COLORADO
Department of Health Care Policy & Financing

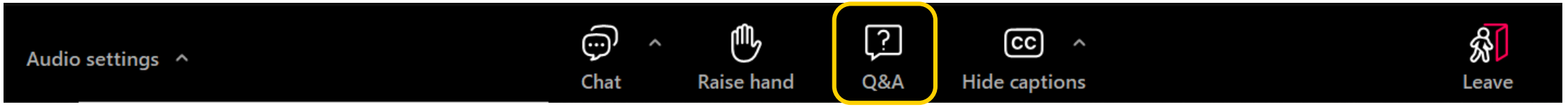
Primary Care Payment Structure: Medical Home Payment

PCMP Education Session

March 27, 2025

Webinar Logistics

- Today's session is being recorded.
- A recording and materials will be posted to the APM 2, PACK, and ACC webpages.
- For questions: Please use the question and answer (Q&A) feature on the Zoom toolbar.
  - During the Q&A period, we will also take verbal questions and comments as time allows. Please use the raise hand function to make a verbal comment.



Agenda

1. Overview of Medical Home Payment
2. Practice Assessment Overview
3. Deep Dive: Care Delivery Domains
4. Q&A
5. What's Next?

Objectives for Today's Session

1. Preview the new Primary Care Payment Structure
2. Understand the details of Medical Home Payment and the updated Practice Assessment Tool with a focus on Care Delivery Domains
3. Answer questions regarding Medical Home Payment

Who We Are

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Finance Office

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1. Overview of Medical Home Payment

Primary Care Payment Structure

Payments from HCPF

- Primary Care Services Payment

Payments from RAEs (criteria and rates vary)

- Medical Home Payments
- Access Stabilization Payments*

Pay for Performance from RAEs

- Quality Payments
- Shared Savings Payments

**Access Stabilization Payment is subject to legislative approval*

Primary Care Payment Structure

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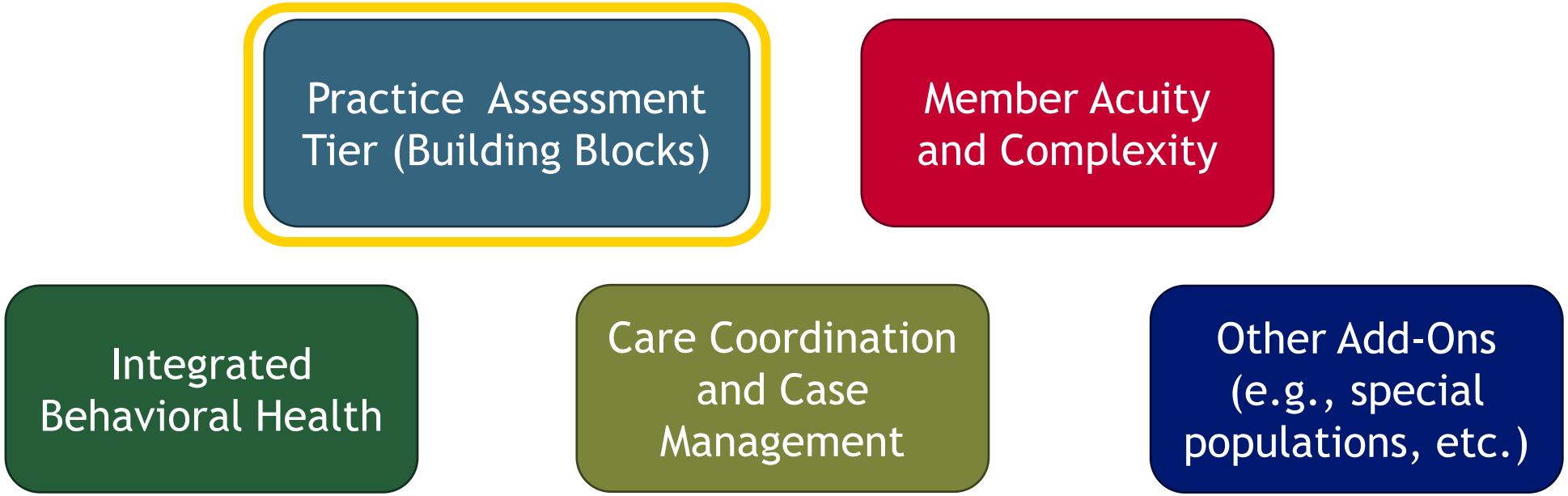
Key Changes for ACC Phase III

- Creating **standardization** in Phase III by:
  - Establishing **statewide parameters** around medical home payment.
  - Standardize tiering by shifting from regional approach to **statewide practice assessment tool**.
  - Building **multi-payer alignment** on metrics (DOI) and eventually practice assessments.

