FY24-25 Colorado Access Administrative Payment Models - Frequently Asked Questions

General Questions:

1. **When will I receive my new contract?**
   Contracts were sent out beginning May 14, 2024. For 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, 2024.

3. **What happens if I don't sign my contract by June 30, 2024?**
   If contracts are not signed and received by June 30, 2024, there may be impacts to your July (and subsequent month(s), if furthered delayed) capitation payment.

4. **When will I receive my July capitation?**
   If you signed and submitted your contract by June 30, 2024, capitation will be issued the week of July 22nd.

5. **Where can I find model program and measure specification documents?**
   Current model program and measure specification documents can be found on the COA Provider Resource page under Value Based Payments: https://www.coaccess.com/providers/resources/vbp/

6. **Where can I find the Pay for Performance Program Document?**
   Current program documents can be found on the COA Provider Resource page under Value Based Payments: https://www.coaccess.com/providers/resources/vbp/

7. **What is the performance measurement period?**
   The performance measurement period is calendar year 2023. Claims data for December 2023 was pulled mid- March 2024 to allow for claims runout. Membership numbers are based upon March 2024 attribution.

8. **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 general inquiries, email providerrelations@coaccess.com

Non-Utilizer Payment

1. **Why did COA retire the $0.50 non-utilizer PMPM payment?**
   Payment Reform at Colorado Access is starting early and taking a phased approach to implementing some of many new requirements that are required under ACC Phase III, one of which being the retirement of the non-utilizer payment due to all non-utilizers being attributed to the RAE beginning July 1, 2025. HCPF has additionally asked the RAEs to increase their focus on utilizing members. Our analysis showed that by March 2024 the COA Medicaid member mix had shifted to 95% utilizer and complex members for the RAE 3 & 5 PCMPs. With these data Payment Reform determined it was

best to reinvest the non-utilizer PMPM to cover the increased costs associated with those members currently utilizing and engaging with the Medicaid system while maintaining the current Utilizer PMPM rates. Payment Reform recognizes that there are challenges within the provider community at this time, and it was our intent to prepare the PCMP network now with small transitions that will be applicable to ACC Phase III while maintaining a stable Utilizer PMPM rate.

2. **Why do ECP sites receive a payment for non-utilizers?**
   As in prior years, ECP sites have a care management payment that stacks on top of the Utilizer, Non-utilizer, and Complex member payments. While the non-utilizer payment now $0.00 PMPM, ECP sites will continue to have their care management payment ($2.50-$4.50) stack on top of that $0.00 PMPM.

3. **Do ECP care management payments still stack on top of the $0.00 non-utilizer PMPM?**
   Yes, ECP sites will continue to receive the care management payment for their non-utilizer members. The expectation remains that if an attributed member that has not previously engaged with the ECP site requires care management services that the ECP site delivers the necessary services as they've received care management PMPMs for this member.

4. **What is the split between Utilizers/Complex Members and Non-utilizers?**
   The March 2024 member mix was 95% utilizers/complex members and 5% non-utilizers.

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. **Why does the Family Medicine model have a higher earning potential than the Pediatric model?**
   In the Family Medicine model, there are a total of five metrics, whereas the Pediatric model technically contains only four. The HEDIS well-visit measure consolidates both the 0-15 months and 15-30 months of life stages into a single measure, rather than treating them separately. Furthermore, the Family Medicine model allocates its attention between both adult and pediatric patients. Rates for SFY24-25 remain unchanged from the previous year.

3. **Why did Family Medicine move to W30 from W15?**
   As the largest provider cohort, having Family Medicine providers perform well on this measure will assist the Colorado Access regions in achieving HCPF KPI goals. Additionally, the Family Medicine cohort has historically struggled to perform as well on this measure.

4. **Why is the Mid-level PMPM worth more on WCV than W30 for Family Medicine?**
   The Mid-level PMPM is worth $0.25 more on WCV to incent the Family Medicine cohort to reach the HEDIS 5th performance percentile. The state of Colorado is currently ranked 10th in the nation on the WCV metric and as we get closer to the point in time where the State's Medicaid budget will be linked to performance on measures such as WCV it is of paramount importance to improve our standing before potential budgetary impacts.

4. **Why is my site being measured on WCV when I had at least 10 infants in the W15 and/or W30 measure? Which metric should I be focused on improving?**
   In the SFY23-24 Provider Forum, Colorado Access intended to transition from Child and Adolescent Well Visit W15 (KPI Part 1a) to W30 (KPI Part 1b) to support incentive alignment with screening, treatment, and billing for preventive care. Due to the financial impacts this would have on your clinic's capitated payments, Colorado Access is instead including the well child visit (WCV) measure into your model for this fiscal year to mitigate revenue impacts.

