



**COLORADO**  
Department of Health Care  
Policy & Financing

1570 Grant Street  
Denver, CO 80203



# Primary Care Alternative Payment Model Guidebook

November 2019

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



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## Introduction

The Department of Health Care Policy and Financing's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. The Medicaid program currently serves 1.3 million Coloradans, many of whom have complex health needs either because of life circumstances or disability. To meet the unique needs of those we serve, the Department has a long history of innovation to improve access, health care quality and the health of its members.

The Accountable Care Collaborative (ACC) is the core of the state's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way. The ACC provides the framework in which other health care initiatives, such as payment reform, can thrive. This guide focuses on the Alternative Payment Model for Primary Care (APM) and is intended to help ACC Primary Care Medical Providers (PCMPs) and their staff successfully implement the APM in their practices. The ACC PCMPs include individual providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other groups with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

The APM is part of the Department's efforts to transform payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is committed to aligning performance incentives across the delivery system to support primary care provider success in the APM. For example, the Department has created incentive payment programs for Regional Accountable Entities (RAEs) to support primary care in meeting the demand for services with greater emphasis on screening and detection in the primary care setting. In addition, the Department is working with hospitals on payment models incentivizing transitions of care, data sharing, and support of integrated care through the Hospital Transformation Program; has engaged with the Multi-Payer Collaborative to expand and support primary care transitions across the state; and has engaged with commercial payers to seek alignment on measures.

Since the Fall of 2016, the Department has engaged many stakeholders in the design and implementation of the APM. Workgroups convened during the design phase had input on almost every aspect of the APM, including selection of measures and design of the payment structure. These workgroups included primary care physicians, primary care practice coordinators, office managers, and other key stakeholders. Near the end of the first performance year (2019), a series of public meetings was held to solicit feedback on updates to the measure set, point assignments, and Department goals for each measure. The Department intends to conduct an annual stakeholder engagement process to inform updates to the model for each performance year.



## Alternative Payment Model Goals

The Department collaborated with stakeholders during the design of the APM to identify the following goals for the program:

1. Provide long-term, sustainable investments into primary care;
2. Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to PCMPs, and;
3. Align with other payment reforms across the delivery system.

## Design of the Alternative Payment Model

The APM is designed to provide investment, reward performance, and introduce accountability for all PCMPs, including FQHCs. Most components of the program are the same for all providers, but there are a few important differences for FQHCs. These differences are described throughout the Guidebook. The most important difference is how providers get paid under the APM, which is explained here:

### For Primary Care Medical Providers (PCMPs) that are not FQHCs

The Affordable Care Act provided federal funding, known as the 1202 bump, for a temporary increase in primary care rates starting in 2013. After the federal funding ended, the lump sum payments under 1202 were transformed through state legislative action into a permanent rate increase for a set of codes primarily used in primary care. The permanent rate increase was approved by the General Assembly of Colorado on the condition that it would be paid through a value-based payment structure. **The APM is that value-based payment structure.**

The APM allows providers to continue to receive the increased payments in exchange for meeting performance goals. Each practice chooses 10 quality measures to report. Practices that successfully report on the selected measures and demonstrate high or improved performance will continue to receive increased rates for a set of primary care services.

### For Federally Qualified Health Centers (FQHCs) Only

FQHCs are paid differently than other providers in Colorado, so payments under the APM work a little differently too. FQHCs in Colorado have two rates: a Prospective Payment System (PPS) rate, which is the federally defined minimum rate that Medicaid must pay FQHCs for one-on-one, face-to-face encounters with Medicaid patients, and the Alternative Payment Model (APM) which establishes Colorado-specific rates calculated annually as part of each FQHC's cost report process. This original APM is a cost-based calculation and over time in most instances is higher than the PPS rate. For FQHCs, the APM described in this guidebook (also known as the "Value-Based APM" to FQHCs) is a modification to the cost-based calculation by which a portion of the FQHC's APM rate will be tied to quality activities and performance metrics.



## Eligibility Criteria

The APM applies to providers designated as a Primary Care Medical Provider (PCMP) in the ACC. For more information about PCMP designation, please visit the [ACC website](#).

To be eligible for the APM, PCMPs must have either 200 ACC enrollees or more than \$30,000 in historical annual paid claims associated with services defined in the [APM Code Set](#). The APM Code Set is available on the [APM website](#).