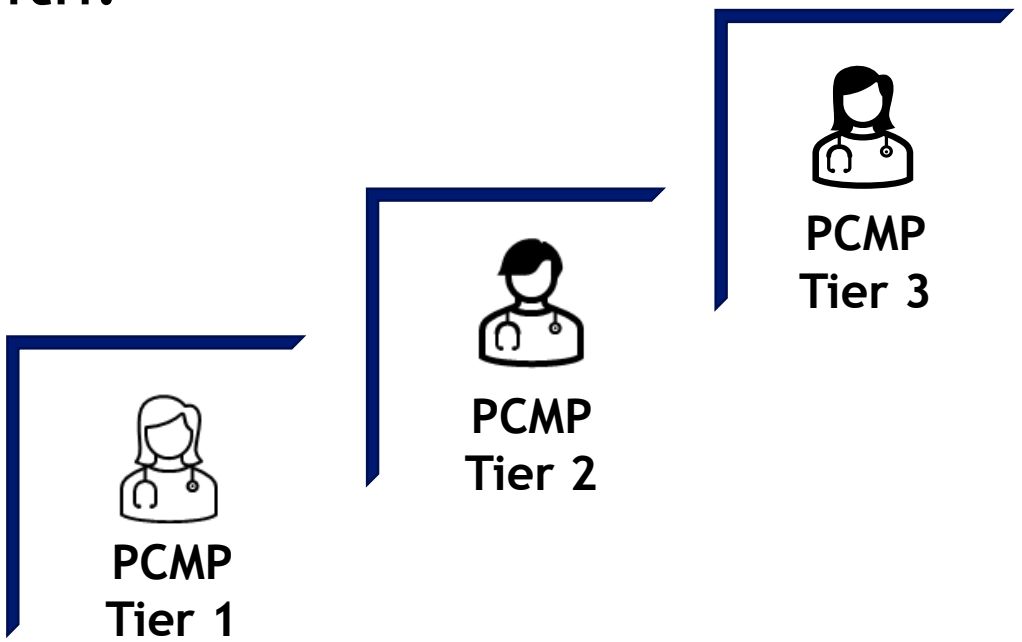
Medical Home (PMPM) Payment Opportunities



