Schedule 13

Department of Health Care Policy and Finance

Funding Request for The FY 2019-20 Budget Cycle

Request Title

R-07 Primary Care Alternative Payment Models

Dept. Approval By: 11/1/18

OSPB Approval By:

	Supplemental FY 2018-19
	Budget Amendment FY 2019-20
X	Change Request FY 2019-20

Summary Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$65,081,509**	**$0**	**$68,309,171**	**$2,570,871**	**$2,171,713**
	FTE	465.8	0.0	471.3	1.8	2.0
	GF	$22,647,653	$0	$24,393,858	$535,928	$557,897
	CF	$6,820,115	$0	$6,711,778	$281,908	$293,461
	RF	$2,633,535	$0	$2,654,319	$0	$0
	FF	$32,980,206	$0	$34,549,216	$1,753,035	$1,320,355

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$34,785,923**	**$0**	**$36,413,166**	**$119,889**	**$130,798**
	FTE	465.8	0.0	471.3	1.8	2.0
	GF	$11,935,474	$0	$12,577,193	$39,282	$42,856
	CF	$3,129,300	$0	$3,273,826	$20,663	$22,543
	RF	$2,242,657	$0	$2,274,826	$0	$0
	FF	$17,478,492	$0	$18,287,321	$59,944	$65,399
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,647,883**	**$0**	**$4,655,713**	**$15,854**	**$15,854**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,575,324	$0	$1,651,283	$5,195	$5,195
	CF	$399,501	$0	$409,280	$2,732	$2,732
	RF	$135,355	$0	$123,276	$0	$0
	FF	$2,537,703	$0	$2,471,874	$7,927	$7,927

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
	Total	**$60,727**	**$0**	**$66,035**	**$204**	**$222**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$21,043	$0	$24,054	$67	$73
	CF	$5,213	$0	$5,306	$35	$38
	RF	$1,484	$0	$1,522	$0	$0
	FF	$32,987	$0	$35,153	$102	$111
	Total	**$1,855,596**	**$0**	**$1,985,443**	**$5,360**	**$5,847**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$642,806	$0	$723,280	$1,756	$1,916
	CF	$159,439	$0	$159,516	$924	$1,008
	RF	$45,371	$0	$45,699	$0	$0
	FF	$1,007,980	$0	$1,056,948	$2,680	$2,923
	Total	**$1,855,596**	**$0**	**$1,985,443**	**$5,360**	**$5,847**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$642,806	$0	$723,280	$1,756	$1,916
	CF	$159,439	$0	$159,516	$924	$1,008
	RF	$45,371	$0	$45,699	$0	$0
	FF	$1,007,980	$0	$1,056,948	$2,680	$2,923
	Total	**$2,450,635**	**$0**	**$2,245,370**	**$12,704**	**$4,645**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$961,623	$0	$889,835	$4,163	$1,523
	CF	$239,823	$0	$210,072	$2,189	$800
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,235,892	$0	$1,132,166	$6,352	$2,322
	Total	**$15,242,917**	**$0**	**$16,398,142**	**$2,331,500**	**$1,928,500**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$5,270,423	$0	$6,188,036	$457,497	$478,206
	CF	$2,303,928	$0	$1,910,677	$240,653	$251,544
	RF	$150,000	$0	$150,000	$0	$0
	FF	$7,518,566	$0	$8,149,429	$1,633,350	$1,198,750

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
	Total	**$4,182,232**	**$0**	**$4,559,859**	**$80,000**	**$80,000**
01. Executive Director's Office, (F) Provider Audits and Services, (1) Provider Audits and Services - Professional Audit Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,598,154	$0	$1,616,897	$26,212	$26,212
	CF	$423,472	$0	$583,585	$13,788	$13,788
	RF	$0	$0	$0	$0	$0
	FF	$2,160,606	$0	$2,359,377	$40,000	$40,000

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Cost and FTE

- The Department requests $2,570,871 total funds, including $535,928 General Fund and 1.8 FTE in FY 2019-20, $2,171,713 total funds, including $557,897 General Fund and 2.0 FTE in FY 2020-21, and $853,734 total funds, including $0 General Fund and 2.0 FTE in FY 2021-22 to continue work on value-based payment methodologies for primary care and fund the health information technology (HIT) components necessary to make value-based payments. The request includes savings from costs avoided from more expensive medical care starting in FY 2021-22, once the value-based payment methodologies have been fully implemented.

Current Program

- Starting in FY 2020-21, the Department intends to start paying over half of its enrolled primary care practices under an alternative payment model, as authorized through HB 17-1353.
- Through the Colorado State Innovation Model (SIM), substantial work has been completed related to building Health Data Colorado (HDCo), an integrated health information exchange (HIE), in partnership with the Colorado Regional Health Information Organization (CORHIO), Quality Health Network (QHN), and Colorado Community Managed Care Network (CCMCN). These organizations coordinate with Colorado health entities to develop data sharing policies, provide technical assistance, and build electronic infrastructure that allows data exchange between different health systems.
- The Department has also participated in the Colorado Multi-Payer Collaborative as part of SIM and the Comprehensive Primary Care Initiative. The collaborative works on payer alignment and has also set up a tool that aggregates claims data from different payers to support primary care transformation.

Problem or Opportunity

- The Department needs additional staff and contractor resources to set up and implement the next phase of its primary care payment reform program. In this model, practices are paid a revenue-neutral combination of per member per month (PMPM) and traditional fee-for-service (FFS) payments.
- The Department requires additional funding to set up electronic clinical quality measures (eCQMs) leveraging existing health information exchange infrastructure to be used in new, performance based, payment methodologies, as well as to provide publicly funded support for Medicaid's fair share of ongoing work done under the multi-payer collaborative.

Consequences of Problem

- If this request is not funded, the Department would miss an opportunity to better manage care and control costs in a manner that reflects best practices and is aligned with other public and private payers. The Department could not fully set up the eCQMs needed for implementing value-based payment methodologies and evaluating the quality of patient care. Without using eCQMs, the Department risks anchoring itself to obsolete and less impactful provider performance measurement, not leveraging the large SIM investment in data infrastructure, and pushing measure reporting burden onto primary care practices themselves.

Proposed Solution

- The Department requests funding for staff and contractor resources to implement new payment methodologies, build necessary eCQM infrastructure, and continue participating in the Multi-Payer Collaborative. The Department expects these programs would result in greater flexibility for practices, reduce unnecessary care, connect payment to quality of care, reduce reporting burden on primary care providers, and improve patient health outcomes.

Department Priority: ***R-7***

Request Detail: ***Primary Care Alternative Payment Models***

Summary of Incremental Funding Change for FY 2019-20	Total Funds	General Fund
Primary Care Alternative Payment Models	$2,570,871	$535,928

Problem or Opportunity:

The Department is setting up the next phase of its primary care payment reform program as part of its commitment to expanding value-based purchasing methods and maximizing the use of health information technology (HIT) to provide better care for members. The goal of these programs is to tie payments to behaviors that enhance effective care management, positive health outcomes, high quality care, and member engagement. The Department has identified resources needed to implement the next iteration of its primary care alternative payment models, including administrative resources related to applying for the correct federal authorization and maintaining the infrastructure necessary to support alternative payment models, including data aggregation for both clinical and claims-based metrics that are central to primary care payment reform.