**Important notes** regarding eligibility:

- PCMPs that fall below both the 200 ACC enrollee and \$30,000 volume thresholds will be **automatically excluded** from the APM and **will not** experience an increase or decrease in their rates. These providers are not able to opt into the program.
- PCMPs that are eligible to participate in the APM but **choose not to do so** will see a **decrease** in their rates.
- PCMPs that are actively participating in the Comprehensive Primary Care Plus (CPC+) program will automatically earn full payment under the APM in Performance Year 2020.
- Providers that are not contracted as PCMPs in the ACC are **not able to opt in** to the APM.

The Department will calculate PCMP eligibility (including new providers and solo billers) in the APM by reviewing claims data from March 1<sup>st</sup> through February 28<sup>th</sup> (or 29<sup>th</sup>) annually. In May of each year, the Department will announce eligibility for the APM for the following calendar year. Smaller PCMPs that were previously excluded because of low claims volume may become eligible for the APM in the following year, if the PCMP's Medicaid claims volume grows.

### For Federally Qualified Health Centers (FQHCs) Only

The APM applies to all FQHCs in Colorado.



## Payment Model

The APM is a point-based system. Each PCMP is responsible for selecting 10 quality measures to focus on every year. PCMPs earn points by reporting on the selected measures and demonstrating high performance or improvement. The number of points earned by each PCMP determines the impact on payment for that practice.

### Measure Point Values and APM Quality Score Goal

Each measure in the APM measure set is assigned a point value based on several factors, including the potential value gained by improved outcomes for that measure and the difficulty of achieving improvement. Measures that align with Department and stakeholder priorities for improving care (e.g., measures focused on highly effective preventive services such as childhood immunizations) are given a higher point value. Measures requiring more resources or more effort to implement or improve are also given a higher point value. Point values were originally determined in collaboration with the design and implementation workgroups and all updates have been vetted through a public stakeholder engagement process.

Point values for individual measures range from 10 to 60 possible points. The points that each practice earns for individual measures are summed to calculate the practice's APM Quality Score. Each PCMP must earn an APM Quality Score of at least 200 points to receive the highest payment rates. Practices with an APM Quality Score of fewer than 200 total points will receive reduced payments. The impact on payment is discussed in the **Impact on Payment** section.

### Measure Options and Selection

Practices can choose measures from the following categories: Structural Measures, Claims Measures, and Electronic Clinical Quality Measures (eQMs).

- **Structural Measures** - These measures focus on a practice's capacity, systems and processes to provide high-quality care. Examples of Structural Measures include integrating behavioral health care, providing alternative types of encounters, or implementing quality improvement activities.
- **Claims Measures** - These measures are calculated from a practice's processed Medicaid claims and indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. Examples of Claims Measures include adolescent well care visits or medication management for people with asthma.
- **Electronic Clinical Quality Measures (eQMs)** - These measures are calculated directly from a practice's electronic medical record (EMR) and reflect the impact of the health care service or intervention on the health status of patients. Examples of eQMs include diabetes hemoglobin A1c poor control or high blood pressure control.



It was the Department's priority, based on guidance from stakeholders, to ensure alignment with other value-based payment efforts to reduce or avoid as much administrative burden on practices as possible. The Structural Measures were developed to align with the [Colorado State Innovation Model \(SIM\)](#), [Comprehensive Primary Care Plus \(CPC+\)](#), and the [National Committee for Quality Assurance \(NCQA\) Patient Centered Medical Home \(PCMH\) recognition program](#). The Claims Measures and the eQMs were developed to align with Colorado SIM, CPC+, and the [Medicare Quality Payment Program \(QPP\)](#).

The full [APM Measure Set](#) is available on the APM website.

Each PCMP must select 10 measures. **PCMPs cannot earn more than 180 points from Structural Measures.** Practices must choose Claims Measures and/or eQMs to earn the remaining 20 points.

### **For Federally Qualified Health Centers (FQHCs) Only**

All FQHCs must choose at least one Claims Measure.

The Department suggests the following questions to consider when selecting measures:

- What are you working on for other payers besides Medicaid?
- What are you working on for your own practice?
- What are the needs of the population you serve?
- What can you realistically change in your practice?

