COLORADO ACCESS

Medical Home Payment Model

FY 2025-26 PROGRAM DOCUMENT

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Contents

I. Background:

Colorado Access (COA), as the Regional Accountable Entity (RAE) of Colorado Region 4, is tasked with building and managing a robust network of primary care medical providers (PCMPs) that serve as medical homes to Health First Colorado Members (Colorado's Medicaid Program). COA aims to create programming that incentivizes medical home practices to employ methods that allow Health First Colorado members to receive high-quality primary care services, grounded in best practices, which result in the best possible health outcomes.

Medical Home Payments are per-member-per-month (PMPM) payments from RAEs to support the PCMP role as a medical home for Health First Colorado members. This payment focuses on building and maintaining advanced primary care activities such as care coordination, integrated behavioral health services and population health management.

II. All-Network Provider Site Payments:

A site's overall medical home payment is determined according to performance or eligibility on the following components as set forth and standardized by Healthcare Policy and Financing (HCPF):

- PCMP Practice Assessment
- Integrated Behavioral Health Payment
- Care Coordination Partner Payment
    - Tier 3 Member Acuity
- PCMP Access Stabilization Payment
    - Pediatric Providers
    - Small Providers

PCMP Practice Assessment: All provider site types are eligible for the PCMP Practice Assessment payment. Providers complete a points-based assessment to determine their placement on the continuum of advanced primary care.

The three tiers are designed to recognize a site's varying experience in value-base care aligning with the Center for Medicare and Medicaid Services CMS) Making Care Primary (MCP) three-track model and Division of Insurance (DOI) House Bill 22-1325 Aligned Primary Care Alternative Payment Model Regulation. **Tier 1** practices are beginning their advanced primary care journey, while **Tier 3** practices reflect the competencies of an advanced practice. There are criteria that practices must pass in order to qualify for Tier 2 and Tier 3 PMPMs. If all "must pass" criteria are

not met, then a practice will fall into Tier 1, regardless of the points received. If a practice is an accredited Patient Centered Medical Home (PCMH) recognized by the National Committee for Quality Assurance (NCQA) or Association for Ambulatory Health Care (AAAHC) and all "must pass" criteria have been met, the practice will be considered Tier 3. For practices that are NCQA PCMH recognized or AAAHC accredited but do not meet all "must pass" criteria, the practice will be considered Tier 2. Practices will be required to complete a full assessment annually.

Practices must submit a new, updated full assessment if there are significant changes to the practice that impact its operations or quality of care. Some examples of significant changes include, but are not limited to: hiring a designated Care Coordinator, Behavioral Health Provider, or other key clinical staff, losing a Behavioral Health Provider, practice acquisition by a health system or larger organization, implementation of a new electronic health record (EHR) system, or receiving PCMH recognition. If any of these or other major changes occur, the practice will submit a full new assessment within 30 calendar days of the significant change to reflect the current structure and capabilities of the practice. A comprehensive reassessment and audit will be conducted upon receiving the updated assessment reflecting the recent changes. If the changes are found to affect payments, any adjustments will apply only to future payments.

Practices will be identified for an audit based on select criteria. For the audit, practices will be required to submit evidence for the criteria attested to as outlined in the practice assessment. Failure to comply in the audit process may result in modification to tiering status, corresponding payment and could impact eligibility to participate in value-based contracts.

If a PCMP declines to engage with a RAE and fails to turn in the practice assessment, practice assessment PMPM will be reduced.

Individual site responses and copies of the assessment tool are available from the practice support team at practice_support@coaccess.com upon request.

PCMP Practice Assessment Scoring

Level	Assessment Points	PMPM Amount
Tier 1 - Incomplete	0	$0.50
Tier 1	1-33	$1.00
Tier 2	34-66	$1.50
Tier 3 or PCMH Certified*	67-100	$3.00

*PCMH certified providers must pass all "must pass" criteria or they are Tier 2

Integrated Behavioral Health: Qualifying providers are identified via the completion of the PCMP

Practice Assessment. These provider sites will receive additional payment for delivering highly integrated care (Level 3) if they meet all standards for integration of primary care and behavioral health as outlined in the Practice Assessment. A practice must have an established relationship with a clinician available onsite or via telehealth to patients on site who is **readily available** to provide brief interventions for behavioral health conditions. Practice sites must utilize a **single integrated health record** to consolidate a patient's physical and behavioral health information. Lastly, the practice site must have an identified interdisciplinary **team of champions** for advancing Integrated behavioral health programming and continuous quality of care.

Integrated Behavioral Health PMPM	
Level	**PMPM Amount**
Does not Meet IBH Criteria	$0.00
Meets IBH Criteria	$1.10

Care Coordination Partner Payment*:* A subset of provider site types called Care Coordination Partners (CCPs), are eligible to receive additional funding to support the provision of care coordination services to their attributed membership. Provider payment is contingent on:

- Being contracted with Colorado Access to provide delegated care coordination services,
- The individual site's ability to care manage their attributed membership, based on NCQA care coordination standards *and*
- Report care coordination and care plan activities back to the RAE quarterly in a required format.