The General Assembly authorized the Department to pursue value-based payment models through HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives." HB 17-1353 requires the Department to submit a budget request for costs associated with the performance-based payments to the Joint Budget Committee on or before November 1 prior to the fiscal year of implementation. This request details the costs associated with the next iteration of primary care performance-based payments.

Alternative Payment Models

In order to move away from volume-based payments in favor of value-based payments that prioritize better patient outcomes, the Department is pursuing two alternative payment models that conceptually follow the Comprehensive Primary Care Plus (CPC+) program piloted by the Centers for Medicare & Medicaid Services (CMS). CMS describes CPC+ as "an advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation."[1] Characteristics of this model include: investments in HIT, population health management, patient access to services and care coordination, and enhanced payments to support these activities. Both alternative payment models are conceptually similar in that both models reward primary care medical providers (PCMPs) with

[1] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

higher payments for improvements in selected structural or performance measures.[2] The models differ in respective payment structures: The first model, APM 1, uses a modification of traditional fee-for-service (FFS) payments, while the second model, APM 2, uses partial capitations to give more financial flexibility to PCMPs that are more experienced in advanced primary care.

In FY 2020-21, the Department will begin paying qualifying PCMPs in the Accountable Care Collaborative (ACC) differently based on performance under APM 1.[3] Starting in CY 2020, the Department plans to implement a voluntary second alternative payment model (APM 2). In APM 2, primary care practices would be paid a budget-neutral combination of prospective per member per month (PMPM) and traditional fee-for-service (FFS) payments. Practices would receive a monthly advance payment (known as a "partial capitation") for the services expected to be provided, and would receive discounted FFS payments based on the actual services provided. In this framework, the monthly partial capitation provides PCMPs more financial flexibility and predictability in running their operations and shifts more of the financial risk and the management of that risk onto PCMPs. It also disincentivizes practices from billing unnecessary medical services that do not improve patient health outcomes or add value to patient care since volume-based reimbursements are discounted. In addition, practices could also earn enhanced reimbursement for high performance on selected eCQM measures, creating an incentive for practices to continue to take steps to improve outcomes. This methodology has the benefit of being familiar to practices who already participate in CPC+ through Medicare.

The payment structure under APM 2 does not conform to either the FFS reimbursement methodology or the structure of traditional managed care currently allowed under the Social Security Act. As a result, the Department must seek a section 1115 demonstration waiver to implement APM 2.[4] Submitting the waiver is a large administrative lift, subject to complex federal requirements involving a budget neutrality demonstration and stakeholder outreach, which would require dedicated staff and contractor resources in order to apply and implement. Furthermore, under APM 2, the Department would need to calculate provider-specific PMPM payments for the approximately ten large practices or systems that are expected to participate initially. The Department does not have the capacity to develop and administer APM 2 and requires additional staff and contractor resources.

Infrastructure for Electronic Clinical Quality Measures (eCQM)

The exchange of eCQM data is critical to the success of the alternative payment models. The Department intends to move away from claims-based measures and rely more on performance-based and outcomes-based

[2] Structural measures are related to the practices' characteristics and include measures such as the practice's collection and review of electronic clinical quality measures (eCQMs), or whether the practice has individual patient care plans and integrated behavioral health. Performance measures are related to clinical processes or outcomes, such as controlling high blood pressure and A1c levels for diabetes management.

[3] Please refer to the "Primary Care Alternative Payment Model Survival Guide" for more detail on APM 1. https://www.colorado.gov/pacific/sites/default/files/12.01.17%20Alternative%20Payment%20Model%20Survival%20Guide.pdf

[4] "Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations." https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

measures for evaluating practice performance. Claims data is not timely due to the time between when a service is performed, and when a bill is submitted to the Department, adjudicated, and paid. Also, claims information is not always actionable for PCMPs because the information comes from billing data, and not the providers' own medical records. The eCQMs are based on provider electronic health records (EHRs) and provide the best information about the performance of a PCMP, as well as actionable data and metrics for providers to improve upon to improve the health of their population. For example, if a provider's eCQM data shows their practice is performing below average in a metric like maternal depression screenings, the provider can adjust their behavior and offer more depression screenings to new mothers to better their eCQM score and improve maternal and child health. For APM 2 to function, health information must be available, integrated, consistent, trusted, and reportable.

The Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN) both maintain health information exchanges (HIE), collectively known as Health Data Colorado (HDCo), that aggregate clinical data from EHRs across the state. These organizations, along with the Colorado Community Managed Care Network (CCMCN), an entity founded to work closely with Colorado's Federally Qualified Health Centers (FQHCs), are creating the standards for data exchange in Colorado. They also provide services such as supporting both provider submission of data to HIE, and use and understanding of the information returned from the HIE. Together, the organizations represent more than 75 percent of practice sites in the State, and 95 percent of hospital beds. This HIE infrastructure was leveraged by the Colorado State Innovation Model (SIM), a federally funded, Governor's Office initiative to support data sharing and reporting, including reporting a limited number of eCQMs. The Department plans to use and expand upon eCQM infrastructure set up and funded by SIM. The Medicaid alternative payment models will move beyond the limited number of SIM practices to all qualifying Medicaid primary care practices. It will also include a larger number of performance measures, providing choice of measures for those practices participating in the alternative payment models. The Department would require a vendor, or combination of vendors, to automatically extract the necessary data elements from each practices' EHR system, calculate the associated eCQM measures for each practice, and then report practice performance on eCQMs to the Department.

Funding from SIM was used in FY 2018-19 to launch efforts with CORHIO and other entities to advance eCQMs. The project was listed in the Colorado Health IT Roadmap Initiatives Capital Construction Request from the Governor's Office of eHealth Innovation (OeHI) to show alignment and the source of the initial pilot funding. OeHI was appropriated funds for FY 2018-19 to evaluate and expand this infrastructure statewide. The funding for OeHI is for statewide infrastructure, and was not specifically appropriated to support the Department with internal technology needs and practice readiness for APM 2. The appropriated funding is insufficient for the collection of the specific eCQMs by which practices participating in the APMs would be assessed. Additionally, the funding did not account for provider onboarding into the health information exchange, practice support, or technical assistance in their submittal of data to the registry. While those variable costs of implementation remain, those already fixed costs of the infrastructure, previously funded via a combination of private and public dollars, need not be replicated and are therefore not part of this request.

Multi-Payer Collaboration Work

In the early stages of the Comprehensive Primary Care initiative (CPCi), the predecessor to CPC+, as well as the SIM program, multi-payer collaboration was identified as a critical element of making these programs successful because primary care practices serve a diverse group of individuals and accept payments from a wide variety of public and private payers. Since 2012, the Department has participated in the Colorado Multi-Payer Collaborative (MPC), which is a multi-payer network fostering collaboration between public and private health care payers to strengthen primary care and align support for payment transformation. Working together with other payers allows the Department to benefit from more rapid and comprehensive primary care transformation than the Department would be able to drive on its own as over half of primary care practices have a small number of Medicaid members.

Multi-payer data aggregation has been identified as a crucial component of multi-payer collaboration. Historically, practices would receive disparate information on their performance from different payers, as each payer would employ their own performance measurement metrics and calculation methods. As a result, it was difficult to engage practices in payment reform initiatives when oftentimes these different initiatives from different payers did not align and if one payer only made up a small volume of the practice's claims there was little incentive to change. To address this problem, the Department worked with eight other private and public payers to agree on using identical claims-based metrics, as well as funding the multi-payer data aggregation service to compile the specific claims data to calculate those metrics.