PCMPs should also keep in mind the following when selecting measures:

- Structural Measures are pass/fail; therefore, it should be easy for a PCMP to determine how many Structural Measures they can meet.
- Claims Measures will be run for all participants in the APM regardless of individual practice measure selection.
- Practices that select eQMs will be able to earn half of the points for a given measure by reporting data in APM Performance Year 2020, even if performance goals are not met. For more information, see the **Measure Point Calculation and Reporting** section.

### **Comprehensive Primary Care Plus (CPC+) Credit**

All practices that are actively participating in CPC+ will automatically earn 200 points for the APM program in APM Performance Year 2020.



### Patient Centered Medical Home (PCMH) Credit

PCMPs can earn half their points (100 out of 200) through Patient Centered Medical Home (PCMH) recognition. PCMPs that earn PCMH credit need to select six measures to earn the remaining 100 points. The Department accepts PCMH recognition status from the following organizations:

- [National Committee for Quality Assurance \(NCQA\)](#)
- [Utilization Review Accreditation Commission \(URAC\)](#)
- [Accreditation Association for Ambulatory Health Care \(AAAHC\)](#)
- [The Joint Commission](#)

PCMPs that earn PCMH credit can only choose the following Structural Measures as part of their six measures: Accepting New Patients and Interdisciplinary Team. One or both measures may be chosen but no other Structural Measures may be chosen, as the remaining Structural Measures are considered duplicative of PCMH requirements. A PCMH practice may also choose six Claims Measures and/or eQMs and no Structural Measures.

#### For Federally Qualified Health Centers (FQHCs) Only

FQHCs that earn PCMH credit may not choose any Structural Measures as part of their six measures. The two Structural Measure choices available to other PCMH recognized practices (Accepting New Patients and Interdisciplinary Team) are considered duplicative of FQHC requirements.

### Submission of Measure Selection

Practices are expected to submit measure selections by electronic survey between November 12, 2019 and December 31, 2019. Click [here](#) to access the electronic survey. The Department may extend the deadline for individual practices for a “good cause” petition submitted before December 31, 2019. The Department will coordinate with the RAEs and the Colorado Community Health Network (CCHN) to support practices with measure selection for 2020. If PCMPs do not select measures by January 31, 2020, the Department will automatically assign measures to practices. **Once measure selection is complete, measures cannot be changed during 2020.**

#### For Federally Qualified Health Centers (FQHCs) Only

Every year, the CCHN board selects measures on behalf of all FQHCs. If an individual FQHC would like to select different measures, that should be communicated to CCHN as soon as possible and no later than January 15, 2020.





## Measure Reporting and Point Calculation

### Structural Measures

Structural Measure achievement, including PCMH status, is collected by RAEs for PCMPs and by CCHN for FQHCs shortly after the end of each measurement year, in the first quarter of the next year. All Structural Measures are pass/fail, so a practice will earn all or none of the possible points for that measure. The Department supplies an electronic survey for RAEs and CCHN to document practice attestation of each Structural Measure chosen by each practice.

### Claims Measures

For Claims Measures, the Department automatically collects the baseline and performance years data from submitted claims. All Claims Measures are calculated using the **Close the Gap Calculation** which is described below. It is possible for a practice to earn any point value between zero and the maximum possible points for each measure, based on the practice performance.

### Electronic Clinical Quality Measures (eCQM)

Health Data Colorado (HDCo) collects eCQM data directly from each practice and reports aggregated numerators and denominators for the baseline and performance years for each practice. Practices that do not have an EMR or cannot accurately extract electronic data from their EMR will be allowed to manually report on measures through HDCo. All eCQMs are calculated using the **Close the Gap Calculation** which is described below. It is possible for a practice to earn point values between zero and the maximum possible points for each measure, based on the practice performance.