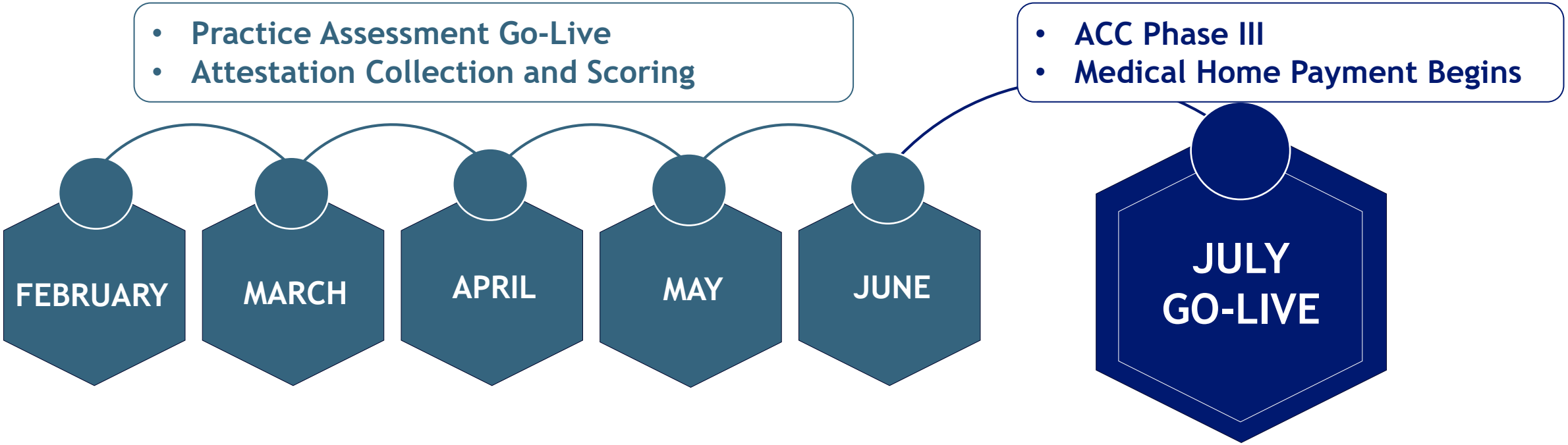
2. Practice Assessment Overview

Practice Assessment

- Three-tier assessment to incentivize progress along the continuum of advanced primary care.
- Assessment designed in alignment with:
  - DOI Primary Care APM Regulation.
  - Bodenheimer building blocks.
- PCMH recognition will be counted towards tiering placement.



Timeline


• Practice Assessment Go-Live
• Attestation Collection and Scoring
• ACC Phase III
• Medical Home Payment Begins
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
GO-LIVE

Practice Assessment: RAE Roles and Responsibilities

Facilitation
Schedule and execute timely assessment process via PCMP attestations, audits and calculation of results.

Support & Training
Offer resources and practice consults to support PCMP with completion of Practice Assessment.

Communication
Provide clarity around PCMP expectations and practice-level Practice Assessment results.

Practice Transformation
Coach PCMPs in implementation of PCMH best practices and assist them with implementation of activities to get to the next tier.

Payment
Determine the payment allocations for PCMPs within each of the tiers.

3. Deep Dive: Care Delivery Domains

Four Components of Assessment Tool

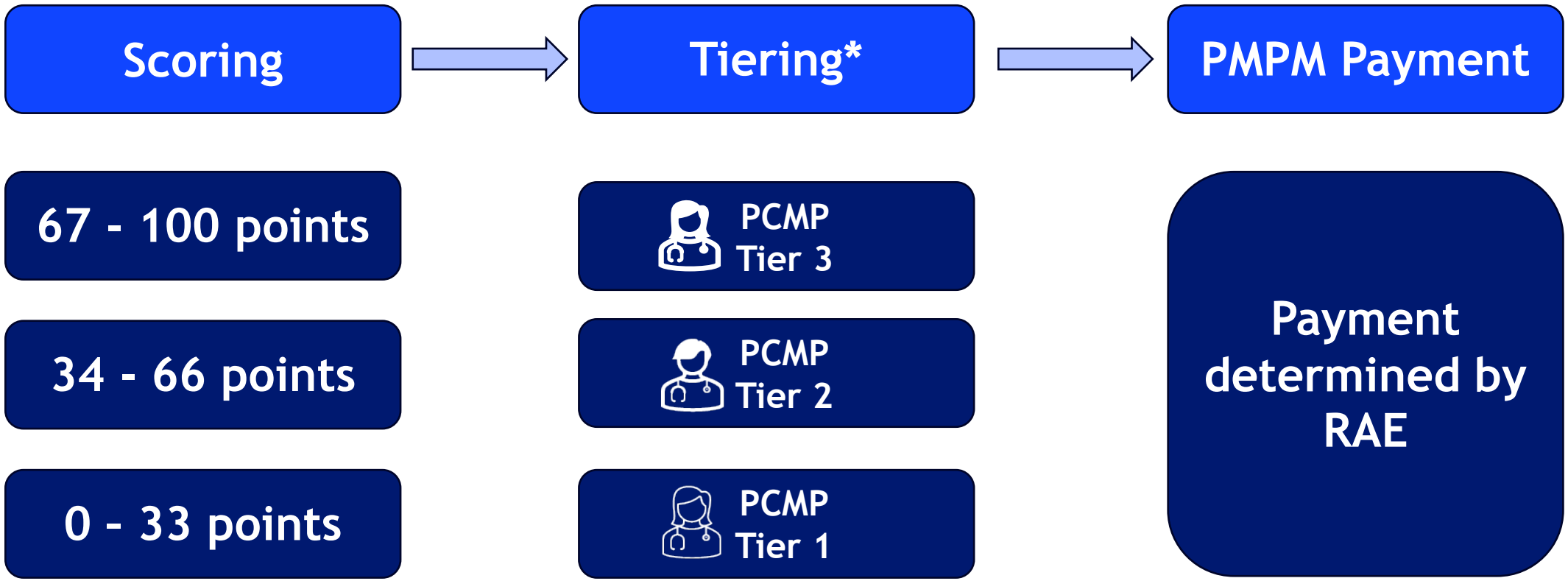
Instructions Worksheet: This worksheet offers an overview of information that practices need to be aware of when completing the Practice Assessment Tool.