Complex Member Payment

1. **What is the SFY24-25 regional Complex Member definition?**
   The **Adult Complex Member** definition is Members with ≥4 of 8 priority health conditions:
   - Asthma
   - Cardiovascular disease
   - Chronic pain
   - COPD
   - Depression or anxiety
   - Diabetes
   - Hypertension
   - SUD

   The **Pediatric Complex Member** definition is Members with ≥3 of 8 priority health conditions:
   - Asthma
   - Depression or anxiety
   - Diabetes
   - Obesity
   - Autism spectrum disorder (previously (Pervasive developmental disorder)
   - Pregnancy
   - Health related social needs (Z-code diagnosis)
   - SUD

2. **Why aren't health related social needs included in the Adult Complex Member definition?**
   In the short term we are monitoring the use of health related social needs (Z-code diagnosis) for adults and children via the Pediatric Complex Member definition to understand the prevalence of health related social needs in our population. We will evaluate the impact of including health related 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 mom" 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.

6. **What is complex extended care coordination?**
   Complex extended care coordination refers to a comprehensive approach to managing the care of individuals with complex medical needs over an extended period. The complex extended care coordination rate ("Complex ECC") is the percentage of attributed complex members who received extended care coordination in the previous 12 months. Complex members are determined by factors that may include but are not limited to condition, acuity, and ability to impact through intervention. The ECC rate only applies to PCMP+ and ECP designated sites.

7. **What data is reported back to COA on care management?**
   We have 11 specified encounter types, and PCMP+/ECPs submit the breadth of their care management and population health activities to COA quarterly, categorized by these encounter types.

8. **What will the complex member definition and care management requirements look like under ACC Phase III?**
   HCPF has developed new care coordination tiers that providers can opt into and has taken back the complex member definition. The table below from the draft show the three newly released care management tiers which tie back to the conditions and populations that HCPF would like prioritized.

Tier	Area of Focus	Minimum Proposed Populations by Tier *(To be determined with Contractor and finalized prior to operational start date)*		
		Adults & Children	Adults	Children

Tier 3: Complex Care Management (4-6% of Members)	Longitudinal, evidence-based, and proven programs involving multi-disciplinary care approaches to maintain or improve Member health.	• TBD # of physical and/or Behavioral Health conditions
		• Utilization (in previous TBD # of months):
		  ◦ TBD # of hospital readmissions
		  ◦ TBD # of days inpatient
		  ◦ TBD # of crisis encounters
		  ◦ TBD # of ED Visits
			• Chronic Over-Utilization Program (COUP)
			• Individuals involved in Complex Solutions Meetings
			• Deemed Incompetent to Proceed (ITP) in previous year
				• Individuals involved in Creative Solutions Meetings
				• Foster care and foster care emancipation
				• Individuals at risk of out of home placement due to Behavioral Health conditions
				• Individuals who meet IBHS criteria outlined in GA v. Bimestefer Implementation Plan (coming FY24-25)

Tier 2: Condition Management	Interventions to ensure Members with diagnosed conditions receive appropriate services to improve health outcomes and prevent disease progression.	• Diabetes • Asthma • Pregnancy (including pre- & post-natal) • Other conditions TBD	• TBD Value-based payment (APM2) identified conditions not already listed under "Both" category, such as COPD and heart disease	• Conditions TBD
Tier 1: Preventative Health Promotion	Proactive and responsive interventions that assist Members in accessing evidence-based preventive care services as well as support for health-related social needs.	• All Members not in other tiers	• All Members not in other tiers	• All Members not in other tiers

PCMP+/ECP Ascension

9. **What are the criteria for becoming an ECP provider site?**
   To ascend to ECP designation, a site must have ascended to the PCMP+ designation and maintain this designation for a minimum of two years before being eligible for an ECP site designation review. This two-year review gives COA the ability to collect and evaluate care management data and quality of care planning activities. To be eligible for a PCMP+ designation a provider must score in the 80th percentile on at least two pre-determined clinical metrics for a minimum of nine of the 12 months in the previous calendar year measurement period. Additionally, the provider must meet

specific engagement and structural performance requirements. Performance is calculated annually and reported at the COA PCMP network level.

10. **Is there an opportunity to get an ECP contract?**
    Not for this contract year, but we encourage sites to speak with your Practice Facilitator if your organization is interested in exploring this further and reviewing how your site performed on the annual Ascension model performance review.

11. **Are we the only RAE that have ECP?**
    All RAEs have some form of delegated care management but the responsibilities, incentives, and arrangements look different across RAEs.

12. **What does the Ascension model look like moving into ACC Phase III?**
    What the Ascension model will look like under ACC Phase III is still being determined. We are hypothesizing that some form of the clinical and structural standards will continue to play a pivotal role in supporting quality outcomes in ACC Phase III.

13. **Do we anticipate ECP descension in the future?**
    It's a possibility. We want to give providers the opportunity to improve, and not penalize. It is also possible that this model will change in ACC Phase III, with requirements to align value based payments across Colorado payers.

Care Management Payment (ECP Sites Only)

1. **Are there any adjustments to the process or criteria for case reviews?**
   The sole modification scheduled for implementation will occur in August 2024. At that time, we will initiate audits for opt-out or unreachable members if your organization reports those encounter types. Otherwise, the procedure will remain consistent for both the August and February 2025 case reviews.