Quality Metrics Payment

Colorado Indigent Care Program Clinics

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Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Payment Change Background

- In April 2017, the Department took new CICP rules to the Medical Services Board (MSB)
- New rules reorganized and modernized the existing CICP rules effective July 1, 2017, including adding in a quality metric based payment for clinics effective July 1, 2018
- New methodology shifted the data reports to calendar years to more closely match the quality metrics and split the money into two pots: 75% for cost based reimbursement, 25% for quality based reimbursement.

Cost Based Reimbursement

- This methodology hasn't changed from how it was previously calculated. Providers are reimbursed based on their portion of the total write off costs for all participating CICP clinics.
- For example, if a clinic has 5% of the total write off costs, they receive 5% of the Cost Based reimbursement pot.

Quality Metrics

- Four quality metrics were chosen to be used in the Quality Metric payment calculation:
  - Body Mass Index (BMI) Screening and Follow-Up
  - Screening for Clinical Depression and Follow-Up Plan
  - Controlling High Blood Pressure (Hypertensive Patients with Blood Pressure < 140/90)
  - Diabetes: Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%)

Healthy People 2020 Goals

- Each of the four quality metrics has been paired with a Healthy People 2020 Goal as a benchmark:
  - BMI Screening with Nutrition and Weight Status 6.3 (NWS-6.3)
  - Depression Screening with Mental Health and Mental Disorders 11.1 (MHMD-11.1)
  - Hypertension with Heart Disease and Stroke 12 (HDS-12)
  - HbA1c with Diabetes 5.1 (D-5.1)

BMI and Depression

- The Healthy People 2020 goals associated with BMI and Depression are based on a visit basis instead of a patient basis. Therefore, these two goals have been adjusted to reflect patients instead of visits using the CICP average of 3.3 visits per client for all CICP clinics.
  - BMI goal for HP2020 is 15.2% of visits, CICP goal will be 50.2% of clients
  - Depression goal for HP2020 is 2.4% of visits, CICP goal will be 7.9% of clients

BMI Calculation

Total number of visits	1000
% of visits with BMI Screening (HP2020 goal)	15.2%
Number of visits with BMI Screening	152 (1000 x 15.2%)
Total number of clients (using CICP Average of 3.3)	303 (1000/3.3 ≈ 303)
% of clients with BMI Screening (CICP goal)	50.2% (152/303 = .5016)

Depression Calculation

Total number of visits	1000
% of visits with Depression Screening (HP2020 goal)	2.4%
Number of visits with Depression Screening	24 (1000 x 2.4%)
Total number of clients (using CICP Average of 3.3)	303 (1000/3.3 ≈ 303)
% of clients screened for Depression (CICP goal)	7.9% (24/303 = .0792)

Quality Score

- Each of the four quality metrics are assigned a Quality Score.
- The Quality Score is awarded as follows:
  - 1 point if the metric falls between 0% and 20%
  - 2 points if between 20.1% and 40%
  - 3 points if between 40.1% and 60%
  - 4 points if between 60.1% and 80%
  - 5 points if between 80.1% and 100%
- Exception: Diabetes has a reversed scale.

Quality Score (cont.)

- Additionally, each quality metric is awarded one point if the provider has met or exceeded the associated Healthy People 2020 goal, or two points if the provider has met or exceeded the Healthy People 2020 goal and has maintained or improved upon their quality metric percentage from the previous year.
- The total Quality Score for each metric falls between 1 and 7 points, for a total possible Quality Score falling between 4 and 28.

Quality Tier

- Providers are assigned to a Quality Tier based on their Quality Score. The Quality Tiers are as follows:

Tier	Lower Bound	Upper Bound
1	4	8
2	9	12
3	13	16
4	17	20
5	21	28

Quality Metric Reimbursement

- The quality metric payment is based on each provider's Quality Score adjusted by their total visits
  - The calculation is adjusted by visits to ensure that a small clinic is not receiving the same payment as a large clinic with the same Quality Score.
- The Quality Score multiplied by total visits creates the provider's Quality Points.
- The Quality Points are then multiplied by the payment for the Quality Tier in which the clinic falls.

Quality Tier Amounts

- The Quality Tier payment amounts will be adjusted at least annually to ensure that the entire appropriation is paid out. Below is this year's payment amount for each tier.

Tier	Lower Bound	Upper Bound	Payment per Quality Point
1	4	8	$0.50
2	9	12	$0.62
3	13	16	$0.75
4	17	20	$0.87
5	21	28	$1.00

Setting the Quality Tier Amounts

- The Quality Tier table is set up so that providers in Tier 5 are paid twice as much per point as providers in Tier 1. The total appropriation for the Quality Payment is divided by the total number of Quality Points for all providers, and then the Quality Tier amounts are set by a built in Excel feature called “Goal Seek”.
- Goal Seek automatically runs through thousands of combinations to figure out where to set the tiers so that the entire appropriation amount will be distributed.

Example of Payment Calculation

- Provider A has a Quality Score of 20 and has reported 210 visits for the year. Provider A's Quality Points equal 4200 (20 x 210 = 4200).
- Provider A's Quality Score of 20 puts them into the fourth payment tier, so they will be paid $0.87 per point (note that the $0.87 is rounded to the nearest penny here, but not in the calculations).
- Provider A's Quality Payment is $3,672.50

  (4200 x .874404 ≈ $3,672.50)

What happens if funds are redistributed?

- If there should be money that needs to be redistributed from the Cost Based payment, that money will be redistributed as it always has been.
- If there should be Quality Metric payment money that needs to be redistributed, the redistribution will work exactly the same as the original distribution, but the Quality Tier table will be updated to ensure the entire amount of redistributed funds is disbursed.

Additional Payment Impacts

- Beginning with program year 2018-19, the Department has contracted with Public Consulting Group, Inc. (PCG) to conduct audits of our providers, replacing the required provider conducted audit.
- The clinic funds used for the audit for 2018-19 total $28,864, however the impact on the total payment funds total $57,728, twice the total clinic funds used for the audit.
- This is due to the fact that the CICP sends the clinic funds to Children's Hospital Colorado to distribute, which allows us to draw federal matching money.

Audits in 2019-20 and Beyond

- The 2018-19 audit is smaller than the audits will be in subsequent years. This year, we are auditing 12 of our providers whereas beginning in 2019-20, we will be auditing approximately 24 of our providers annually.
- The clinic funds used for the audits beginning in 2019-20 will total $40,187, making the impact on the total payment funds $80,374.

Payment Impacts of the Audit

- Audit findings will only impact the cost-based payment.
- The Department allows for a 2% variance in billing findings, so any findings will be lowered by 2%.
  - For example, if the findings show an error of 3%, the payment would only be impacted by 1%.
- Any reduction in payment to providers caused by the audits will be redistributed to the other providers in the last payment of the program year in May.

Questions?

Contact Information

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Thank You!