- SUD – F code diagnosis
- Anxiety or Depression
- Obesity
- Pervasive Developmental Disorder
- Social Determinants of Health Diagnosis – Z codes

PCMP+ & ECP Model Elements

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PCMP+/ECP Sites Only

Complex Member Payment

Complex Claims Engagement

0 = 0-50%
1 = 51-65%
2 = 66-80%
3 = 81-100%

+

Complex Extended Care Coordination (ECC)

0 = 0-10%
2 = 11-25%
4 = 26-49%
6 = 50-100%

FY23-24 Rates

Payment Level	Points	PMPM
None	0	Utilizer Payment
Min	1-3	$5.00
Mid	4-7	$10.00
Max	8-9	$15.00

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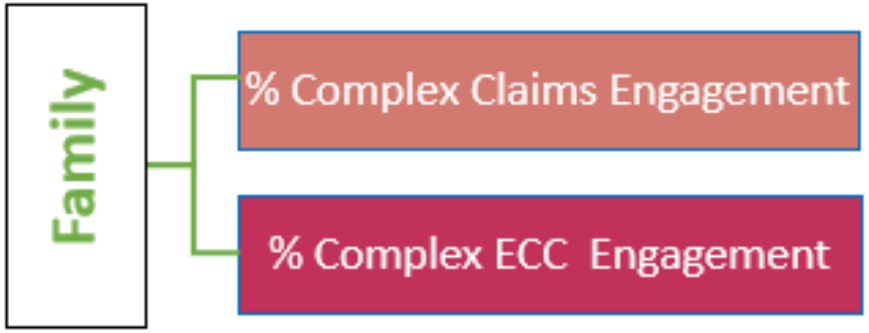
Complex Member Payment Example



Complex Claims Engagement		Complex Extended Care Coordination (ECC)
0 = 0-50% 1 = 51-65% 2 = 66-80% 3 = 81-100%	+	0 = 0-10% 2 = 11-25% 4 = 26-49% 6 = 50-100%

None = Util PMPM	Min = $5.00	Mid = $10.00	Max = $15.00
0 points	1-3 points	4-7 points	8-9 points