Questionnaire & Attestation Worksheet: This worksheet features a practice questionnaire and an attestation to confirm the accuracy of submitted information.

Scoring Summary Worksheet: This worksheet provides a detailed overview of the scores a practice has achieved across all criteria.

Care Delivery Domain Worksheets: These worksheets include detailed information about the criteria and require practices to indicate whether they have met each criteria or not.

How Does this Impact Payment?



*If a practice is NCQA or PCMH Accredited and meets all "Must Pass" criteria, practice is considered **Tier 3.**

Care Delivery Domains

Care Delivery Domain Worksheets: These worksheets include detailed information about the criteria and require practices to indicate whether they have met each criteria or not

Worksheet Sections

Criteria: The high-level Care Delivery function that HCPF is determining whether a Practice completes or not. For example, "Personal Clinician Assignment: Assigns patients to a clinician that is accountable for patient's care."

- The Care Delivery Function has further subsets of criteria (e.g., criteria might read, "Does the practice have a process to assign patients to a specific clinician, prioritizing patient preference when applicable?"

Evidence: Describes the proof required to demonstrate performance against each criteria. Practices selected for verification must share this evidence for each criterion marked with a "Yes" response

- Evidence is NOT required to be submitted with Practice Attestation

Shared or Site-Specific: Indicates whether criteria and can be met at organization level or must be met at site-specific level

Response (Yes/No): A column for practices to a indicate whether they have met each criteria

Points Received: This column automatically populates based on a practice's response and points available

Points Available: A column indicating how many points are available for each criteria or whether the criteria is Must Pass

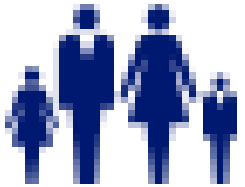
Practice Assessment: Care Delivery Domains

Leadership

Data Driven Quality Improvement

Empanelment

Team Based Care

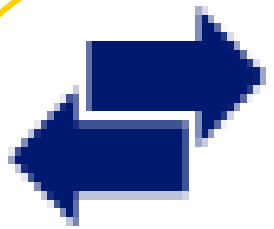


Patient and Family Engagement

Population Management

Continuity of Care

Access



Comprehensiveness and Care Coordination

Integrated Behavioral Health

Access

Colorado Department of Health Care Policy and Finance
Practice Assessment Tool
Access
SFY2025

Total # of Must Pass Criteria Met	Total # of Must Pass Criteri
-	-
Total Points Received	**Total Points Available**
-	17

Instructions: Select Yes/No from the drop-down in Column F.

