COLORADO ACCESS ADMINISTRATIVE PAYMENT MODEL PROGRAM FY 2021-2022

FY 2021-22 | A Performance-Based Payment Program

I. Background:

Colorado Access (COA), as the Regional Accountable Entity (RAE) of Colorado Regions 3 and 5, is tasked with building and managing a robust network of primary care medical providers (PCMPs) that serve as patient-centered 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.

The patient-centered medical home (PCMH) model is, to date, considered the vehicle that delivers the highest quality of primary care for patients with one or more chronic conditions[1]. Preliminary evidence also shows that the PCMH model produces better clinical outcomes, higher adherence and lower emergency department utilization for low-income populations[2].

Colorado Access collaborates and consults with network providers regularly prior to the creation or modification of every component of our value based payment models. Stakeholder meetings are held approximately 6 to 8 months prior to a new model's inception where new ideas for the model are vetted by providers to ensure that the model is fair (rewards high performance, is not unfairly punitive and does not inadvertently include perverse incentives), administratively manageable (minimally burdensome), and progressively focused on improving member health and outcomes.

II. Evolution of COA's Administrative Payment Model Program:

Phase 1: The first phase of COA's PCMP Administrative Payment Model was the implementation of a $3.00 per member per month payment that incentivized providers to open their panels to Health First Colorado members, allowing all members to be assigned to a medical home. This phase was in place from July 1, 2018 through December 31, 2020.

Phase 2: The second phase of the PCMP Administrative Payment Model includes the introduction of member classifications: **utilizers**, **non-utilizers** and **complex members**. The Utilizer per member per month (PMPM) payment is based on a provider's proportional engagement with their attributed member panel (engagement rate score) as well as the presence of medical home best practices, as outlined in Addendum 1 of the PCMP contracts (practice assessment score). These two scores blend together to determine provider site's Utilizer PMPM payment. A $0.50 PMPM add-on payment to the Utilizer PMPM was awarded to all providers that participate in HCPF's Alternative Payment Model (APM) program.

1. Jackson GL, Powers BJ, Chatterjee R, et al. The patient centered medical home. A systematic review. *Annals of Internal Medicine* 2013 Feb 5; 158(3):169-78.
2. Van den Berk-Clark C, Doucette E, Rottnek F, et al. Do patient-centered medical homes improve health behaviors, outcomes, and experiences of low-income patients? A systematic review and meta-analysis. *Health Services Research* 2018. Jun; 53(3):1777-1798.

The PCMP+ provider tier was also introduced in Phase 2. These are providers that perform well on engagement rate and practice assessment scores and demonstrate that they have the clinical and reporting capabilities to care manage their attributed complex members and send a summary of their care management activities to the RAE in a required report format. These providers, as well as all ECP providers, receive $5.00 PMPM base for all complex members and an additional PMPM payment for each Complex Member they engage with in the previous 12 months (**complex claims engagement rate**). This phase of the model was put into place January 1, 2021 and will continue through June 30, 2021.

Phase 2.5: This phase largely carries over the elements from Phase 2. The Utilizer PMPM continues to be determined by provider performance on engagement rate and practice assessment scores, although performance expectations have been altered slightly. The negative impact of COVID on member behaviors related to their seeking of primary care services caused an overall reduction in engagement rates across the network. Therefore engagement rate requirements were reduced by 2% across the board. However expectations were increased for PCMP Assessment scores by 10%, where a minimum score of 81% is required to earn points toward the Utilizer PMPM payment.

Colorado Access retired the $0.50 PMPM add-on payment for participation in HCPF's APM program and replaced it with its own pay for participation program, **Controlled Chronic Conditions: Emergency Department Reduction Program (C^3EDR).** This program incentivizes the use of registry, claims or EHR data to identify and prioritize members that are most in need of help with managing their diabetes, asthma and/or COPD. It also incentivizes the implementation of intervention programs that are aimed at helping members achieve control over their chronic condition(s) with the goal of keeping them out of the ED. Participating providers receive $0.50 PMPM for participation in this program. The program is optional for PCMPs and PCMP+s with 200 or more attributed members and those that participated in HCPF's APM program last year. Program participation is required for ECPs. More information about this program can be found at https://www.coaccess.com/providers/resources/.