67% = 2 **17% = 2**

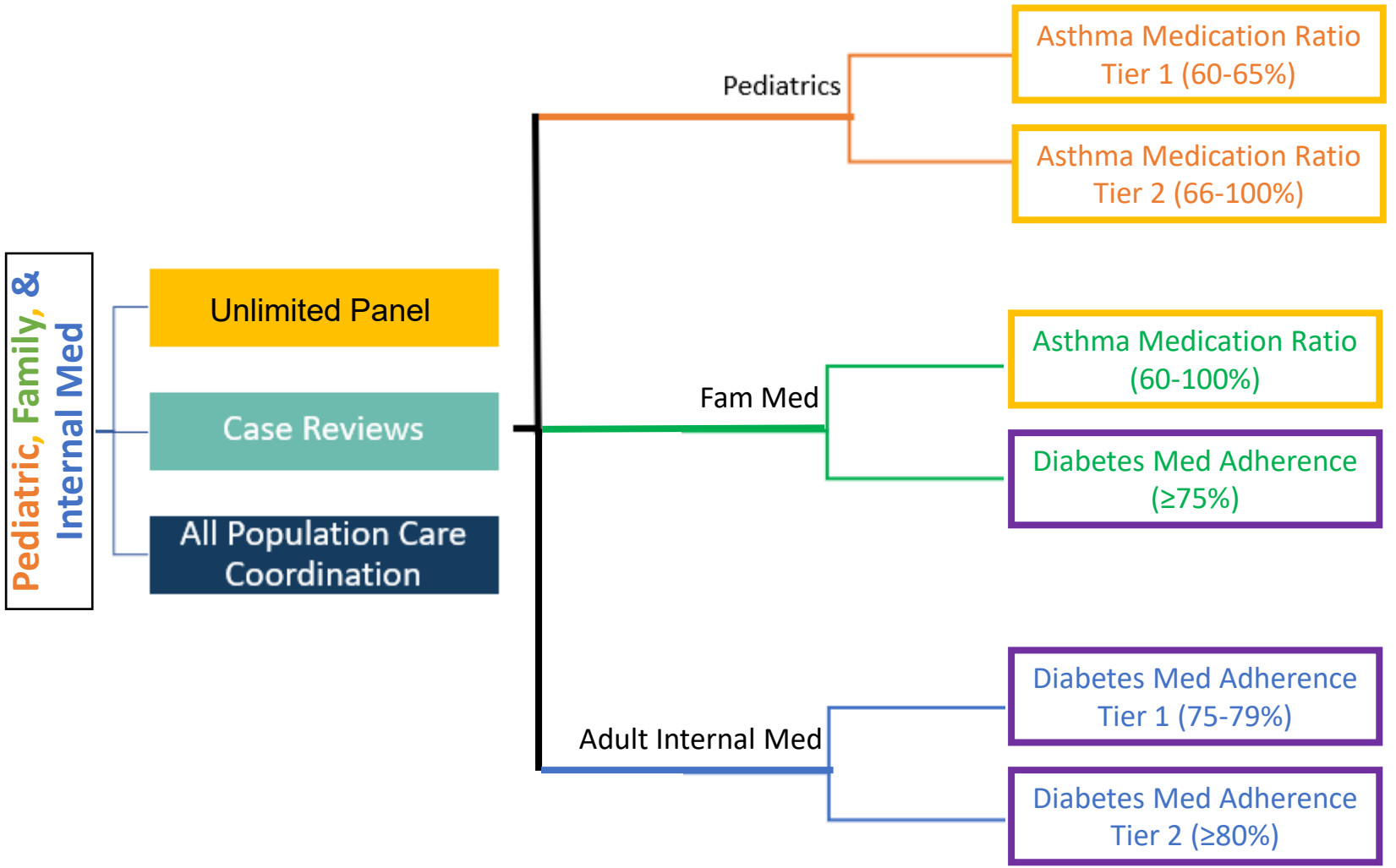
4 = Mid = $10.00 PMPM

Clinic A Complex Rate = $10.00 PMPM

Clinic A Monthly Complex Payment = 145 x $10.00 = $1,450

ECP Sites Only

ECP Care Management Payment Model



CMS Core Measure

Lead Measure to CMS Core

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ECP Sites Only

Family Med: FY 23-24 ECP Care Management Performance Standards

Unlimited Panel

0 = No
1 = Yes

+

Case Reviews

0 = 0-35
1 = 36-40
2 = 41-42

+

All Population Care Coordination

0 = 0-9%
1 = 10-20%
2 = 21-40%
3 = 41-76%
4 = 77-100%

Diabetes Medication Adherence

None = 0-74%
Max = 75-100%

+

Asthma Medication Adherence

None = 0-59%
Max = 60-100%

FY23-24 Rates

Payment Level	Unlimited Panel	Case Reviews	All Pop Care Coord
Min (0-3 pts)	$2.50		
Mid (4-5 pts)	$3.25		
Max (6-7 pts)	$4.00		

Diabetes Med Adherence	Asthma Med Adherence
$0.50	$0.50

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ECP Sites Only

Pediatric: FY 23-24 ECP Care Management Performance Standards

Unlimited Panel

0 = No
1 = Yes

+

Case Reviews

0 = 0-35
1 = 36-40
2 = 41-42

+

All Population Care Coordination

0 = 0-9%
1 = 10-20%
2 = 21-40%
3 = 41-76%
4 = 77-100%

Asthma Medication Adherence

None = 0-59%
Min = 60-65%
Max = 66-100%

FY23-24 Rates

Payment Level	Unlimited Panel	Case Reviews	All Pop Care Coord
Min (0-3 pts)	$2.50		
Mid (4-5 pts)	$3.25		
Max (6-7 pts)	$4.00		

Asthma Med Adherence
$0.50
$1.00

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ECP Sites Only

Internal Med: FY 23-24 ECP Care Management Performance Standards

Unlimited Panel

0 = No
1 = Yes

+

Case Reviews

0 = 0-35
1 = 36-40
2 = 41-42

+

All Population Care Coordination

0 = 0-9%
1 = 10-20%
2 = 21-40%
3 = 41-76%
4 = 77-100%

Diabetes Medication Adherence

None = 0-74%
Min = 75-79%
Max = 80-100%

FY23-24 Rates

Payment Level	Unlimited Panel	Case Reviews	All Pop Care Coord	Diabetes Med Adherence
Min (0-3 pts)	$2.50			$0.50
Mid (4-5 pts)	$3.25			
Max (6-7 pts)	$4.00			$1.00

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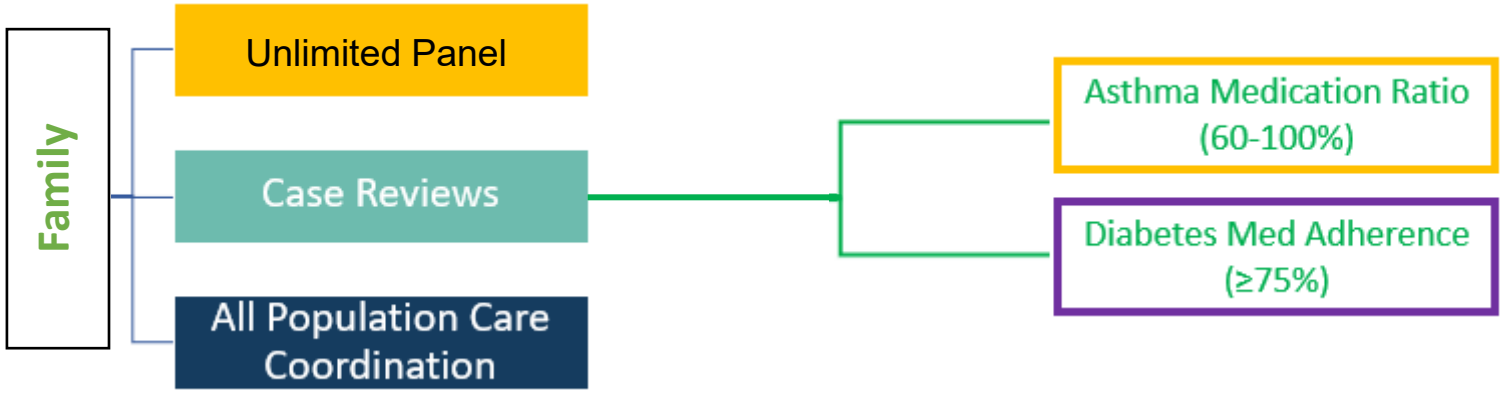
ECP Sites Only