The data aggregation service facilitates how practices interact with their patient's health data by allowing access to data elements and assessments such as: summary reports, key performance indicators, trends, population health metrics, Healthcare Effectiveness Data and Information Set (HEDIS) quality/care gaps, continuity of care, medical costs, provider analysis, registries, and drilldown reports. Practices can compare their costs against those of other primary care practices and evaluate actions they can take to better control costs. For example, through the drill-down feature, the practice might find they use more expensive medications or pay more in lab services than other PCMPs because they send their tests to a more expensive lab facility. Compared to inactive users of the data aggregation tool, active users had 48% fewer ED admissions per 1,000 patients and 80% fewer 30-day readmissions.[5] Currently, only claims data are aggregated through this process, but the long-term vision is to also incorporate EHR data.

The data aggregation process is performed by a third-party vendor selected by the MPC. The Department is currently evaluating how to procure and proceed with the Multi-Payer Aggregation. At this time for Medicaid, the Center for Improving Value in Health Care (CIVHC) provides data aggregation services. The purpose of this data aggregation process is to transform claims data across multiple payers into a common format in the multi-payer claim tool that practices can access to understand their costs and clinical outcomes. The payers in the Multi-Payer Collaborative share costs based on attributed lives. The Department has not been paying for the Medicaid share due to a lack of funding. The Department funded some of the up-front investments in CPCi in FY 2015-16 and FY 2016-17 through funding requested in FY 2015-16 R-16, "Comprehensive Primary Care Initiative Funding." The SIM grant covered some of the costs in the interim,

[5] Please see Appendix A

but the grant will expire in 2019. The Department must begin paying its fair share of the data aggregation costs to continue participation in the MPC.

Proposed Solution:

The Department requests $2,570,871 total funds, including $535,928 General Fund and 1.8 FTE in FY 2019-20, $2,171,713 total funds, including $557,897 General Fund and 2.0 FTE in FY 2020-21, and $853,734 total funds, including $0 General Fund and 2.0 FTE in FY 2021-22 in order to continue work on the primary care alternative payment models. The funding would be used to operationalize value-based payment methodologies for primary care, as well as fund the health information technology (HIT) related components that are necessary for assessing patient care, making value-based payments, and aligning incentives with other payers. The request includes savings from costs avoided from more expensive medical care starting in FY 2021-22, once the value-based payment methodologies have been fully implemented.

If this request is not funded, the State would miss an opportunity to improve member care and control costs in a manner that is aligned with best practices, as well as payment methodologies of other public and private payers. Alternative payment models, such as those used in the CPC+ model, are in the process of being implemented throughout the country. Characteristics of these models include making a greater volume of payments value-based and shifting more financial risk to providers, which is anticipated to improve health outcomes and decrease total cost of care.[6] Additionally, without additional funding the Department would not be able to fully set up the eCQM infrastructure needed for implementing value-based payment methodologies and evaluating the quality of patient care both in primary care and hospital settings. eCQMs, which utilize information from providers' electronic health records (EHRs), enable the Department to more robustly and accurately measure providers' efforts to meet specific clinical standards and client outcomes. Their statewide adoption among other public and private payers is already occurring, so the Department risks anchoring itself to obsolete and less impactful provider performance measurement, not leveraging a large SIM investment in data infrastructure, and pushing measure reporting burden onto primary care practices themselves.

Implementing APM 2

The Department requests two FTE, contractor resources, and operational funding to submit an 1115 waiver to implement and support ongoing operations of APM 2.

One FTE (Value-Based Payment Stakeholder Relations Specialist), in conjunction with the requested contractors, would develop and submit the required federal 1115 demonstration waivers. Responsibilities would include: drafting the waiver application with a comprehensive program description of the demonstration's goals, objectives, and an estimate of expenditures; establishing budget neutrality to the Federal government; designing an evaluation structure for the waiver with research hypotheses and plans to test those hypotheses; and maintaining documentation of the Department's stakeholder outreach process. These resources would also be needed for ongoing work and evaluation related to APM 2. An evaluation must be submitted to CMS at the end of every demonstration year[7] and include information on any policy or

[6] CPC+ Payment Methodology Paper: https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf

[7] 1115 waivers can be approved for an initial five-year period and be extended after in three- or five-year increments.

administrative difficulties; outcomes of care, quality of care, cost of care and access to care for demonstration populations; results of any audits, investigations or lawsuits that impact the demonstration; the financial performance of the demonstration; any State legislative developments that would affect the demonstration; and any other factors relevant to the demonstration. A consulting contractor with expertise in developing and evaluating 1115 demonstration waivers related to alternative payment models in other states would provide invaluable support in creating and maintaining the waiver. An actuarial contractor would also be required in the first year to develop budget neutrality calculations.

Additionally, one FTE (Value-Based Payment Reform Analyst) and an actuarial contractor would calculate provider-specific partial capitation amounts for primary care practices participating in APM 2. These payments would be determined by claims submitted to the Department in the baseline year. This FTE would also oversee the administration of the APM 2 incentive structure for quality performance, help implement changes with the HIEs and vendors when the measures within the incentive structure are updated, adjust each provider's FFS rates to account for partial capitation payments (to keep total payment budget-neutral) and adjust for quality performance, manage and coordinate provider communications for the program with staff across the Department, and serve as a stakeholder point-of-contract for the program.

Health Information Technology

The Department requests $1,636,500 total funds in FY 2019-20, $1,233,500 total funds in FY 2020-21, and $1,308,500 total funds in FY 2021-22 to appropriately support eCQMs in the alternative payment model programs. The funding would enable Colorado's HIEs to connect to practices' EHRs for practices that were not previously connected through SIM, extract the specific data elements necessary for each eCQM, calculate each eCQM by practice, transfer the results of the eCQM calculations to the Department for internal payment processing, and provide onboarding and support services to practices who may need assistance. There is a large degree of variation in HIT proficiency by practice. Additional technical assistance[8] involves conducting practice site visits where a Clinical Health Information Technology Advisor (CHITA)[9] walks practices through where certain pieces of information related to calculating the eCQM are located in their EHR. The CHITAs also assess and support practice data capacity, as well as assist practices with development of a data quality improvement plan and workflow plan for data collection, reporting, and analysis. Work performed by these CHITAs would be contracted through Colorado's HIEs.

It is crucial that eCQMs are trusted by both providers and the Department for tracking and evaluating practice performance and administering the alternative payment models. To ensure eCQMs are reliable, the Department also requests resources related to eCQM data validation from a third-party vendor that is a separate entity from Colorado's HIEs and CHITAs

Multi-Payer Collaborative Work

The Department requests $500,000 total funds, including $163,825 General Fund in FY 2018-19 and ongoing for the multi-payer collaborative work, including Medicaid's share of costs associated with multi-payer

[8] Technical Assistance varies slightly based on the location of the provider and whether EHR information is uploaded to the HIE maintained by CORHIO or QHN.

[9] Clinical Health Information Technology Advisors (CHITA) were created through the SIM program to help support practices with adopting HIT.

claims aggregation. The funding would pay for work to transform claims data across multiple payers into a common format and the aggregated claims platform used by practices to assess their practice's financial performance.