The Complex PMPM payment was also adjusted to be a performance based payment determined by the blending of two metrics: **Complex Claims Engagement** and **Complex Extended Care Coordination Engagement**. More weight was given to the extended care coordination engagement rate, as this payment is intended to incentivize care planning activities. The Complex PMPM payment is tiered by performance and paid to PCMP+ and ECP providers.

The ECP assessment was also introduced in this version of the model. The assessment has 2 parts: Addendum 2 compliance and case reviews. The addendum 2 compliance component assesses ECPs' abilities in quality improvement, population management and care management activities. Case reviews assess 5 patients' individualized care plans for presence of evidence-based best practices associated with the patients' diagnoses.

This version of the Administrative Payment Model is effective July 1, 2021 and will continue through June 30, 2022.

Phase 3: Colorado Access plans to adjust the model again in July, 2022 to move further toward incentivizing good health outcomes for Medicaid members. Phase 3 will focus on obtaining provider data that demonstrates control of chronic diseases across the providers' attributed population (example: A1c control, blood pressure control, etc.). It will also seek data that demonstrates good preventive maintenance practices (example: cancer screenings, depression screenings, etc.).

Colorado Access recognizes that the PCMP provider network is diverse and therefore includes providers with different levels of resources and experience with population health management best practices. For this reason, it is very likely that only providers with advanced quality improvement and technological capabilities will be required to move to Phase 3 in July, 2022. Many providers will be allowed to continue with Phase 2.5 for at least an additional year. Colorado Access believes that provider participation with the C^3EDR program in FY 2021-22 will demonstrate which providers are ready to progress to Phase 3 in FY 2022-23.

III. PCMP All-Network Provider Payments:

There are four potential payments that PCMPs may receive under Addendum 1. These payments apply to all provider types (PCMPs, PCMP+s and ECPs).

Payment # 1 – Utilizer Payment. A site's Utilizer Payment is calculated according to provider performance on 2 metrics: (a) Engagement Rate score and (b) Practice Assessment score. These scores are blended together to determine the practice's Utilizer Payment as demonstrated in Figure 1 below. PCMPs will not receive a Base Payment for members identified as Non-Utilizers.

A. ***Engagement Rate.*** The total number of unique attributed Members for which PCMP has submitted at least one claim in the previous calendar year (from any PCMP site within the provider's Tax ID), calculated as a percentage of the practice site's total attributed Members. Attribution will be based on the number of attributed Members the practice was assigned in the last month of the measurement period (December, 2020).

> Example: PCMP X provided billable services to 575 of their 1000 attributed Members in the 12-month measurement period. Provider X's Engagement Rate is 57.5%.

a. If PCMP or COA identifies an attribution anomaly, each party must notify the other party in writing as soon as the anomaly is detected. Attribution is

determined by HCPF and reported to COA. Once confirmed by COA, anomalies will be addressed by substituting the average attributed membership of the last six months of the previous calendar year's attributed membership.

B. ***Practice Assessment Score.*** The Practice Assessment measures provider compliance with provider responsibilities as they are outlined in Addendum 1. The assessment focuses primarily on the presence of the key elements of the patient centered medical home model. Individual site responses are available from the Practice Support team at Practice_Support@coaccess.com upon request.