ECP Care Management PMPM Calculation: Family Med Example



Clinic A (ECP) Care Management Rate = $3.50 PMPM

Total Members = 3500 Members

Clinic A (ECP) Monthly Care Management Payment = $12,250.00

Unlimited Panel	Case Reviews	All Population Care Coordination
0 = No 1 = Yes	0 = 0-35 1 = 36-40 2 = 41-42	0 = 0-9% 1 = 10-20% 2 = 21-40% 3 = 41-76% 4 = 77-100%
No = 0 points	**36 = 1 point**	**23% = 2 points**
Min = $2.50	**Mid = $3.25**	**Max = $4.00**
0-3 points	4-5 points	6-7 points
Min (3 points) = $2.50 PMPM		

+

Asthma Medication Adherence	Diabetes Medication Adherence
None = 0-59% Max = 60-100%	None = 0-74% Max = 75-100%
62% = Max	**75% = Max**

Payment Level	Asthma PMPM	Diabetes PMPM
None	$0.00	$0.00
Max	$0.50	$0.50

$0.50 PMPM (Asthma) + $0.50 PMPM (Diabetes)

$1.00 PMPM Add-On

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PCMP+ & ECP Ascension Model

Clinical Group Metrics

Clinical Metrics:

Clinical metrics applicable to provider's model (Family Medicine, Internal Medicine, Pediatrics, and Reproductive Health)

- Depression Screening (all)
- Well-visits first 15 months of life (Peds/Fam Med)
- A1c Testing (Fam Med/Internal Med)
- Well Child 15-30mos (Peds)
- Well Child 3-21yrs[Δ] (Peds/Fam Med)
- Contraceptive Counseling (Reproductive)

Engagement Metrics:

Member/patients engagement rates, calculated as a percentage of an attributed population or sub-group

- Engagement Rate (full panel)
- Complex Claims Engagement Rate
- Complex ECC Engagement Rate
- CM Engagement Rate –all types/full panel (ECPs only)

Δ limited to Pediatric or Family Med providers with fewer than 10 babies in 0-15 or 15-30mos

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SITE ASCENSION & DESIGNATION REVIEW

Performance Requirements 1

1. Achieve **COA 80th percentile** performance on **at least 2 Clinical metrics (9/12 months)**
2. Achieve above COA median performance on **Engagement Rate**
3. Achieve 96% on **Practice Assessment**
4. Achieve COA median performance on **Complex Claims Engagement**
5. Presence of **structural requirements**
6. Agree to **submit CM data**

To become a **PCMP+** (initial year)

2 years as PCMP+

Performance Requirements 2

PCMP+ → ECP (year 3)

1. Maintenance of **Performance Requirements 1**
2. Achieve COA median performance on **Complex Member Extended Care Coordination Rate**
3. Achieve COA median performance on **ECP Medication Adherence Metric(s)**
4. Performance on **Case Reviews & full ECP assessment**

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Structural Gate Measures

- Integrated in-person/virtual behavioral health services
- Established quality improvement program
- Care management resources/best practices
- Care management reporting capabilities

NEW! Infrastructure Investment Payments

PCMP providers (non-ECPs) that qualify for ascension based on 80th percentile performance on 2 or more clinical metrics are eligible to apply for our new infrastructure investment program

Decision: Interest in ascension to PCMP+ VS No Interest in ascension

Investment may fund:

- Integrated in-person/virtual behavioral health services
- Established quality improvement program
- Care management resources/best practices
- Care management reporting capabilities

Investment may fund:

- Integrated in-person/virtual behavioral health services
- Established quality improvement program

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Vulnerable Populations Provider Support Payment

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Purpose

The Vulnerable Populations Provider Support Payment awards funding to Primary Care Medical Providers (PCMPs) in RAE Regions 3 and/or 5 that seek to reduce health disparities, improve clinical outcomes, enhance the member experience, and reduce inappropriate utilization of healthcare services by increasing access to enhanced care for vulnerable populations.

Goal

To fund enhanced care projects that would aid PCMPs in better serving vulnerable populations. Proposals must identify and report on outcomes that will lead to improved health for vulnerable populations.

Examples

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 Indian and Alaskan Native
- Other marginalized groups

Enhanced Care

- 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

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Eligibility Criteria

1. Region 3 and/or Region 5 PCMPs participating in a Colorado Access Administrative Payment Model.

2. PCMPs should have onsite staffing and/or supports in place to administer the enhanced care project. The intent of these funds is not to support off site referrals to care or community organizations.