The risk of not funding the multi-payer work is losing the collaborative process and partnerships that were established under the MPC through SIM funding. Colorado payers and participating practices were able to align health goals and metrics, and agree to fund a shared claims aggregation platform, enhancing the internal efficiency of a practice. Because of the diverse mix of payers a practice might work with, it would be difficult for a single payer to pursue this project on its own, and achieve the same meaningful results. Participation of all payers is needed for the multi-payer collaborative to be successful.

Anticipated Outcomes:

The Department anticipates patient health outcomes would improve with greater use of immediately accessible and actionable eCQMs and that there would be less utilization of higher cost medical care like hospitals. The Department expects that if practices have better information on overall patient performance through eCQMs, practices would be better able to manage their patients' conditions on an individual level. For example, a practice that selects an eCQM performance measure of "Diabetes: HbA1c Poor Control (>9%)" could offer more nutrition and lifestyle counseling to try to improve their eCQM score. In both alternative payment models, a portion of the payments are connected to improvements in patient health outcomes.

The payment and incentive structure of the Department's proposed APM 2 allows for providers to be more innovative and flexible in how they operate, while holding them accountable for quality and efficiency. Practices would have more administrative flexibility under the hybrid PMPM-FFS payment structure. As reimbursement is decoupled from the volume of billed procedure codes and practices have better expectations of their monthly cash flow, practices can use their additional financial capacity to keep the clinic open for longer hours, offer telehealth or after-hours support, or perform other actions that support patients in a person-centered manner.

In the Department's FY 2018-19 Performance Plan, the Department committed to expanding the use of value-based purchasing methods and tying more provider payments to quality or value as part of its strategic policy initiative for tools of transformation.[10] The adoption of APM 2 would further the Department's Performance Plan goals.

Furthermore, the work done with entities such as CORHIO, QHN, CCMCN, and the Colorado Multi-Payer Collaborative supports the Department's strategic policy initiative to leverage partnerships with other organizations to improve Medicaid member's health outcomes and overall population health.

Assumptions and Calculations:

Please see Appendix B for detailed calculations and tables.

[10] https://www.colorado.gov/pacific/sites/default/files/HCPF%202018-2019%20Performance%20Plan.pdf

Department Resources for Alternative Payment Models

Department Staff

The Department requests 1.0 Administrator III FTE as the Value-Based Payment Stakeholder Relations Specialist. The position would be responsible for policy development of the APM 2 model. The position would be responsible for researching and analyzing value-based payments in other states and with other payers and related policy issues. The position would oversee the effort related to developing the 1115 waiver, including managing the contractor for the waiver, coordinating any related State Plan Amendments, communicating with the federal Department of Health and Human Services, CMS, and completing all stakeholder outreach and public notice. Ongoing duties of this position would be to monitor and assess the program after implementation, including assuring that the quarterly and annual reports are completed, approved, and submitted to CMS, as well as directing rule and agency letter changes. The position would also be responsible for managing stakeholder engagement with practices and potentially other payers on the design of APM 2, including the measures by which PCMPs are evaluated. This position would work closely with the Value-Based Payment Reform Analyst.

The Department requests 1.0 Rate/Financial Analyst III FTE as the Value-Based Payment Reform Analyst. This position would be responsible for working with the contracted actuary in developing provider-specific PMPM payments. The position would ensure the PMPM payments and incentives remain within budget and that the Department pays the appropriate level of incentive to encourage behavior change and performance. The position would also support the Value-Based Payment Stakeholder Relations Specialist in developing and submitting the 1115 waiver to CMS, as well as assisting with stakeholder engagement with participating PCMPs.

The Department assumes these FTE would be hired by September 2019 and with assistance from the consulting contractor could submit the 1115 demonstration waiver to CMS by March 2020. The Department assumes the waiver approval process would require one year and the first partial capitation payments could be made starting in July 2021, although this timeline is subject to the Department receiving approval of the waiver from CMS.

Contractor Resources

The Department requests funding for a contractor to help develop the waiver application, as well as a plan for evaluating the waiver. The contractor scope of work would include developing, writing, and submitting the waiver, which must include a comprehensive program description of the demonstration, including the goals and objectives. The application must also include an estimate of expenditures, the research hypotheses, a plan for testing the hypotheses, and a design of the evaluation. Based on prior contracts of a similar nature, the contractor would cost $200,000 in the first year and $150,000 in subsequent years at a rate of $200 per hour (1,000 hours in the first year and 750 hours ongoing). Ongoing funding is required to assist Department staff with submitting an annual report to CMS after each demonstration year.

The Department assumes an actuarial contractor would also be required. The actuary would be responsible for developing an analysis that demonstrates the waiver's budget neutrality. Additionally, the actuary would assist the Department in calculating practice-specific PMPM payments for practices participating in APM 2. The Department estimates that the actuary contract would require ongoing funding to develop budget

neutrality calculations for the waiver in the first year. In subsequent years, the funding requirements would increase for developing PMPM payments as the number of participating PCMPs increases. The costs are estimated assuming a rate of $200 per hour for 375 hours in the first year, 625 hours in the second year, and 875 hours in the third year and ongoing.

Operational Costs/Mailing

The Department requests $2,340 total funds in FY 2019-20, $2,745 total funds in FY 2020-21, and $3,150 total funds in FY 2021-22 to send communication to PCMPs in APM 1 and 2. The Department predicts one mailer would need to be sent to primary care practices to inform them if they have met the claims volume requirement to participate in an alternative payment model. For practices participating in one, the Department assumes four mailers would be sent to communicate updates on the program. The Department estimated these costs using the FY 2017-18 cost of $1.80 per mailer.

Contractor Funding for eCQM Collection

The following components are necessary for ensuring the eCQMs are set up for the alternative payment models. The Department assumes some of these activities would be eligible for an enhanced federal financial participation (FFP) rate of 90% under the Health Information Technology (HITECH) administrative funding authorized by the American Recovery and Reinvestment Act of 2009 (ARRA). The eCQM development qualifies for this enhanced rate as HIE infrastructure development.[11] These estimates were developed in consultation with an HIE partner.

Start-Up and Ongoing Administration

The Department requests funding for the vendor's ongoing administration costs associated with supporting the eCQMs. This funding would support initial evaluations of operational readiness, development of policy and procedures, as well as creating and updating a training manual for practices. This funding would also be used to compile a flat data file of eCQMs from practices participating in the alternative payment models. The Department assumes these costs would qualify for 90% FFP in FY 2019-20.

Additionally, the funding would be used to pay for HIE subscription costs for certain practices. To remain sustainable, HIEs charge subscription fees for their health data exchange services. Small, frontier, and rural practices are more sensitive to ongoing-EHR related fees, especially early in production before those practices see a return on investment. Depending on the size of the system, purchasing and implementing an EHR could cost tens of millions of dollars for large practices and tens of thousands for smaller practices. EHR-related costs pose a significant barrier to adoption of EHRs and using them to their full potential. Offsetting the subscription allows for practices that might otherwise not be able to afford connecting to the HIE to do so without the financial burden. It is an opportunity for the Department to prove the value of connecting to HIEs to practices and their patients.

