SOLICITATION #:
2017000265

Appendix M
Primary Care Alternative Payment Methodology

APPENDIX M

Primary Care Alternative Payment Methodology (APM)

OVERVIEW AND HISTORY

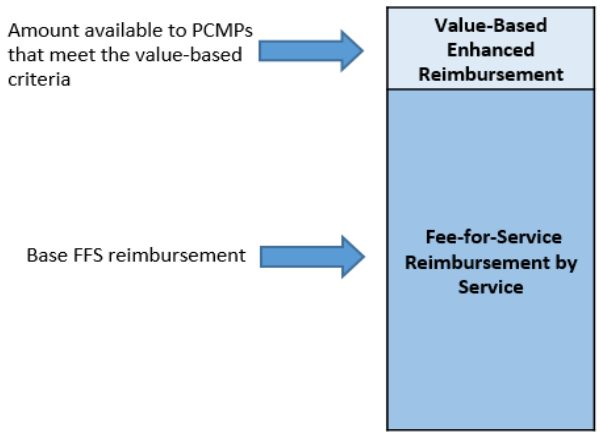
Since Section 1202 of the Patient Protection and Affordable Care Act (PPACA) expired at the end of 2014, Colorado Medicaid has continued to pay providers an increased rate (above the amount paid prior to the start of Section 1202) for a select group of billing codes related to primary care. The Department has state authority to continue this current structure through June 2017. The Department has requested a continuation of these funds from the state legislature to use for the Primary Care APM. Contingent upon federal approvals and state readiness, the first eighteen months of implementation (July 2017-December 2018) will primarily be for preparation, measuring, and reporting; payment will continue under the current structure. Thereafter, payment will shift to the new Primary Care APM.

PROPOSED MODEL

The Department, with stakeholder engagement, is currently developing the Primary Care APM framework. The Department has formed stakeholder workgroups on criteria, measurement, provider designation, payment design and attribution. The description and timing of the Primary Care APM is current as of submission of this paper.

Beginning January 1, 2019, after a preparation year, primary care providers (excluding FQHCs) will receive regular FFS payments based on the fee schedule set prior to implementation of Section 1202. Providers who are Primary Care Medical Providers (PCMPs), the patient-centered medical homes operating within the ACC, and that meet certain value-based criteria, will be eligible to earn higher reimbursement on a limited set of primary care codes, equivalent in aggregate to what they could have earned under Section 1202 and its extension. For the highest performing PCMPs, reimbursement could be higher than what they would have earned at current reimbursement rates.

Please note that in addition to the Primary Care APM described in the following sections, the Department intends to offer a second APM track for primary care providers. The second APM would be similar to Medicare's CPC+ Track 2 model. Additional information on the concept of the model can be found here: https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf.

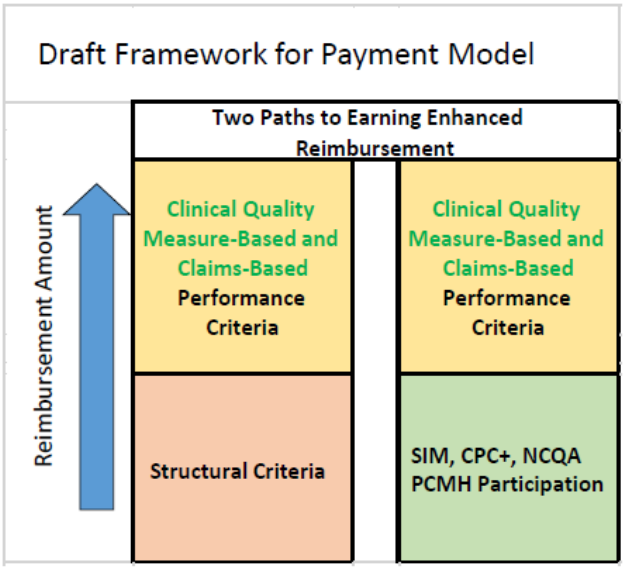


APPENDIX M

Primary Care Alternative Payment Methodology (APM)

Primary Care APM Framework

As shown in the draft framework for the payment model below, there are two paths for a PCMP to earn enhanced reimbursement, comprised of structural criteria or participation in SIM, CPC+ or NCQA PCMH, and performance criteria. The Primary Care APM will be similar to the MACRA Merit-based Incentive Payment System (MIPS) program. Within the structural and performance criteria domains, individual metrics will be assigned a certain amount of points, calculated based off a resource intensity weight. Each PCMP participating in the Primary Care APM will receive an overall score that will be translated into a payment adjustment for that payment period. This score will be from a combination of points out of both the structural and performance categories. High performing PCMPs will be able to receive the full value-based reimbursement in addition to their FFS reimbursement (bringing them to 100% of the available reimbursement).