3. Funds must be dedicated towards improving access to enhanced care for vulnerable populations.

4. Able to provide attestation of culturally responsive care training for staff at the organization.

Funding Amounts & Requirements

Tier 1 Payment ($200,000)

- Funds are to be used for support of a new or ongoing enhanced care project.
- The enhanced care project has previous results or baselines to improve upon.
- Project includes the reporting of two (2) outcome measures (1 clinical and 1 social).

Tier 2 Payment ($100,000)

- Funds are to be used for support of a new or ongoing enhanced care project.
- The enhanced care project has previous results or baselines to improve upon.
- Project includes the reporting of one (1) outcome measure (clinical or social).

Tier 3 Payment ($50,000)

- Funds are to be used for support of a new enhanced care project.
- The enhanced care project does not have established baseline measurements or outcome measures.

- Successful proposals may be funded up to $200,000 total per TIN* for a 1 year period. Receipt of support funds are not an indication of future funding awards.

*A maximum of one (1) proposal may be awarded per TIN. If more than one proposal is received per TIN, the proposal with the greatest potential to increase access to enhanced care for vulnerable populations will be prioritized to receive support.

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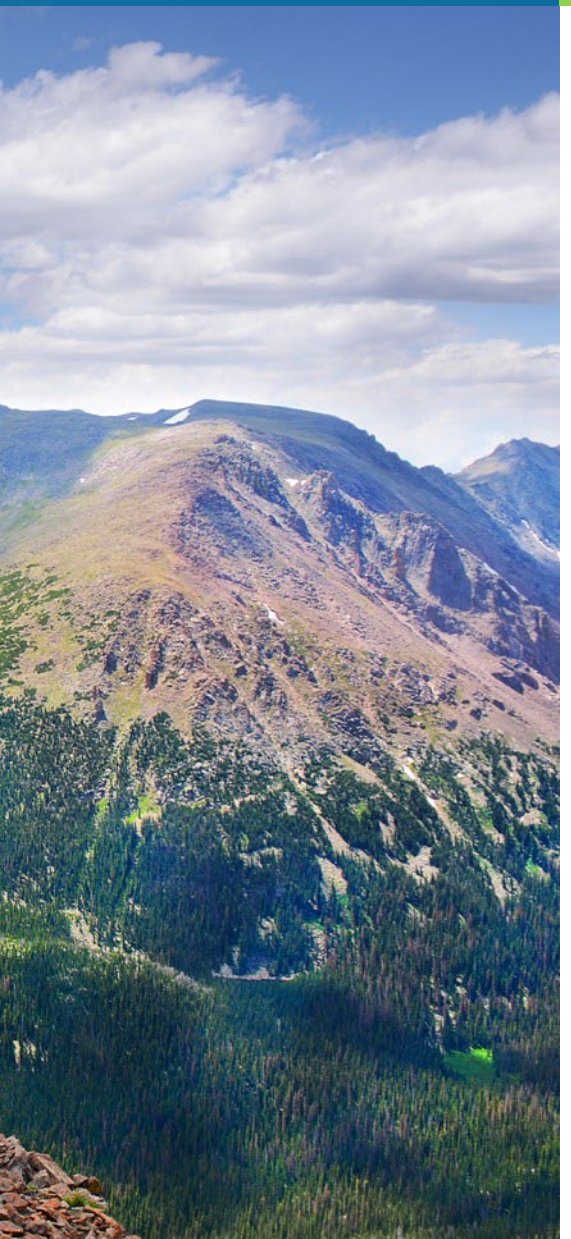
Reporting Requirements – Due Year End

1. Final written report with a description of how the project was implemented and if the objectives were met.

2. Submission of 2-3 member experience vignettes based upon the enhanced care project implemented during the year.

3. Outcome reporting



Evaluation Criteria & Application Process

- Proposals will be evaluated on the:
  - Relevance to reducing health disparities, improving clinical outcomes, enhancing the member experience, and reducing inappropriate utilization of healthcare services by increasing access to enhanced care for vulnerable populations.
  - Ability to track and report on outcome measures and the population being served by the project.

- RFP and application has been posted on the Value-Based Payments page of the COA website

- Proposals and supporting documentation must be submitted in a single email by **5 PM MST on July 31st**

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Vulnerable Populations Provider Support Payment Timeline