8. Access: Provides ways for patients to receive care in a prompt manner and in alignment with needs/preferences.

ID	Criteria	Evidence	Shared or Site-Specific	Response (Yes/No)	Points Received	Points Available
8.1 Appointment Availability: Assesses and provides appropriate appointment availability, including same day and third next available appointments.						
8.1.1	Does the practice assess and/or track how quickly patients/caregivers can access care at the clinic (i.e., 3rd Next Available or other tool)?	- Documented policy, procedure, workflow, report, or 3rd next available appointment data for well and acute visits	Shared with site-specific results		-	1
8.1.2	Does the practice utilize their access analysis (from 8.1.1) to identify and address disparities in access?	-Example of implementation	Shared		-	2
8.1.3	Does the practice offer same day appointments(1)?	- Example demonstrating implementation and explanation of process assessment	Site-specific		-	1
8.2 Method for Making Appointments: Offers the ability for patients/caregivers to make appointments via a secure electronic system						
8.2.1	Does the practice offer the ability for patients/caregivers to make appointments via a secure electronic system?	- Example demonstrating implementation	Shared		-	1
8.3 Types of Access: Provides alternative(s) to traditional in person office visits, including telehealth, telephone.						
8.3.1	Does the practice provide alternative(s) to traditional in person office visits	- Documented policy, procedure, workflow, or example demonstrating	Shared		-	1

Comprehensiveness and Care Coordination

Colorado Department of Health Care Policy and Finance
Practice Assessment Tool
Comprehensiveness and Care Coordination
SFY2025

Total # of Must Pass Criteria Met	Total # of Must Pass Criteria
-	4
Total Points Received	**Total Points Available**
-	54

Instructions: Select Yes/No from the drop-down in Column F.

9. Comprehensiveness and Care Coordination: Allows patients to receive the primary care they need in a coordinated manner.

ID	Criteria	Evidence	Shared or Site-Specific	Response (Yes/No)	Points Received	Points Available
9.1 Transition of Care: Assists patients/caregivers with post-emergency department and hospitalization discharge planning, medication reconciliation, effective information sharing among providers and caregivers, follow-up, and monitoring.						
9.1.1	Does the practice have a method of receiving daily Admission, Discharge, and Transfer (ADT) data?	-Documented policy, procedure, workflow, or example demonstrating implementation	Shared with site-level data		-	1
9.1.2	Does the practice have a method of daily, bi-directional information sharing in regards to patient care with hospitals	-Documented policy, procedure, workflow, or example demonstrating implementation	Shared with site-level data		-	2
9.1.3	Does the practice contact/follow-up with patients/caregivers within 2 business days after patient discharge from hospital[(2)] and 5 business days after discharge from the emergency department, respectively?	-Documented policy, procedure, workflow, or example demonstrating implementation	Shared with site-level data		-	2
9.2 Community Resources Connection: Coordinates patient/caregiver connections to community resources and other local programs.						
9.2.1	Does the practice screen all patients for Health Related Social Needs (HRSN)?	Example of screening tool	Site-Specific		-	**2**
9.2.2	Does the practice utilize a resource tool to connect patients/caregivers with **school, community, and social service** organizations?	-Demonstration of tool used	Shared		-	1