Practice Onboarding

The Department would support practice onboarding to the Colorado Health Information Exchange Network (i.e., CORHIO and QHN) and CCMCN with a Provider Onboarding Program. Practice onboarding is necessary for achieving interoperability between the provider's EHR system and the HIE. EHR systems have

[11] https://www.medicaid.gov/medicaid/data-and-systems/hie/federal-financial-participation/index.html

different vendors and they are not always able to "talk" with the systems of other providers. The best way to achieve system interoperability is to connect those systems to HIE. HIEs facilitate the exchange of data from one system to another using a variety of means including sending direct messages or pushing notifications to a primary care practice; for example, information that a patient was recently seen at an emergency room. The onboarding program facilitates connections between the EHR and the HIE. Without onboarding, EHR systems would have limited interoperability, meaning practices would have a more difficult time getting necessary information so that they can provide the most appropriate care. Furthermore, health care data would remain siloed in individual systems, clinics, and practices.

Medicaid Practice Onboarding includes the following:

- Providing interfaces to participating practices to connect to the Colorado HIE network (Health Data Colorado) and paying for subscription costs. Practices use the interface to submit and validate EHR data.
- Funding for a vendor to assist practices with work on creating a Continuity of Care Document (CCD)[12], including validation, normalization, and delivery of the CCD into the HIE. HIEs uses the CCD as part of building a comprehensive overview of a patient's treatment across the medical neighborhood. This information is necessary for calculating eCQMs and building the data visualization tool that highlights gaps in care.

The Department assumes approximately 90 practices participating in the alternative payment models would be onboarded through SIM by FY 2019-20. As such, the Department would need to provide funding for additional practices that were not onboarded through SIM. Please refer to Table 3.2 and Table 3.3 for more detail.

The Department assumes this funding would qualify for 90% FFP up until the expiration of enhanced HITECH match rate on September 30, 2021.

Data Quality and Technical Assistance for Practices

The Department would expand traditional Regional Extension Center (REC) services to include participating practices that were not eligible to receive REC services under the Office of the National Coordinator's definition. Expansion of eligible practices serves to increase provider adoption of EHRs, as well as provide education and technical services by funding personnel to perform technical assistance and programmatic assistance. Technical assistance would include working with practices to understand their EHR measures and inputting them correctly into the exchange. The Department assumes participating PCMPs would each need ten hours of support each year at a rate of $150 per hour. The Department assumes this support would be ongoing as new eCQMs are developed and selected by practices in future years of the request. The

[12] A Continuity of Care Document (CCD) is an electronic document exchange standard for sharing critical summary information on a patient between different providers. The CCD includes the most relevant administrative, demographic, and clinical information on a patient so that a provider (usually one that is not the patient's primary care provider) can treat a patient with whom they may not be as familiar.

Department anticipates the majority of data quality and technical assistance provided to practices would be related to submission of EHR that relate to eCQMs used in the alternative payment models.

Clinical Staff Validation of eCQMs

A portion of the funding would be used for the eCQM vendor to hire clinical staff to analyze data and encounters to ensure eCQMs are accurately being compiled. The clinical staff would also be responsible for arbitrating disputes over data submission. Clinical staff are valuable in this role due to their medical knowledge and ability to communicate with other clinicians.

Global Measure Development

The Department assumes new eCQMs would replace old claims-based measures over time. This cost reflects development of 18 new measures in FY 2019-20, and five new measures each year in FY 2020-21 and FY 2021-22. The new eCQMs would each require 15 hours of development time in FY 2019-20 and 30 hours subsequent years at a rate of $175 per hour. The Department expects more time is necessary for developing in future years due to increasing complexity of measures. The Department assumes this funding would qualify for 90% FFP up until the expiration of enhanced HITECH match rate on September 30, 2021. [13]

Clinical Gap Analysis and Data Visualization

The clinical gap analysis and data visualization tool identifies gaps in care based on the eCQM information and Continuity of Care Documentation (CCD). The funding would pay for licensing for the Department and Regional Accountable Entities (RAEs) to use this tool. RAEs can then work with PCMPs to determine how practices can better their eCQMs.

eCQM Audit & Data Validation

The Department assumes it would need to hire a contractor to perform data validation on a sample of practices each year to ensure eCQMs have been appropriately compiled. The Department is requesting funding to allow for 25 practices to be audited each year; the Department assumes that each practice audit would require sixteen hours at a rate of $200 per hour.

Multi-Payer Collaboration and Data Aggregation

The Department's share of the total cost of the multi-payer work, including the data aggregation, data aggregation tool, and facilitation costs is based on a tiered cost allocation methodology that was agreed upon by Colorado's payer-group, based on an estimate of the proportion of each payer's total members. The data aggregation costs are roughly based on the current annual charges that assume a maximum of 650,000 attributed lives and 400 license-holders. The Department would receive a 50% federal financial participation (FFP) rate on its share of administrative costs.

Savings from Improved Health Outcomes

The Department anticipates the General Fund costs of this request would be offset by costs avoided from more expensive medical care starting in FY 2021-22. FY 2021-22 is the first full year of both alternative

[13] The Department assumes that the match rate would remain at 50% FFP through FY 2022-23 and would include an annualization to true up funding for the change in the match rate through the FY 2022-23 budget process.

payment models being in place and the Department assumes approximately 275 practices would be using eCQMs by this time.

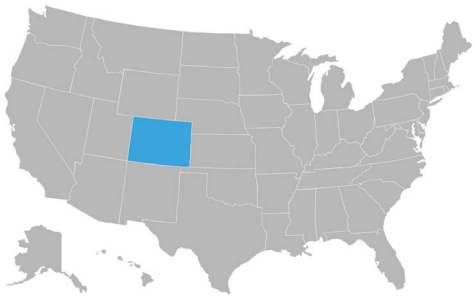
In Table 4.1, the Department estimates the minimum number of avoided hospital or antidiabetic drug utilizers needed to offset the General Fund costs in FY 2021-22. On an annual basis, the alternative payment models would need to prevent 150 hospitalizations (0.55 hospitalizations per participating practice) or help improve the health conditions of 637 members (2.32 members per participating practice) with diabetes such that they no longer require medication. The Department assumes these avoided costs represent a reasonable minimum that practices can achieve as part of improving their eCQM performance measures. Alternative payment models and their use of eCQMs are a new and evolving means of controlling medical costs. Due to limitations in literature evaluating savings from these alternative payment models, the Department was unable to estimate a more precise range of savings from funding these programs.

Colorado Multi-Payer COLLABORATIVE

OVERVIEW

The Colorado Multi-Payer Collaborative (MPC) is a working collaborative of payer organizations focused on transforming care and reforming payment in Colorado. The MPC has brought traditionally competing organizations together to ***share resources***, ***align quality measures***, and ***align support for payment transformation*** to support primary care practices in the pursuit of increased quality of care, all while controlling cost and encouraging appropriate utilization.

The MPC has been collaborating since 2012, and is comprised of public and private health care payers. Originally established as a result of the Centers for Medicare and Medicaid's Comprehensive Primary Care (CPC) initiative, the MPC has used the momentum of early efforts to expand health care transformation activities and support throughout Colorado. The MPC currently includes nearly all payers operating in Colorado, including CMS. Members of the MPC participate in three initiatives in various configurations (i.e. not all payers participate in all initiatives): 1) Comprehensive Primary Care Plus, 2) State Innovation Model, and 3) data aggregation. The MPC meets monthly, and operates in compliance with federal and state antitrust laws.