5 PM MST
July 31, 2023

- Proposals and supporting documentation due

August 2023

- Review of proposals

September 2023

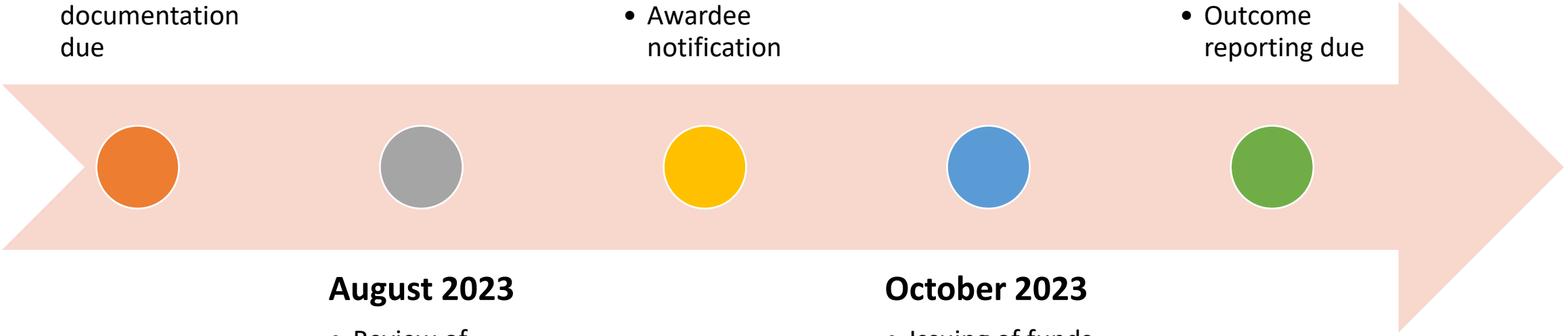
- Awardee notification

October 2023

- Issuing of funds

December 2024

- End of year reporting requirements due
- Outcome reporting due



APM 2 Early Adoption Incentive

- TINs that join HCPF's APM 2 program during SFY23-24 are eligible for a one-time incentive payment of $10,000.
- New participating TINs will be collected quarterly. Funds will be paid out by COA on the following cadence:
  - October 2023
  - January 2024
  - April 2024
  - July 2024

Questions after today should go to:

- Janet Milliman (Director of Payment Reform)
  Janet.milliman@coaccess.com

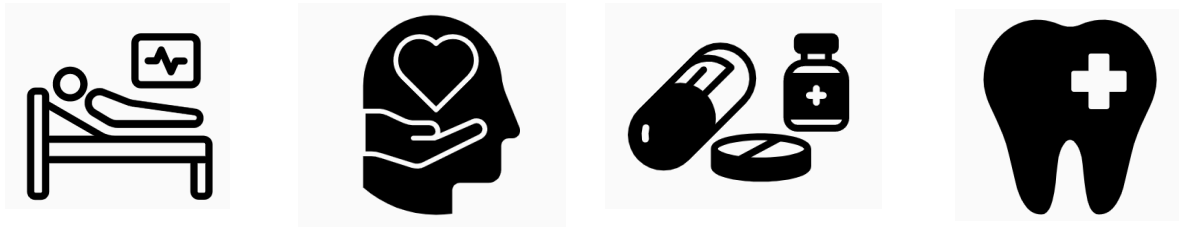
- Your Practice Facilitator
  Practice_Support@coaccess.com

- www.coaccess.com/providers/resources/vbp
  - Administrative Payment Model Program Documents
  - Administrative Payment Model Measure Specs
  - Vulnerable Populations Provider Support Payment
  - Pay-for-Performance Incentive Sharing Program Document

Appendix

Terminology

Utilizer PMPM



Attributed patients that have had at least 1 claim of any kind within the Medicaid system in the previous 18 months

Provider will receive their Utilizer PMPM for each utilizer

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Terminology

Non-Utilizer PMPM

Non-utilizer

attributed patients that have not had any kind of claim within the Medicaid system in the previous 18 months

Providers will receive $0.50 PMPM for each non-utilizer

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Engagement Rate Calculation

$$\textbf{Engagement Rate} = \frac{\text{\# Engaged attributed patients}}{\text{Total \# of attributed patients}}$$

*Number of attributed patients in the last month of the calendar year
Engagement rate are calculated annually.

PCMP Practice Assessment = Addendum 1 Compliance

Assesses for the Elements of a Patient Centered Medical Home

1) Member access – extended hours, 24/7 phone coverage
2) Referral processes – medical, behavioral, community
3) Use of standardized screening tools
4) Identification of special populations (complex needs)

Positive Depression Screen Follow-up Plan

Follow-up Plan Requirements:
Documented follow-up for a **positive depression screening** *must* include one or more of the following:

- Referral to a practitioner for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen,
- Pharmacological interventions, or
- Other interventions or follow-up for the diagnosis or treatment of depression.

Examples of qualifying follow-up plans include but are not limited to:

- Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

The documented follow-up plan must be related to the positive depression screen.

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Additional Resources – Follow Up After a Positive Depression Screen

- **Colorado Access Behavioral Health Care Management Team:** bhcaremanagement@coaccess.com
- **Colorado Access Behavioral Health Practice Facilitators:** Bhoperations@coaccess.com
- If you are interested in becoming a **Virtual Care Collaboration and Integration (VCCI) Program** partner, please contact George Roupas at George.Roupas@coaccess.com

  Colorado Access members are eligible to receive telebehavioral health services through the VCCI program, which is offered by AccessCare services, the virtual care delivery arm of Colorado Access. AccessCare Services helps increase access to behavioral health for contracted Colorado Access primary care practices by taking referrals from practices that agree to work with them. VCCI services are offered at no cost to all Colorado Access contracted primary care practices, and can be provided with minimal setup. AccessCare Services is comprised of virtual psychiatrists and clinically licensed therapists that provide pharmacologic and therapeutic interventions over telehealth. VCCI services can be rendered in the primary care setting and/or in the patient's home.