Figure 1: Utilizer PMPM Scoring Criteria

Engagement Rate		Practice Assessment Score	
0-18%	0		
19-31%	1	0-80%	0
32-44%	2	81-90%	1
45-56%	3	91-95%	2
57-65%	4	96-100%	3
66-100%	5		

Score Determines Utilizer PMPM Payment		
0-3 = $1.00 PMPM	4-6 = $2.75 PMPM	7-8 = $3.25 PMPM

Payment #2 – Add-on Payment for C^{3}EDR Program. An additional $0.50 PMPM will be added to the Base Payment for all practice sites that participate in COA's Controlled Chronic Conditions: ED Reduction (C^{3}EDR) Program. This Add-on payment is only applicable to Members classified as Utilizers. Additional information about this program can be found on the COA website alongside the Provider Manual (scroll down) www.coaccess.com/providers/resources/.

A. Eligibility Criteria for C^{3}EDR Program: Provider practice site must have a minimum of 200 attributed members to participate in this program.
B. Eligible PCMPs and PCMP+s may choose to opt-in or opt-out of this program. Providers should alert their practice facilitator of their desire to participate in this program by **May 15, 2021**.
C. ECPs are **required** to participate in this program and will automatically be enrolled and allotted the $0.50 PMPM add-on payment.

Payment # 3 – Non-Utilizer Payment. PCMP will receive $0.50 PMPM for Members classified as Non-Utilizers.

EXAMPLE: UTILIZER, ADD-ON AND NON-UTILIZER PAYMENTS

Provider X has a 57.5% Engagement Rate and earned a score of 89.3% on their most recent Practice Assessment. They have opted into COA's C^3EDR program.

Engagement Rate 58% = 4 points Practice Assessment Score 89% = 1 point

Total Score of 5 = $2.75 PMPM

$2.75 PMPM (**Payment 1**) + $0.50 PMPM for C^3EDR participation (**Payment 2**), therefore,

Provider X receives $3.25 PMPM for all Utilizers

Provider X receives $0.50 PMPM for all Non-Utilizers (**Payment 3**)

Example of Provider X's monthly payments: Provider X from above has 1000 attributed Members, where 858 have had a claim within the Medicaid program within the previous 18 months.

Utilizers: 858 x $3.25 = $2,788.50 (includes $0.50 PMPM for C^3EDR participation)

Non-utilizers: 142 x $0.50 = $71

Provider X's Month 1 payment = $2,859.50

Payment # 4 – KPI Incentive Payment. KPI Incentive Payments are earned through HCPF's Pay-for-Performance program at the regional level and are distributed to providers by the RAE. The **Pay-for-Performance Incentive Sharing Program document**, which outlines the KPIs and other pay for performance metrics and associated potential incentive payments, is posted on the COA website alongside the COA Provider Manual (scroll down): https://www.coaccess.com/providers/resources/

IV. PCMP+ and ECP Complex Member Payments

A subset of providers (PCMP+ and ECP) are eligible for enhanced PMPM payments for Complex Members due to their ability to care manage Complex Members and report care plan activities back to the RAE in a required format.

Payment # 5– Complex Member Payment. Providers shall receive a PMPM for each Complex Member attributed to the site(s). If the provider receives the Complex Member Payment for a Member, they are not entitled to the Utilizer Payment in Addendum 1 for the same Member. This is a monthly payment.

A site's Complex Member payment is calculated according to each site's performance on 2 metrics. These two metrics will be blended to determine a site's Complex Member Payment (see Figure 2).

A. ***Complex Claims Engagement Rate.*** The percentage of unique attributed complex Members who had a claim with one of the ECP's sites in the previous 12 months..
B. ***Complex Extended Care Coordination Rate.*** The percentage of members that received extended care coordination in the previous 12 months

Figure 2: Complex PMPM Scoring Criteria

Complex Engagement (Claims)		Complex Engagement (Extended Care Coordination)	
0-50%	0	0-10%	0
51-65%	1	11-25%	2
66-84%	2	26-49%	4
85-100%	3	50+%	6

Score Determines Complex PMPM Payment		
0-4 = $5.00 PMPM	5-8 = $10.00 PMPM	9 = $15.00 PMPM

EXAMPLE: COMPLEX MEMBER PMPM

Provider Y has provided billable services to 75 of their 100 complex members. The care coordination report they provide to COA demonstrates that they have engaged 34 of their complex members in extended care coordination.