In APM Performance Year 2020, a practice can earn eCQM points in several ways:

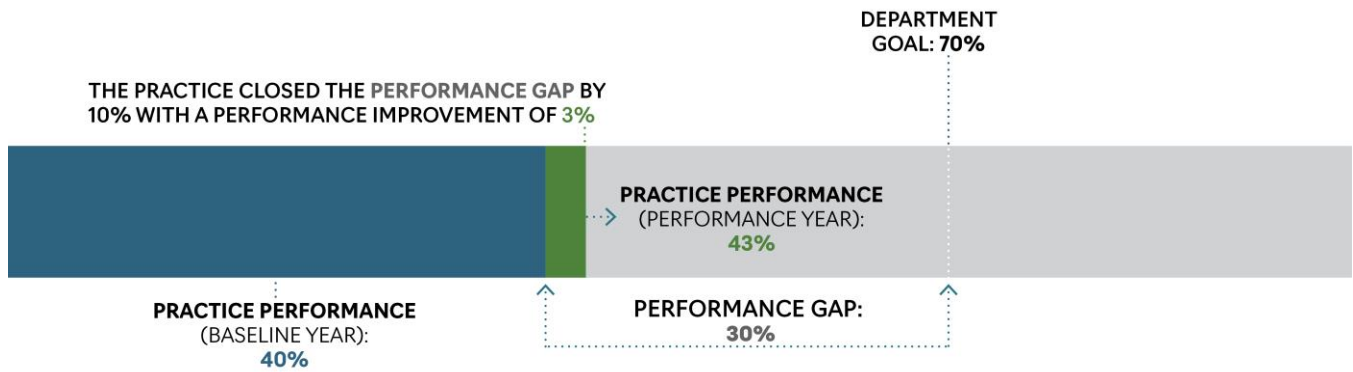
- To earn the full point value of an eCQM, the practice must
  - report data for both the baseline (2019) and performance (2020) years and demonstrate Close the Gap improvement, *or*
  - report data for the performance year (2020) and achieve the Department goal for the measure.
- If a practice can report two years of data and demonstrate Close the Gap improvement between five to 10 percent, the practice will earn between half and the full point value for the measure as described below.
- If a practice cannot achieve the Department goal or supply both years of data and demonstrate at least five percent Close the Gap improvement in the measure, the practice will still earn no less than half the full points for the measure by reporting at least one year of data either electronically or manually. This policy is intended to reward practices for trying to report eCQMs and to recognize that reporting eCQMs may be more resource intensive for practices than the other measure types.



### Close the Gap Calculation

The Department has developed statewide goals for each Claims Measure and eQCM. To receive full points for a measure, PCMPs are expected to demonstrate improvement by “closing the gap” between their own baseline performance and the Department’s statewide goal by 10 percent. Thus, PCMPs are measured against their own historical baseline, rather than against other practices during the same period. If a PCMP’s performance is at or above the statewide goal, the practice will receive full points for that measure.

Figure 1. Close the Gap Calculation Example



If a practice does not close the gap by the full 10 percent but does demonstrate some improvement, the practice will still earn partial points for the measure. Partial points are calculated linearly based on the demonstrated improvement. For example, a practice that closes the gap by five percent would earn 50% of the full points for that measure.



## APM Quality Score Calculation

The APM Quality Score is the sum of all points a practice has earned through individual quality measures. Each practice must earn an APM Quality Score of at least 200 points to receive the maximum payment rate available.

In the following example, a hypothetical practice selected three eCQMs, four claims measures, and three structural measures. The practice achieved the Department goal for two eCQMs but could only report one year of data and did not achieve the Department goal for the third eCQM. In addition, the practice closed the performance gap by at least 10% for one claims measure, made improvement but did not close the gap for two claims measures, and did not make any improvement on the fourth claims measure. Finally, the practice completed the requirements for two structural measures but failed to produce the required documentation for the third structural measure. Summing the points earned from all ten measures, the practice achieved an APM Quality Score of 220 points and earned the maximum payment available.

Figure 2. APM Quality Score Calculation Example

MEASURE TYPE	MEASURE DESCRIPTION	POSSIBLE POINTS	PROGRESS TOWARD GOAL	RESULT
eCQM	Diabetes Poor A1C Control	50	100%	50
eCQM	Controlling High Blood Pressure	50	100%	50
eCQM	Screening for Clinical Depression and Follow-Up Plan	30	50%	15
Claims	Adolescent Immunizations	50	30%	15
Claims	Chlamydia Screening	10	100%	10
Claims	Colorectal Cancer Screening	30	66%	20
Claims	Adult BMI	20	0%	0
Structural	Patient Satisfaction	50	100%	50
Structural	Quality Improvement	10	100%	10
Structural	Accepting New Patients	50	0%	0

TOTAL POINTS POSSIBLE **350**      TOTAL POINTS EARNED **220**

0%  
PAYMENT  
REDUCTION

For more details on how individual measures are scored, please see the **Measure Reporting and Point Calculation** section.