All Models 2023 Spec Change – Depression Screen (Engaged Members)

FY22-23 Spec

Denominator: All engaged members age 12 and older at the beginning of the measurement period with at least one eligible outpatient encounter during the measurement period.

Numerator: Engaged members age 12 and older who received a depression screen as indicated by **G8431** (screening for depression is documented as being positive and a follow-up plan is documented) or **G8510** (screening for depression is documented as negative, a follow-up plan is not required) in an outpatient setting.

FY23-24 Spec

HCPF Billing Rule: Beginning **July 1, 2023**, a billing modifier on ALL depression screens delivered to Members using G8431 or G8510 will be required.

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

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.

Exclusions: Screens billed with unique **modifier U2 or U3**.

Fam/Internal Med Models

2023 Spec Change – A1c Testing

Measure Description: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

FY22-23 Spec

Denominator: Members ages 18-75 on the COA diabetes registry at the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) within the last three years.

Numerator: Members who had an HbA1c test (CPT codes 3044F, 3046F, 3051F, 3052F, 83036, or 83037) during the measurement period.

FY23-24 Spec

Denominator: Members ages 18 to 75 at the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. **Members with diabetes are identified through claim and pharmacy data.**

Numerator: Members who had an HbA1c test (CPT codes 3044F, 3046F, 3051F, 3052F, 83036, or 83037) during the measurement period.

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Reproductive Health Model

2023 Spec Change – Contraceptive Care Postpartum Women

FY22-23 Spec

Denominator: The eligible population includes women ages 15 to 44 who had a live birth in the measurement period.

Numerator: Members that were provided a most or moderately effective method of contraception within 60 days of delivery.

FY23-24 Spec

Denominator: The eligible population includes women ages 15 to 44 who had a live birth in the measurement period.

Numerator: Members that were provided a most or moderately effective method of contraception **within 90 days of delivery.**

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Fam Med Model | 2024 Metric Change – Well-visits 15-30 months

FY23-24 Spec (W15)

Measure Description: Children who turned 15 months old during the measurement year with 6 or more well-child visits on different dates of service on or before the 15-month birthday

	Newborn	3-5 days	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo
Visit Opportunities	•	•	•	•	•	•	•	•

FY24-25 Spec (W30)

FY24-25 Measure Description: Children who turned 30 months old during the measurement year with 2 or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.

Denominator: Children who turn 30 months old during the measurement period.

Numerator: Number of members who had **two or more visits** on different dates **between the child's 15-month birthday and 30-month birthday.**

	15 mo	18 mo	24 mo	30 mo
Visit Opportunities	•	•	•	•

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Fam/Internal Med Models

2024 Metric Change – HbA1c Control (HBD)

FY24-25 Measure Description: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose HbA1c was at <8.0% during the measurement year.

FY23-24 Spec

Denominator: Members ages 18 to 75 at the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. Members with diabetes are identified through claim and pharmacy data.

Numerator: Members who had an HbA1c test (CPT codes 3044F, 3046F, 3051F, 3052F, 83036, or 83037) during the measurement period.

FY24-25 Spec

Denominator: Members ages 18 to 75 who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. Members with diabetes are identified through claim and pharmacy data.

Numerator: Members whose most recent HbA1c level is <8.0% during the measurement period. **CPT Category II codes to identify numerator compliance include:**

- Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (3051F)
- Most recent hemoglobin A1c (HbA1c) level less than 7.0% (3044F)

The member is not numerator compliant if the testing claim is missing a result, the result for the most recent HbA1c test is ≥8.0%, or if an HbA1c test was not done during the measurement year.