Eligibility for Coordination Partner Payments will be reviewed annually. Care Coordination Partner practices will participate in biannual audits aligned with NCQA's Complex Case Management standards, specifically focusing on:

- **Identification and Assessment**: Evaluating processes for identifying eligible members and conducting comprehensive assessments.
- **Care Planning**: Reviewing the development of individualized care plans that address members' unique needs.
- **Care Monitoring**: Assessing ongoing monitoring activities to track members' progress and adjust care plans as necessary.
- **Care Coordination**: Examining coordination efforts among various care providers to ensure seamless service delivery.

Performance in these audits will directly impact the ongoing eligibility to maintain Care Coordination Partner status.

Care Coordination Partner PMPM	
Level	**PMPM Amount**
CCP Adult/Fam/Int Medicine	$4.50
CCP Pediatrics	$3.50

Tier 3 Member Acuity Payment: Care Coordination Partners (CCPs), are eligible to receive the Tier 3 Member Acuity PMPM to incentivize the establishment of longitudinal centralized care coordination and care management for Members with high acuity needs. The following care coordination performance standards need to be met and will be used to evaluate care management effectiveness:

- Ensure that at least 25 care plans per 1,000 assigned members per year are created for members eligible for Tier 3 Care Management.
- Maintain the Hospital All-Cause Readmission rate for Tier 3 Care Management members at or below the previous three-year average.
- Improve emergency department (ED) visit performance for members eligible for Tier 2 Care Coordination and Tier 3 Care Management, following an agreed-upon annual improvement methodology.
- Maintain the dental visit engagement rate at or above the previous three-year average.

Tier 3 Member PMPM	
Level	**PMPM Amount**
Tier 3 Members	*

*The member acuity PMPM will be applied to Tier 3 members. While the specific population for this Tier is still being determined, it will be finalized June 1, 2025.

PCMP Access Stabilization Payments: RAEs will serve as a pass through for Access Stabilization payments. These payments are a dedicated pool of funds, directed to specific types of PCMPs who have been unable to participate in value-based payments in the past due to their population size or type. Colorado Access will distribute access stabilization payments to **HCPF identified PCMPs**.

Access Stabilization Payments applicable to Region 4 providers include those for:

1. Small PCMPs – Independent practices who are operating with one to five individual providers.
2. Pediatric PCMPs – Practices where more than 80% of the members served are 0-18 years old.

Providers that qualify for more than one of these categories will only receive one Access Stabilization Payment. As of April 1, 2025, the Colorado legislature has advanced this budget resolution. However, the long bill still requires the governor's signature. If it is not signed, the requested payment of $2.51 PMPM will not be issued.

Medical Home Payment Example:

Provider X is a Family Med Provider that has a total attributed membership of 1,900 at the end of December 2024.

Provider X completed the practice assessment and met the qualifications for an integrated behavioral health provider according to the practice assessment.

Payment Category	PMPM Rate	Applicable Members	Total Monthly Payment
Base Tier 3 Payment	$3.00	1,900	$5,700
Integrated Behavioral Health (IBH) Payment	$1.10	1,900	$2,090
Total Monthly Payment			**$7,790**

III. Glossary

ACC Phase 3 Attribution. As applicable to the RAE, those members attributed to the provider by the State under a benefit program or otherwise provided for under the RAE and based on claims history. The number of members attributed to a provider is subject to periodic adjustment by HCPF.

Care Management/Care Coordination. The deliberate organization of Member care activities between two or more participants (including the Member and/or family members/caregivers) to facilitate the appropriate delivery of physical health, Behavioral Health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, and other services. Care Coordination may range from deliberate Provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs.

Health First Colorado. Colorado's Medicaid program. It was re-named July 1, 2016.

Medical Home. An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers, and where appropriate, the member's family.

Patient Centered Medical Home (PCMH). If recognized by an official entity, PCMPs shall provide copies of certification or accreditation as a patient-centered medical home (PCMH). Recognition,

certification, or accreditation as a PCMH may be granted by any of the following entities:

- National Committee for Quality Assurance (NCQA)
- Accreditation Association for Ambulatory Healthcare (AAAHC)

Per Member Per Month (PMPM). A fixed reimbursement methodology for a provider, for attributed members, paid monthly.

PCMP Practice Assessment Score. The score that resulted from each practice site's most recent PCMP Practice Assessment evaluation in accordance with CMS's Making Care Primary (MCP) three-track model and DOI HB 22-1325 Aligned Primary Care APM Regulation.

Primary Care Medical Provider (PCMP). A physician who is a participating provider and who is responsible for coordinating and managing the delivery of covered services to members. In addition, PCMPs are defined by the following services provided: health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). PCMPs are PCPs who provide additional services to members. As applicable to the RAE, a PCMP is contracted with a RAE to participate in the Accountable Care Collaborative (ACC) as a network provider and may be an M.D., D.O., or a N.P., and is a specialist in one of the following: family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, community mental health center, HIV/infectious disease. PCMPs must provide definitive care to the undifferentiated patient at the point of first contact and take continuing responsibility for providing the patient's comprehensive care, with the majority of patient concerns and needs being cared for in the primary care practice itself.

RAE Assigned Member. Under ACC Phase III members without a claim history to a PCMP will be attributed to the RAE.

Reattribution. The process of attributing a Member to a new PCMP based upon new information (e.g., claims information). Reattribution will occur quarterly.