## Impact on Payment

PCMPs that achieve an APM Quality Score of at least 200 points will receive the maximum available payment rates. Practices that achieve an APM Quality Score of fewer than 200 points will receive lower payments. The percentage reduction is calculated linearly based on the number of points earned for the APM Quality Score. For PCMPs that are not FQHCs, the payment reduction is applied to reimbursement rates for codes defined in the [APM Code Set](#).

The table below specifies the APM Quality Score Range and the corresponding payment reductions:

APM Quality Score Range	Payment Reduction %
0 to 50	3% - 4%
51 to 100	2% - < 3%
101 to 150	1% - < 2%
151 to 200	0% - < 1%

Example Payment Reduction Calculation:

- Practice earns an APM Quality Score of 125 points out of 200 points.
- $(200-125) \times 0.02\% = 1.5\%$  **Payment Reduction**

### For Federally Qualified Health Centers (FQHCs) Only

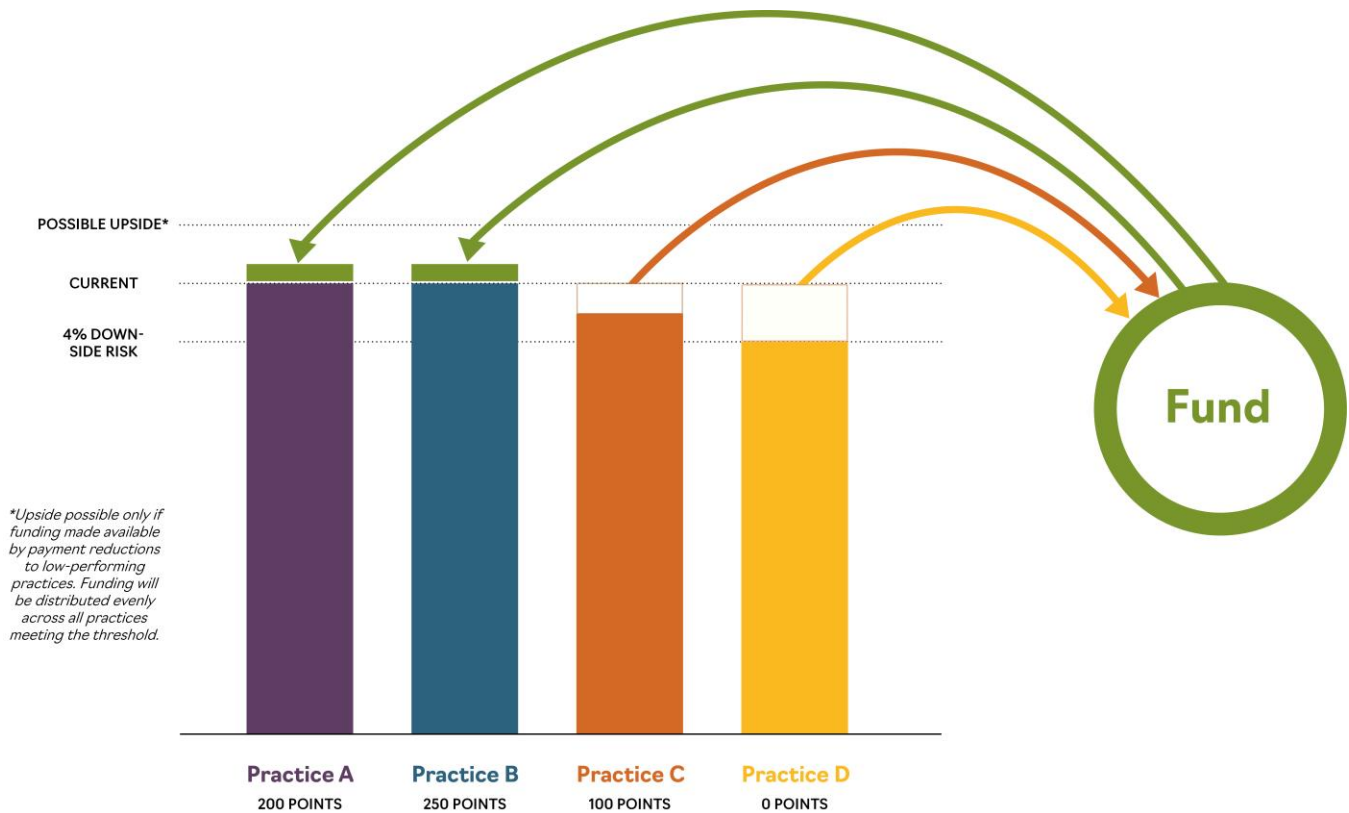
For FQHCs, the payment reduction percentage is applied to the cost-based reimbursement rates for physical and behavioral health services.