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SDOH ICD-10 Code Definition

ICD Code	Description
Z550	ILLITERACY AND LOW-LEVEL LITERACY
Z551	SCHOOLING UNAVAILABLE AND UNATTAINABLE
Z552	FAILED SCHOOL EXAMINATIONS
Z553	UNDERACHIEVEMENT IN SCHOOL
Z554	EDUCATIONAL MALADJUSTMENT AND DISCORD WITH TEACHERS AND CLASSMATES
Z555	LESS THAN A HIGH SCHOOL DIPLOMA
Z558	OTHER PROBLEMS RELATED TO EDUCATION AND LITERACY
Z559	PROBLEMS RELATED TO EDUCATION AND LITERACY, UNSPECIFIED
Z560	UNEMPLOYMENT, UNSPECIFIED
Z561	CHANGE OF JOB
Z562	THREAT OF JOB LOSS
Z563	STRESSFUL WORK SCHEDULE
Z564	DISCORD WITH BOSS AND WORKMATES
Z565	UNCONGENIAL WORK ENVIRONMENT
Z566	OTHER PHYSICAL AND MENTAL STRAIN RELATED TO WORK
Z568	OTHER PROBLEMS RELATED TO EMPLOYMENT
Z569	UNSPECIFIED PROBLEMS RELATED TO EMPLOYMENT
Z570	OCCUPATIONAL EXPOSURE TO NOISE
Z571	OCCUPATIONAL EXPOSURE TO RADIATION
Z572	OCCUPATIONAL EXPOSURE TO DUST
Z573	OCCUPATIONAL EXPOSURE TO OTHER AIR CONTAMINANTS
Z574	OCCUPATIONAL EXPOSURE TO TOXIC AGENTS IN AGRICULTURE
Z575	OCCUPATIONAL EXPOSURE TO TOXIC AGENTS IN OTHER INDUSTRIES
Z576	OCCUPATIONAL EXPOSURE TO EXTREME TEMPERATURE
Z577	OCCUPATIONAL EXPOSURE TO VIBRATION
Z578	OCCUPATIONAL EXPOSURE TO OTHER RISK FACTORS
Z579	OCCUPATIONAL EXPOSURE TO UNSPECIFIED RISK FACTOR
Z586	INADEQUATE DRINKING-WATER SUPPLY
Z590	HOMELESSNESS
Z591	INADEQUATE HOUSING
Z592	DISCORD WITH NEIGHBORS, LODGERS AND LANDLORD
Z593	PROBLEMS RELATED TO LIVING IN RESIDENTIAL INSTITUTION
Z594	LACK OF ADEQUATE FOOD
Z595	EXTREME POVERTY
Z596	LOW INCOME
Z597	INSUFFICIENT SOCIAL INSURANCE AND WELFARE SUPPORT
Z598	OTHER PROBLEMS RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES
Z599	PROBLEM RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES, UNSPECIFIED
Z600	PROBLEMS OF ADJUSTMENT TO LIFE-CYCLE TRANSITIONS
Z602	PROBLEMS RELATED TO LIVING ALONE
Z603	ACCULTURATION DIFFICULTY
Z604	SOCIAL EXCLUSION AND REJECTION
Z605	TARGET OF (PERCEIVED) ADVERSE DISCRIMINATION AND PERSECUTION
Z608	OTHER PROBLEMS RELATED TO SOCIAL ENVIRONMENT
Z609	PROBLEM RELATED TO SOCIAL ENVIRONMENT, UNSPECIFIED
Z620	INADEQUATE PARENTAL SUPERVISION AND CONTROL
Z621	PARENTAL OVERPROTECTION
Z622	UPBRINGING AWAY FROM PARENTS
Z6222	CHILD IN FOSTER CARE
Z623	HOSTILITY TOWARDS AND SCAPEGOATING OF CHILD
Z626	INAPPROPRIATE (EXCESSIVE) PARENTAL PRESSURE
Z628	OTHER SPECIFIED PROBLEMS RELATED TO UPBRINGING
Z629	PROBLEM RELATED TO UPBRINGING, UNSPECIFIED
Z630	PROBLEMS IN RELATIONSHIP WITH SPOUSE OR PARTNER
Z631	PROBLEMS IN RELATIONSHIP WITH IN-LAWS
Z633	ABSENCE OF FAMILY MEMBER
Z634	DISAPPEARANCE AND DEATH OF FAMILY MEMBER
Z635	DISRUPTION OF FAMILY BY SEPARATION AND DIVORCE
Z636	DEPENDENT RELATIVE NEEDING CARE AT HOME
Z637	OTHER STRESSFUL LIFE EVENTS AFFECTING FAMILY AND HOUSEHOLD
Z638	OTHER SPECIFIED PROBLEMS RELATED TO PRIMARY SUPPORT GROUP
Z639	PROBLEM RELATED TO PRIMARY SUPPORT GROUP, UNSPECIFIED
Z640	PROBLEMS RELATED TO UNWANTED PREGNANCY
Z641	PROBLEMS RELATED TO MULTIPARITY
Z644	DISCORD WITH COUNSELORS
Z650	CONVICTION IN CIVIL AND CRIMINAL PROCEEDINGS WITHOUT IMPRISONMENT
Z651	IMPRISONMENT AND OTHER INCARCERATION
Z652	PROBLEMS RELATED TO RELEASE FROM PRISON
Z653	PROBLEMS RELATED TO OTHER LEGAL CIRCUMSTANCES
Z654	VICTIM OF CRIME AND TERRORISM
Z655	EXPOSURE TO DISASTER, WAR AND OTHER HOSTILITIES
Z658	OTHER SPECIFIED PROBLEMS RELATED TO PSYCHOSOCIAL CIRCUMSTANCES
Z659	PROBLEM RELATED TO UNSPECIFIED PSYCHOSOCIAL CIRCUMSTANCES

Clinical Metric Performance Requirements

SFY23-24 Performance Requirements 1: PCMP → PCMP+		
Metric	**Model**	**Performance Requirement Example**
Depression Screening	All	80th Percentile (~48%)
Well-visits 0-15 months	Peds/Fam Med	80th Percentile (~72%)
A1c Testing	Fam Med/Internal Med	80th Percentile (~86%)
Well-visits 15-30 months	Peds	80th Percentile (~71%)
Well-visits 3-21 years$^{\Delta}$	Peds/Fam Med	80th Percentile (~47%)
Contraceptive Counseling	Reproductive	80th Percentile (~15%)
Engagement Rate	All	Median (~38%)
Practice Assessment Score	All	96%
Complex Claims Engagement	All	Median (~67%)

Δ limited to Pediatric or Family Med providers with fewer than 10 babies in 0-15 or 15-30mos.