The Multi-Payer Collaborative sees itself at the nexus of transformation in Colorado and desires to play a pivotal role as the focus on health care deepens. The MPC is committed to building on and expanding initial efforts to transform and support health care transformation throughout Colorado. MPC members would like to discuss their potential role in alignment with the Lieutenant Governor's goals and priorities.

STATE INNOVATION MODEL

Colorado SIM is a broad-based reform initiative that includes both public and private sector investments in comprehensive, whole person care. Colorado SIM is focused on behavioral health and primary care integration, and available to practices at every state of transformation. The MPC has actively worked to develop a framework for whole person care, as well as specific milestones to guide practice transformation efforts, and has expanded value-based payments to support this work. The MPC also helps coordinate and align SIM with other regional and enterprise initiatives to best enable practice transformation and improve patient care.

The Colorado Multi-Payer Collaborative (MPC) is a highly functional collaborative of payer organizations focused on transforming care and reforming payment in Colorado to improve the health of all Coloradans. MPC participants include representatives from Anthem BCBS, the Centers for Medicare and Medicaid Services, Cigna, Colorado Choice Health Plans, the Colorado Department of Health Care Policy and Financing, Kaiser Permanente, Rocky Mountain Health Plans, and United Healthcare.

COMPREHENSIVE PRIMARY CARE PLUS

CMS' Center for Medicare and Medicaid Innovation (CMMI) is sponsoring the Comprehensive Primary Care Plus (CPC+) initiative, a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. CPC+ provides practices with enhanced alternative payments, a robust learning system, and actionable patient-level cost and utilization data feedback, to support practice transformation. CPC+ launched January 1, 2017 and will run through December 31, 2021. CMS has selected 14 regions, comprised of 2,893 practices. In Colorado, the MPC supports 207 practice sites and more than 300,000 patients.

DATA AGGREGATION PROJECT

Recognizing the importance of data to inform change, and the burden to practices in accessing, synthesizing, and effectively using claims data across payers, the MPC developed an aggregated data tool to accelerate practice transformation. The MPC used a rigorous and transparent process, that included representatives from all payers participating payers and practice leadership, to identify, select, and contract with Rise Health (now part of Best Doctors) to provide Stratus™ to CPC practice beginning in 2015.

Stratus™ aims to enhance and improve delivery of care to Coloradans, as well as reduce overall cost of care by providing aggregated administrative data at the point of care. Colorado's data aggregation effort is unique in the nation, and is oft-heralded by federal partners and others as a "best practice." This type of coordination is rare outside an in-tact system, such as Kaiser Permanente. Stratus™ aims to support the type of informed decision-making that is needed as risk and accountability shifts towards providers. This shift requires the availability of information related to quality, coordination of care, medical costs, patient risk and population health.

Prior to this project, providers received multiple reports from each payer and had to log on to several different websites to access patient data, making it cumbersome and inefficient to coordinate a patient's care. Stratus™ now provides a single source of claims data for patient-level information that can help providers save time and resources, and enable them to spend more time with patients. For the first time Status™ has enabled practices to see the impact of their decisions across the medical neighborhood. Practices are using Stratus™ to better manage care to reduce ED utilization, change referral patterns, and target high-risk patients and chronic care populations in order to reduce inappropriate utilization and lower costs. Although data is currently updated quarterly, during the first year of the data aggregation project more than 85% of practices used Stratus™ at least monthly as part of their transformation work.

Stratus™ also provides analytic tools that help practices improve workflow, identify high-risk patients, and proactively manage open care gaps. Best Doctors has partnered with CIVHC and the APCD, and other state and local entities to enhance Stratus™ and help ensure a comprehensive approach to data aggregation. This is particularly valuable for practices participating in multiple initiatives, as Stratus™ enables an efficient and streamlined data tool across projects.

In August 2017, the MPC and Best Doctors compared clinical outcomes across a group of active Stratus™ users with inactive users. Analysis revealed that compared to inactive users, active Stratus™ users had:

- 48% fewer ED admissions per 1,000
- 80% fewer 30-day readmissions
- 6% fewer high-cost patients
- 3% higher in-patient stays per 1,000

Practices seeking to expand on the success of Stratus™ have also contracted with Best Doctors to support the inclusion on MSSP data, and pilot test clinical data aggregation. Practices and payers are committed to supporting the further improvement and development of data aggregation to support Colorado practices.

Table 1.1: FY 2019-20 Costs by Appropriation of Primary Care Alternative Payment Models							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Comments**
A	**Total Request**	**$2,570,871**	**1.8**	**$535,928**	**$281,908**	**$1,753,035**	**Total of Rows B through I**
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$119,889	1.8	$39,282	$20,663	$59,944	From Table 5 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$5,195	$2,732	$7,927	From Table 5 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$204	0.0	$67	$35	$102	From Table 5 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, Amortization Equalization Disbursement	$5,360	0.0	$1,756	$924	$2,680	From Table 5 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Supplemental Amortization Equalization Disbursement	$5,360	0.0	$1,756	$924	$2,680	From Table 5 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$12,704	0.0	$4,163	$2,189	$6,352	From Table 5 FTE Calculations + Table 2.1 Row D
H	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$2,331,500	0.0	$457,497	$240,653	$1,633,350	Table 2.1 Rows B, C, F, G, H, I, J, K, N
I	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$80,000	0.0	$26,212	$13,788	$40,000	Table 2.1 Row L

Table 1.2: FY 2020-21 Costs by Appropriation of Primary Care Alternative Payment Models							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Comments**
A	**Total Request**	**$2,171,713**	**2.0**	**$557,897**	**$293,461**	**$1,320,355**	**Total of Rows B through I**
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$130,798	2.0	$42,856	$22,543	$65,399	From Table 5 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$5,195	$2,732	$7,927	From Table 5 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$222	0.0	$73	$38	$111	From Table 5 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, Amortization Equalization Disbursement	$5,847	0.0	$1,916	$1,008	$2,923	From Table 5 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Supplemental Amortization Equalization Disbursement	$5,847	0.0	$1,916	$1,008	$2,923	From Table 5 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$4,645	0.0	$1,523	$800	$2,322	From Table 5 FTE Calculations + Table 2.2 Row D
H	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$1,928,500	0.0	$478,206	$251,544	$1,198,750	Table 2.2 Rows B, C, F, G, H, I, J, K, N
I	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$80,000	0.0	$26,212	$13,788	$40,000	Table 2.2 Row L

Table 1.3: FY 2021-22 Costs by Appropriation of Primary Care Alternative Payment Models							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Comments**
A	**Total Request**	**$853,734**	**2.0**	**$0**	**$375,698**	**$478,036**	**Total of Rows B through J**
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$130,798	2.0	$42,856	$22,543	$65,399	From Table 5 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$5,195	$2,732	$7,927	From Table 5 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$222	0.0	$73	$38	$111	From Table 5 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, Amortization Equalization Disbursement	$5,847	0.0	$1,916	$1,008	$2,923	From Table 5 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Supplemental Amortization Equalization Disbursement	$5,847	0.0	$1,916	$1,008	$2,923	From Table 5 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,050	0.0	$1,655	$870	$2,525	From Table 5 FTE Calculations + Table 2.3 Row D
H	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$2,053,500	0.0	$634,414	$333,711	$1,085,375	Table 2.3 Rows B, C, F, G, H, I, J, K, N
I	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$80,000	0.0	$26,212	$13,788	$40,000	Table 2.3 Row L
J	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($1,443,384)	0.0	($714,237)	$0	($729,147)	Table 2.3 Row O