PCMPs that achieve an APM Quality Score of 200 points or greater may receive a slight payment increase through the APM. The APM must be budget neutral, which means that increased payments are only possible if some practices earn less than the maximum available payment rate by earning fewer than 200 points. Funds that are made available through unearned payments will be redistributed evenly across all practices that achieve an APM Quality Score of 200 points or greater. An example of how this might work across four hypothetical practices is shown on the next page.

Funding is separate between FQHCs and non-FQHCs; therefore, only FQHCs will receive increased payments as a result of unearned payments made available by other FQHCs and only non-FQHCs will receive increased payments as a result of unearned payments made available by other non-FQHCs.



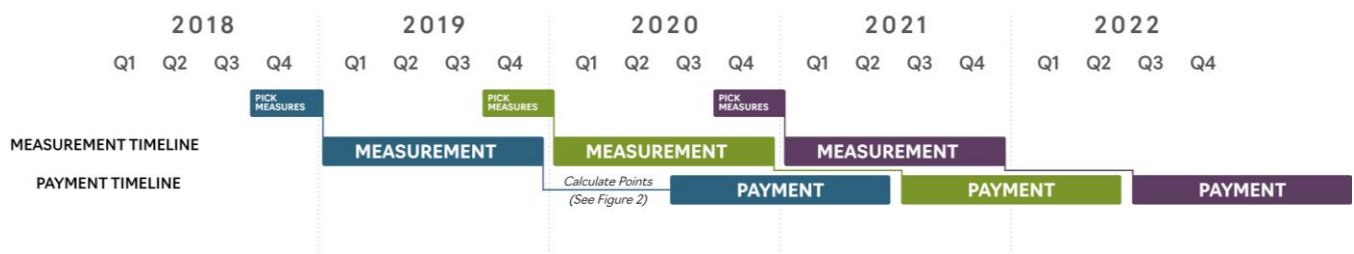
Figure 3. Potential Payment Redistribution Across Four Hypothetical Practices



### APM Payment Timeline

Payment will be adjusted six months after the conclusion of the measurement year (with the start of the state’s next fiscal year on July 1). This allows the Department six months to calculate payment adjustments and review with PCMPs.

Figure 4. APM Payment Timeline



# Support, Contacts & Resources

## How will Practices be Supported in the APM?

RAEs are responsible for helping PCMPs in the following ways:

- Assist practices to implement practice transformation and process improvement efforts.
- Designate and communicate a single point of contact for practice questions and support with the APM.
- Help practices select appropriate measure for participating in the APM. This decision should account for the practice's client panel and/or community, as well as leverage efficiencies by aligning with other initiatives the practice is working on.
- Provide ongoing education and support to the practice to help ensure successful participation in the APM.
- Attest to the practice's achievement of Structural Measures and PCMH status.

### For Federally Qualified Health Centers (FQHCs) Only

CCHN will also support FQHCs with the activities listed above. For questions about support available contact CCHN.

## Contact

Questions? Please contact [HCPF\\_primarycarepaymentreform@hcpf.state.co.us](mailto:HCPF_primarycarepaymentreform@hcpf.state.co.us)

## Resources

- [Alternative Payment Model for Primary Care Website](#)
- [Electronic Clinical Quality Improvement \(eCQI\) Resource Center for eQIM Specifications](#)
- [Centers for Medicare and Medicaid Services Quality Payment Program](#)
- [Colorado State Innovation Model](#)
- [Comprehensive Primary Care Plus](#)
- [National Committee for Quality Assurance Patient Centered Medical Home Recognition](#)
- [Utilization Review Accreditation Commission Patient Centered Medical Home Certification Process](#)
- [Accreditation Association for Ambulatory Health Care Patient Centered Medical Home Recognition Initiative](#)
- [The Joint Commission Primary Care Medical Home Certification](#)