Clinical metric performance must be achieved for 9 of 12 months.

Denominators below 10 have been excluded from these calculations.

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Clinical Metric Performance Requirements

SFY23-24 Performance Requirements 2: PCMP+ → ECP		
Metric	**Model**	**Performance Requirement Example**
Maintenance of Performance Requirements 1	All	See previous slide
Complex Member Extended Care Coordination	All	Median (42%)
Diabetes Medication Adherence	Fam Med/Internal Med	Median (69%)
Asthma Medication Adherence	Peds/Fam Med	Median (53%)
Case Review Score	All	38 points
ECP Assessment Score	All	95 points

Clinical metric performance must be achieved for 9 of 12 months.

Denominators below 10 have been excluded from these calculations.

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HEDIS/COA Percentiles 2022

Engagement Rate

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Fam Med/Int Med/Rep	5.00%	10.00%	20.00%	28.00%	38.00%	49.00%	53.25%	62.50%	68.25%
COA percentiles:	Peds	13.00%	25.00%	41.50%	47.00%	55.00%	62.00%	64.00%	69.20%	73.00%

Well-Visits in the First 15 Months of Life

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Peds/Fam Med	40.00%	46.60%	55.50%	59.00%	64.50%	68.58%	71.00%	78.00%	83.35%
HEDIS percentiles:	Peds/Fam Med	29.52%	40.74%	49.82%	51.38%	55.64%	58.66%	61.19%	67.56%	71.51%

Well-Visits 15-30 Months of Life

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Peds/Fam Med	40.00%	46.60%	55.50%	59.00%	64.50%	68.58%	71.00%	78.00%	83.35%
HEDIS percentiles:	Peds/Fam Med	49.78%	54.43%	60.53%	62.09%	65.89%	70.08%	72.40%	78.09%	82.75%

Child & Adolescent Well-Visits (Age 3-21)

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Fam Med/Peds	16.20%	17.40%	22.00%	25.00%	30.00%	37.64%	40.00%	46.00%	50.00%
HEDIS percentiles:	Peds	31.95%	36.94%	43.50%	45.73%	48.94%	53.47%	57.54%	62.74%	68.88%

Depression Screening

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Fam Med/Int Med/Repro	0.00%	1.00%	1.00%	2.00%	3.00%	6.00%	14.00%	34.50%	64.25%
COA percentiles:	Peds	8.70%	18.00%	35.50%	41.14%	50.00%	60.14%	63.25%	72.00%	75.00%

Hemoglobin A1c Testing

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Fam Med/Internal Med	61.00%	66.00%	72.00%	75.00%	79.00%	82.00%	84.00%	89.80%	92.00%
HEDIS percentiles:	Fam Med/Internal Med	77.37%	79.44%	82.73%	84.18%	85.89%	87.55%	88.32%	90.51%	91.73%

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HEDIS/COA Percentiles 2022

Contraceptive Counseling (Women Age 15-44)

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Repro	8.00%	8.00%	8.00%	8.96%	13.00%	13.92%	17.00%	26.20%	29.00%

Contraceptive Care – Postpartum Women Age 15-44

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Repro	0.00%	0.00%	0.00%	0.00%	25.00%	33.00%	40.00%	88.80%	100.00%

Complex Member Claims Engagement

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Complex Member	0.00%	10.50%	51.00%	59.41%	67.50%	78.00%	81.75%	94.90%	100.00%

Complex Member Extended Care Coordination

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	Complex Member	0.00%	0.00%	13.25%	22.82%	42.00%	59.82%	65.75%	81.00%	100.00%

All Population Care Coordination

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	ECP Care Management	3.80%	8.80%	19.50%	23.42%	40.00%	64.00%	71.50%	79.60%	82.30%

Asthma Medication Adherence

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	ECP Care Management: Fam Med/Peds	36.20%	38.80%	47.00%	49.00%	53.00%	57.00%	59.00%	63.60%	64.00%
HEDIS percentiles:	ECP Care Management: Fam Med/Peds	51.35%	54.60%	59.94%	61.48%	64.30%	68.21%	69.74%	74.27%	77.68%

Diabetes Medication Adherence

Percentile Levels:	Model(s)	5%	10%	25%	33%	50%	66%	75%	90%	95%
COA percentiles:	ECP Care Management: Fam Med/Int Med	59.45%	61.80%	66.00%	66.57%	68.50%	71.14%	72.75%	75.10%	76.00%

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