PCMP Criteria

As described previously, PCMPs must meet certain criteria to participate in the Primary Care APM. The model includes structural and performance criteria. The performance criteria consist of clinical quality measures and claims-based measures. The box below contains criteria definitions and a few examples.

PCMP Criteria

Structural Criteria	Performance Criteria	SIM, CPC+, NCQA PCMH Participation
Measures a practice's capacity and conditions in which care is provided by looking at continuous quality improvement	A combination of process and outcome measures that assess how services are provided and the results of these services. Practices can	Practices participating in SIM, CPC+ or PCMH will have the opportunity to earn enhanced

activities, team-based care, access, care management, care coordination and self-management support. Examples: Registries, empanelment, availability of appointments and care compacts.	earn up to 100% enhanced reimbursement through this set of criteria. Examples: Suicide risk assessment, ED utilization, breast cancer screening and adult BMI assessment.	reimbursement in lieu of structural criteria, but can earn 100% through performance criteria.

See Attachments 1 and 2 for the full list of draft structural and performance criteria.

PCMP Designation Process

The Regional Entities under ACC Phase II, referred to as Regional Accountable Entities (RAEs), will have the responsibility to assign and designate PCMPs that are eligible to participate in the Primary Care APM, and will provide needed practice support and infrastructure assistance to PCMPs. RAEs will use the structural criteria, that are outlined in this paper, or PCMP participation in SIM, CPC+ or PCMH, to designate PCMPs eligible to participate in the Primary Care APM. RAEs will notify the Department of PCMP designation.

Criteria Measurement

Workgroups composed of Department staff and external stakeholders are in the process of determining how the structural and performance criteria will be measured quantitatively and qualitatively. Validated measures aligned with other initiatives such as SIM, MACRA and CPC+ will be used in the Primary Care APM framework. The Primary Care APM Measurement Criteria includes Structural Elements and Clinical Quality Measures – including Process and Outcomes-Based Performance Measures. The Structural Elements are to be reviewed by the RAE on a regular basis. The Clinical Process Measures and Outcomes-Based Performance Measures are a mix of claims-based measures conducted by the Department and Electronic Clinical Quality Measures (eCQM) Reporting from the practices with that capability. Frequency of reporting structural elements and clinical quality measures is still under discussion.

Provider Reimbursement

Billing will be completed through the Medicaid Management Information System (MMIS). PCMPs will submit fee-for-service claims. The Department will have a limited set of primary care codes that comprise the Primary Care APM. When an eligible PCMP bills a code included in the Primary Care APM code set, the MMIS will make payment at the appropriate enhanced level.

Ongoing Monitoring

The Department will monitor the Primary Care APM on an ongoing basis through several mechanisms. The Department will track and report payments made to PCMPs, and will conduct

data analysis to identify overall performance and outcomes of participating PCMPs. PCMP designation will be conducted on an ongoing basis, not to exceed once every three years and/or upon change in the practice.

Federal Authorities

The Department is requesting support from CMS in identifying and securing the necessary federal authority to operate the Primary Care APM

Attachment 1 Structural Criteria

MEASURE NAME	MEASURE DESCRIPTION
IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES	
QI Strategy & QI Plan	Develop QI Strategy & Agency QI Plan, including a QI Team and regularly scheduled meetings.
Improvement Activities	The practice identifies, sets goals, analyzes data and acts to improve performance on at least one performance measure.
Quality Improvement	The practice identifies, sets goals, analyzes data and acts to improve performance on 3 or more performance measures, including one behavioral health measure.
Use Data Effectively	The practice demonstrates that it collects clinical quality performance data and assesses the results at least quarterly on the practice-level and panel-level to inform strategies to improve population health management.
Patient Satisfaction	The practice involves patients/families in quality improvement activities or on the patient-family advisory council (PFAC).
TEAM BASED CARE	
Empanelment	Assisting patients/families to select a provider and documenting the selection in practice records, review and validate provider empanelment regularly.
Define Team	Identify clinical and non-clinical team members, define roles and responsibilities for each.
Team Training	Develop a team based strategy & on-going training of team members to coordinate care for individual patients, support patients/families in self-management, manage the patient population.
Team Meetings	Holding scheduled team meetings to address practice functioning, and holding scheduled patient care team meetings.
Non-Traditional Team	Utilization of non-traditional team members (Social Worker, Case Workers, etc.).
ACCESS	
Accepting New Patients	The Practice accepts new Medicaid clients for the majority of the year (7 out of 12 months).
Availability of appointments	The practice has standards for appointment availability, including providing same-day appointments. Availability standards may be established and measured for a variety of appointment types (including urgent care, new patient physicals, follow-up appointments) or the practice may set a single standard across all visit types.