Table 2.1: FY 2019-20 Primary Care Alternative Payment Models Summary by Initiative								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Comments**
	Departmental APM Resources							
A	Department Staff	$157,031	1.8	$51,452	$27,064	$78,515	50.00%	Table 3.1 Row A
B	Contractor Costs for Developing 1115 Waiver	$200,000	0.0	$65,530	$34,470	$100,000	50.00%	Table 3.1 Row B
C	Actuarial Contractor	$75,000	0.0	$24,574	$12,926	$37,500	50.00%	Table 3.1 Row C
D	Mailing Costs	$2,340	0.0	$767	$403	$1,170	50.00%	Table 3.1 Row D
E	Total of Departmental APM Resources	$434,371	1.8	$142,323	$74,863	$217,185		
	Contractor Funding for eCQM Collection							
F	Start-up and Ongoing Administration	$44,750	0.0	$2,932	$1,543	$40,275	90.00%	Table 3.1 Row F
G	Provider Onboarding	$952,000	0.0	$62,385	$32,815	$856,800	90.00%	Table 3.1 Row G
H	Data Quality and Technical Assistance for Practices	$262,500	0.0	$86,008	$45,242	$131,250	50.00%	Table 3.1 Row H
I	Clinical Staff Review	$125,000	0.0	$40,956	$21,544	$62,500	50.00%	Table 3.1 Row I
J	Global Development of eCQMs	$47,250	0.0	$3,096	$1,629	$42,525	90.00%	Table 3.1 Row J
K	Data Visualization of Clinical Gaps	$125,000	0.0	$8,191	$4,309	$112,500	90.00%	Table 3.1 Row K
L	eCQM Audit	$80,000	0.0	$26,212	$13,788	$40,000	50.00%	Table 3.1 Row L
M	Total of eCQM Collection	$1,636,500	0.0	$229,780	$120,870	$1,285,850		
	Multi-Payer Collaborative Work							
N	Multi-Payer Claims Data Aggregation	$500,000	0.0	$163,825	$86,175	$250,000	50.00%	Table 3.1 Row N
O	**Total in FY 2019-20**	**$2,570,871**	**1.8**	**$535,928**	**$281,908**	**$1,753,035**		**Sum of Row E, Row M, and Row N**

Table 2.2: FY 2020-21 Primary Care Alternative Payment Models Summary by Initiative								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Comments**
	Departmental APM Resources							
A	Department Staff	$160,468	2.0	$52,579	$27,656	$80,233	50.00%	Table 3.1 Row A
B	Contractor Costs for Developing 1115 Waiver	$150,000	0.0	$49,148	$25,852	$75,000	50.00%	Table 3.1 Row B
C	Actuarial Contractor	$125,000	0.0	$40,956	$21,544	$62,500	50.00%	Table 3.1 Row C
D	Mailing Costs	$2,745	0.0	$900	$473	$1,372	50.00%	Table 3.1 Row D
E	Total of Departmental APM Resources	$438,213	2.0	$143,583	$75,525	$219,105		
	Contractor Funding for eCQM Collection							
F	Start-up and Ongoing Administration	$29,750	0.0	$9,748	$5,127	$14,875	50.00%	Table 3.1 Row F
G	Provider Onboarding	$560,000	0.0	$36,697	$19,303	$504,000	90.00%	Table 3.1 Row G
H	Data Quality and Technical Assistance for Practices	$337,500	0.0	$110,582	$58,168	$168,750	50.00%	Table 3.1 Row H
I	Clinical Staff Review	$125,000	0.0	$40,956	$21,544	$62,500	50.00%	Table 3.1 Row I
J	Global Development of eCQMs	$26,250	0.0	$1,720	$905	$23,625	90.00%	Table 3.1 Row J
K	Data Visualization of Clinical Gaps	$75,000	0.0	$24,574	$12,926	$37,500	50.00%	Table 3.1 Row K
L	eCQM Audit	$80,000	0.0	$26,212	$13,788	$40,000	50.00%	Table 3.1 Row L
M	Total of eCQM Collection	$1,233,500	0.0	$250,489	$131,761	$851,250		
	Multi-Payer Collaborative Work							
N	Multi-Payer Claims Data Aggregation	$500,000	0.0	$163,825	$86,175	$250,000	50.00%	Table 3.1 Row N
O	**Total in FY 2020-21**	**$2,171,713**	**2.0**	**$557,897**	**$293,461**	**$1,320,355**		**Sum of Row E, Row M, and Row N**

Table 2.3: FY 2021-22 Primary Care Alternative Payment Models Summary by Initiative								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Comments**
	Departmental APM Resources							
A	Department Staff	$160,468	2.0	$52,579	$27,656	$80,233	50.00%	Table 3.1 Row A
B	Contractor Costs for Developing 1115 Waiver	$150,000	0.0	$49,148	$25,852	$75,000	50.00%	Table 3.1 Row B
C	Actuarial Contractor	$175,000	0.0	$57,339	$30,161	$87,500	50.00%	Table 3.1 Row C
D	Mailing Costs	$3,150	0.0	$1,032	$543	$1,575	50.00%	Table 3.1 Row D
E	Total of Departmental APM Resources	$488,618	2.0	$160,098	$84,212	$244,308		
	Contractor Funding for eCQM Collection							
F	Start-up and Ongoing Administration	$29,750	0.0	$9,748	$5,127	$14,875	50.00%	Table 3.1 Row F
G	Provider Onboarding	$560,000	0.0	$146,787	$77,213	$336,000	60.00%	Table 3.1 Row G
H	Data Quality and Technical Assistance for Practices	$412,500	0.0	$135,156	$71,094	$206,250	50.00%	Table 3.1 Row H
I	Clinical Staff Review	$125,000	0.0	$40,956	$21,544	$62,500	50.00%	Table 3.1 Row I
J	Global Development of eCQMs	$26,250	0.0	$6,881	$3,619	$15,750	60.00%	Table 3.1 Row J
K	Data Visualization of Clinical Gaps	$75,000	0.0	$24,574	$12,926	$37,500	50.00%	Table 3.1 Row K
L	eCQM Audit	$80,000	0.0	$26,212	$13,788	$40,000	50.00%	Table 3.1 Row L
M	Total of eCQM Collection	$1,308,500	0.0	$390,314	$205,311	$712,875		
	Multi-Payer Collaborative Work							
N	Multi-Payer Claims Data Aggregation	$500,000	0.0	$163,825	$86,175	$250,000	50.00%	Table 3.1 Row N
	Minimum Alternative Payment Model Savings							
O	Potential Savings from Avoided Utilization of Services	($1,443,384)	0.0	($714,237)	$0	($729,147)	50.52%	Table 4.1 Row D and Row E
P	**Total in FY 2021-22**	**$853,734**	**2.0**	**$0**	**$375,698**	**$478,036**		**Sum of Row E, Row M, Row N, and Row O**