Complex Claims Engagement Rate 75% = 2 points

Complex Extended Care Coordination Engagement Rate 34% = 4 points

Total Score of 6 = $10.00 PMPM (**Payment 5**)

Provider Y's Month 1 Complex Payment = $1000

V. ECP Care Management Payments

Enhanced Clinical Partners (ECPs) are paid an additional per member per month payment to provide care management services to their attributed members and to report their care management activities to COA in a required reporting format. All ECPs receive this payment.

Payment # 6 – ECP Payment. ECP shall receive a care management PMPM for each Member attributed to the ECP's site(s). The PMPM amount will be determined by the ECPs

performance score across the two components that make up the COA ECP Assessment. Individual site responses and scores are available from the Practice Support team at Practice_Support@coaccess.com upon request. This is a monthly payment.

A. ***Addendum 2 Assessment Score.*** The Addendum 2 Assessment monitors compliance with provider responsibilities outlined in Addendum 2. The assessment focuses primarily on the quality improvement activities, population management practices and the presence of care management best practices. Individual site responses and scores are available from the Practice Support team at Practice_Support@coaccess.com upon request.

B. ***Case Review Score.*** The Case Review component of the COA ECP assessment is a review of a practice's submission of 5 members' individualized care plans. Case reviewers look for the presence of evidence-based best practices related to the condition being addressed in the care plan. Individual site responses and scores are available from the Practice Support team at Practice_Support@coaccess.com upon request.

Figure 3: ECP PMPM Scoring Criteria

Addendum 2 Assessment Score (out of 50)	Case Review Score (out of 50)
Addendum 2 + Case Review = 0-80	0
Addendum 2 + Case Review = 81-90	1
Addendum 2 + Case Review = 91- 98	2
Addendum 2 + Case Review = 99-100	3

Score Determines Complex PMPM Payment		
1 = $3.75 PMPM	2 = $3.85 PMPM	3 = $3.90 PMPM

Glossary:

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 coordination 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.

Complex Member. A HCPF defined subset of Members determined by factors that may include but are not limited to condition, acuity, cost and ability to impact through intervention. HCPF determines whether a Member is classified as a Complex Member.

Complex Claims Engagement Rate. The percentage of attributed Complex Members who had a claim with one of the ECP's or Primary Care Medical Provider Plus' ("PCMP+") sites in the previous 12 months.

Complex Extended Care Coordination Rate ("ECC Engagement Rate"). The percentage of attributed Complex Members who received extended care coordination in the previous 12 months.

Controlled Chronic Conditions ED Reduction Program (C^3EDR). A program that requires providers to implement an intervention to reduce emergency department visits by working to improve patients' control of their chronic diabetes, asthma and/or COPD.

Engagement Rate. The total number of unique attributed Medicaid Members for which a provider has submitted at least one claim in the previous calendar year (from any PCMP site within the provider's Tax ID), calculated as a percentage of the practice site's total attributed Member panel.

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

Key Performance Indicators (KPIs). Performance measures tied to incentive payments for the Accountable Care Collaborative.

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

Member 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 the State.

Non-Utilizer. A currently eligible Member that has not received a service resulting in a paid Medicaid claim in the previous 18 months.

Per Member Per Month (PMPM). A fixed reimbursement methodology for a provider, for attributed and/or assigned Members, paid monthly.

Practice Assessment Score. The score that resulted from each practice site's most recent evaluation in accordance with the Agreement and applicable Addendum(s).

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 who have selected or been assigned to such physician. 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 assigned 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. 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 Patient-Centered Medical Home (PCMH) may be granted by any of the following entities:

1. National Committee for Quality Assurance (NCQA)
2. The Joint Commission
3. Utilization Review Accreditation Commission (URAC)
4. Accreditation Association for Ambulatory Healthcare (AAAHC)

Utilizer. A currently eligible Member that has received a service resulting in a paid Medicaid claim in the previous 18 months.