No-Show Rates	To provide consistent access and help understand true demand, practices monitor no-show rates. No show rates may be calculated by taking the number of patients who did not keep their pre-scheduled appointment during a specific period of time divided by the number of patients who were pre-scheduled to come for appointments during the same period of time.
Alternative Encounters	Providing alternative types of clinical encounters, including telephone/video chat/secure instant messaging/Group visits or shared medical appointments.
Improving Access	Using data captured in previous access measures, identify opportunities to improve access and act on at least one identified opportunity. Include criteria for selecting areas of focus, describe how the practice monitors these areas of focus, what is the target for improvement, how often are these criteria revisited, and outline when targets may be adjusted.
CARE MANAGEMENT	
Standing Orders	The practices use written standing orders for services.
Screening and Follow-Up	Using standardized screening tools, and developing follow-up process for at least 3 conditions, including one behavioral health condition.
ED & Hospital Follow-Up	Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit. The practice contacts patients to evaluate their status after an ED or hospital visit and schedules follow-up appointments as appropriate.
Risk Stratification	Use department Risk Stratification framework to risk stratify patients - use data to identify patients for care management.
Gaps in Care	Practice identifies a strategy to identify gaps in care, & implements proactive care gap management for high-risk patients. Use data, at least twice a year, to proactively identify populations of patients and remind them or their families, of needed care based on patient information, clinical data, health assessments, and evidence-based guidelines.
CARE COORDINATION	
Clinical Question	Gives consultant or specialist the succinct reason for referral, which may be stated as the "clinical question." The practice includes follow-up communication or information in the referral.
Data Sharing	Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan; including communication needs, primary language, relevant cultural or ethnic information.
Care Compacts	Maintains formal and informal agreements with a subset of specialists based on established criteria (including at least one Behavioral Health provider).
Referral Tracking	Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.
BH Integration	Integration of BH (On-site or through Care Management Agreements)
PROVIDING SELF-MANAGEMENT SUPPORT	
Educational Resources	Provides patient-specific educational and community resources to patients to support patient self-management.

Assess Self-Management Support Capability	Assess practice capability and plan for support of patient's self-management.
Self-Management Tools	Identify Self-Management tools, including tools to address potential barriers to meeting goals.
Implement Self-Management Support	Implement self-management support for at least 3 high risk conditions (including behavioral health condition).
Individual Care Plan	The care team and patient/family collaborate (at relevant visits) to develop and update an individual care plan that includes patient preferences, functional/lifestyle goals, treatment goals, potential barriers to meet goals, a self-management plan, and is provided in writing to the patient/family.

Attachment 2 Performance Criteria

Claims-based Performance Criteria	
Adult practices	**Pediatric practices**
Behavioral Health	
• Depression Remission at 12 months • Suicide Risk Assessment • Maternal Depression Screening	• Maternal Depression Screening • Suicide Risk Assessment
Chronic Care Management	

• Diabetes
  o A1c Test during the Measurement Year
  o Eye Exam
  o Foot Exam
  o Nephropathy Screening
• Medication Management for People with Persistent Asthma
	• Medication Management for People with Persistent Asthma

Cost Containment	
• Use of Imaging Studies in Low Back Pain • ED Utilization • Readmissions • Total Cost of Care	• Appropriate Testing for Children with Pharyngitis • ED Utilization • Readmissions • Total Cost of Care
Preventive	
• Prenatal and Post-Partum Care • Chlamydia Screening • Colorectal Cancer Screening • Breast Cancer Screening	• Well Child Visits 15 months • Well Child Visits 3, 4, 5, 6 years of age • Adolescent Immunizations • Adolescent Well Care Visits • Childhood immunizations

CQM Reporting Performance Criteria	
Adult practices	**Pediatric practices**
Behavioral Health	
• Screening for Clinical Depression and Follow-Up Plan • Depression Remission at 12 months	• Screening for Clinical Depression and Follow-Up Plan
Chronic Care Management	
• Diabetes: HbA1c >9 Poor Control • Controlling High Blood Pressure • Medication Management for People with Persistent Asthma	• Medication Management for People with Persistent Asthma
Preventive	
• Adult BMI Assessment	• Weight Assessment

• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • Tobacco Use: Screening and Cessation Intervention • Alcohol Use: Screening and Brief Counseling	• Counseling for Nutrition and Physical Activity for Children/Adolescents