Table 3.1: Administrative Costs of Primary Care Alternative Payment Models					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
	Departmental APM Resources				
A	Department Staff	$157,031	$160,468	$160,468	Value-Based Payment Stakeholder Relations Specialist & Value-Based Payment Reform Analyst
B	Contractor for Developing 1115 Waiver	$200,000	$150,000	$150,000	1,000 contract hours in the first year and 750 hours in subsequent years at a rate of $200 per hour
C	Actuarial Contractor	$75,000	$125,000	$175,000	FY 2019-20 costs to establish budget neutrality for waiver; ongoing costs for calculating PMPMs for APM 2
D	Mailing Costs	$2,340	$2,745	$3,150	Communication to primary care practices on APMs. Calculations assume a rate of $1.80 per mailer.
E	**Total of Departmental APM Resources**	**$434,371**	**$438,213**	**$488,618**	**Sum of Rows A through D**
	Contractor Funding for eCQM Collection				
F	Start-up and Ongoing Administration	$44,750	$29,750	$29,750	Costs are for development and ongoing maintenance of procedures manual and training manual; assessment of operational readiness and risk reporting; and creation and delivery of eCQM flat data file to the Department.
G	Practice Onboarding	$952,000	$560,000	$560,000	Table 3.2 Row C
H	Data Quality and Technical Assistance for Practices	$262,500	$337,500	$412,500	Rate of $150 per hour and assumes each practice needs 10 hours of support per year.
I	Clinical Staff Review	$125,000	$125,000	$125,000	Clinical staff time spent supporting and reviewing Medicaid-related eCQMs
J	Global Development of eCQMs	$47,250	$26,250	$26,250	Estimate assumes 18 new measures would be developed in FY 2019-20, 5 measures would be developed in FY 2020-21, and 5 measures would be developed in FY 2021-22. New measures require 15 hours of development time at a rate of $175 per hour in the first year. In subsequent years, new measures require 30 hours of development time at a rate of $175 per hour. Additional hours account for increasing eCQM complexity.
K	Data Visualization of Clinical Gaps	$125,000	$75,000	$75,000	Licensing for tool that shows gaps in care
L	eCQM Audit	$80,000	$80,000	$80,000	Audit eCQMs by comparing to provider EHRs. Estimated cost assumes a rate of $200 per hour, 16 hours spent per practice, and 25 providers are audited each year.
M	**Total of Contractor Funding for eCQM Collection**	**$1,636,500**	**$1,233,500**	**$1,308,500**	**Sum of Rows F through M**
	Multi-Payer Collaborative Work				
N	Multi-Payer Claims Data Aggregation	$500,000	$500,000	$500,000	Based on current attribution of Medicaid members to practices participating in MPC work
O	**Grand Total**	**$2,570,871**	**$2,171,713**	**$2,297,118**	**Sum of Row E, Row M, and Row N**

Table 3.2: Estimated Provider Onboarding Costs of eCQM Contractor Funding					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
A	Practice Subscription & eCQM Submission Costs	$102,000	$60,000	$60,000	Table 3.3 Row D * $1,200 (Yearly Rate for eCQM submission and software access to help providers validate measures in the HIE).
B	Creation of Continuity of Care Document (CCD)	$850,000	$500,000	$500,000	Table 3.3 Row D * $10,000 one-time cost per practice for creating, validating, normalizing, and delivering Continuity of Care Document (CCD) to HIE.
C	**Requested Onboarding Costs for Medicaid APMs**	**$952,000**	**$560,000**	**$560,000**	**Row A + Row B**

Table 3.3: Number of Practices using eCQMs and requiring Onboarding					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
A	Estimated Number of Practices Using eCQMs	175	225	275	FY 2019-20 count is based on number of practices that selected an eCQM to be evaluated by in first performance year of APM 1. FY 2020-21 and FY 2021-22 assumes an increase of 50 practices selecting eCQMs each year.
B	Estimated Total Number of Practices Onboarded to HIEs through SIM Program	90	90	90	Estimate from SIM
C	Estimated Total Number of Practices Onboarded to HIEs through Medicaid APM Program	85	135	185	Row A - Row B
D	Estimated Per Year Number of Practices Onboarded to HIEs through Medicaid APM Program	85	50	50	Difference between fiscal years in Row C

Table 4.1: Minimum Estimated Savings in FY 2021-22 from Alternative Payment Models				
Row	**Item**	**Avoided Inpatient Hospital Stays[(1)]**	**Avoided Antidiabetic Drug Use[(2)]**	**Comment**
A	CY 2016 Total Expenditure	$725,787,730	$44,958,888	CY 2016 Demographic and Expenditure tables
B	CY 2016 Total Utilizers	75,232	19,841	CY 2016 Demographic and Expenditure tables
C	CY 2016 Average Cost Per Utilizer	$9,631.95	$2,265.96	CY 2016 Demographic and Expenditure tables
D	FY 2021-22 General Fund Requested (Amount of Offset)	$714,237	$714,237	Table 2.3 Sum of Row E, Row M, and Row N
E	FY 2021-22 Total Funds Requested (Amount of Offset)	$1,443,384	$1,443,384	Row D / 49.48% (Average State FFP of General Fund funded populations for Inpatient and Pharmacy services)
F	Required Decrease in Utilizers to Offset General Fund Costs	150	637	Row E / Row C
G	Required Decrease as a Percentage of Total Utilizers	0.20%	3.21%	Row F / Row B
H	Required Decrease in Utilizers by Participating Practice	0.55	2.32	Row F / 275 Estimated Participating Practices

Footnotes:
(1) Expenditures from Tables B2a, B2b, and B2c of CY 2016 Demographic and Expenditure tables
https://www.colorado.gov/pacific/hcpf/cy-2016-demographics-and-expenditures
(2) Expenditures of Levemir and Novolog from Table B5k: CY 2016 Top 10 Prescription Drugs Ranked by Expenditure
https://www.colorado.gov/pacific/sites/default/files/Demographics%20and%20Expenditures%20B5k.pdf

Table 5 FTE Calculations

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2019-20		FY 2020-21	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
Administrator III	$4,200	0.9	$46,197	1.0	$50,400
PERA			$4,804		$5,242
AED			$2,310		$2,520
SAED			$2,310		$2,520
Medicare			$670		$731
STD			$88		$96
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, #.# FTE		**0.9**	**$64,306**	**1.0**	**$69,436**
Classification Title	Monthly	FTE		FTE	
Rate/Financial Anlyst III	$5,545	0.9	$60,991	1.0	$66,540
PERA			$6,343		$6,920
AED			$3,050		$3,327
SAED			$3,050		$3,327
Medicare			$884		$965
STD			$116		$126
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, #.# FTE		**0.9**	**$82,361**	**1.0**	**$89,132**
Subtotal Personal Services		1.8	**$146,667**	2.0	**$158,568**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.8	$917	2.0	$1,000
Telephone Expenses	$450	1.8	$825	2.0	$900
PC, One-Time	$1,230	1.8	$2,255	-	
Office Furniture, One-Time	$3,473	1.8	$6,367	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$10,364**		**$1,900**
TOTAL REQUEST		1.8	**$157,031**	2.0	**$160,468**
	General Fund:		$51,452		$52,579
	Cash funds:		*$27,064*		*$27,656*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$78,515*		*$80,233*