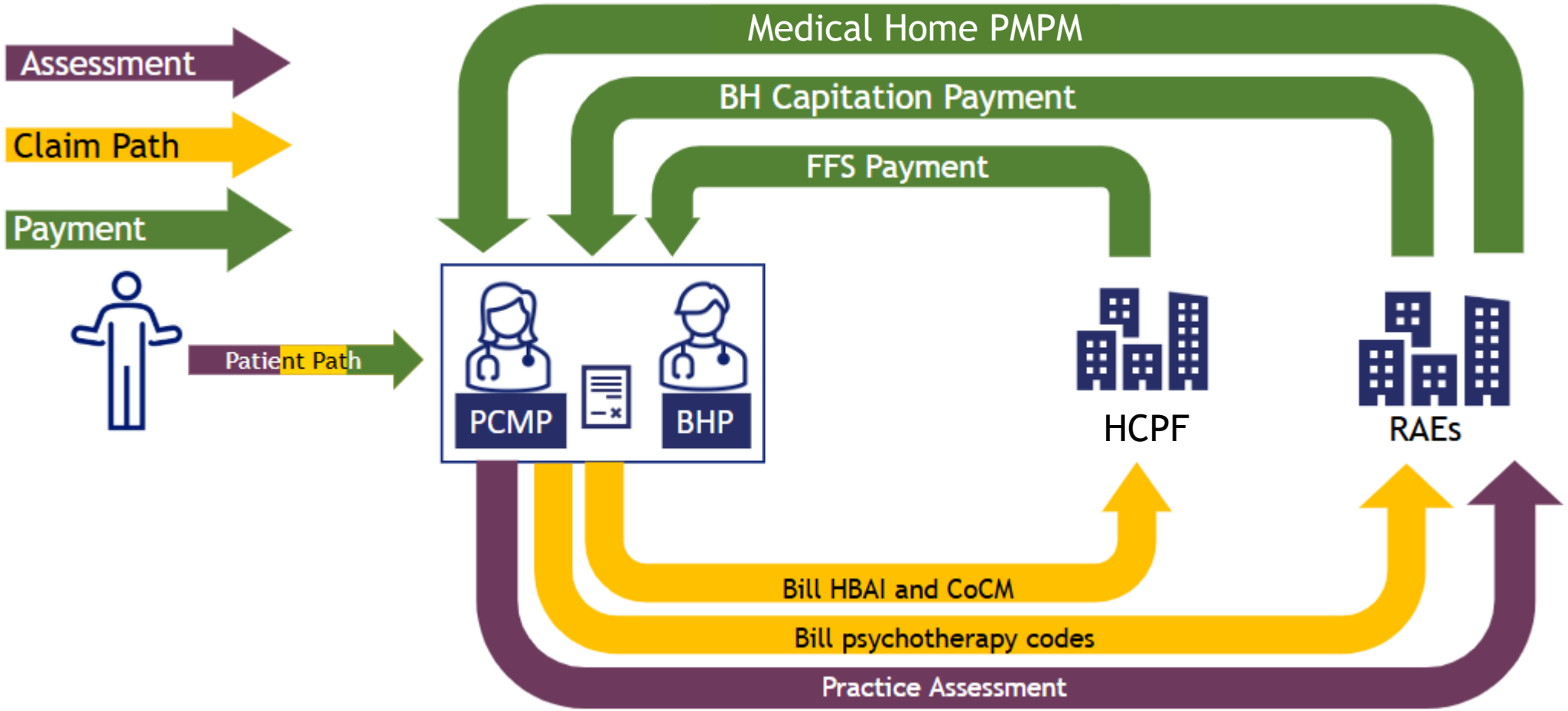
Integrated Behavioral Health

10. Integrated Behavioral Health: Offers an approach to make it easier for primary care patients to receive behavioral health care as needed.

ID	Criteria	Evidence	Shared or Site-Specific	Response (Yes/No)	Detail	Criteria Met?
10.1 Highly Integrated Care						
10.1.1	Does the practice have an established relationship with an integrated behavioral health provider available via **telehealth** to patients and caregivers on site who is readily available to provide brief interventions (2) for patients with behavioral health conditions or those requiring support for behavior change **OR** Does the practice have an **onsite** integrated behavioral health provider who is available to deliver brief interventions (2) for patients with behavioral health conditions or those needing assistance with behavior change?	- Documented policy, procedure, workflow, or example demonstrating implementation or an agreement	Shared - evidence of site-specific availability			
10.1.2	Does the practice have an identified interdisciplinary team of champions for advancing Integrated Behavioral Health programming and continuous quality of care?	- Documented policy, procedure, workflow, or example demonstrating implementation or an agreement	Shared - evidence of site-specific availability			
10.1.3	Does the practice utilize a single integrated health record to consolidate a patient's physical and behavioral health information, **OR** Implement a protocol for effective information integration between these domains that allows timely, collaborative care?*	- Documented policy, procedure, workflow, or example demonstrating implementation or an agreement	Shared - evidence of site-specific availability			

*This does not preclude psychotherapy notes being appropriately protected within the same EHR

Integrated Care Payment Pathways



Scoring and Calculation

The total points achieved will determine the tier that a practice falls within.

Certain "Must Pass" criteria must be met to achieve specific tiers.

The tier will determine the level of payment received from the RAE.

Note: PCMPs that decline to engage with their RAE will not receive the practice assessment portion of the PMPM.

Assessment attestation completed annually.

Practices may be asked to provide supporting documentation to validate answers.

Practices can request RAE assistance in completing assessment.

Scoring Summary Preview

	A	B	C	D	E
7					
8					
9		Practice Designated Tier Based on Criteria Met:	Tier 1		
10					
11		Physical Health Care Delivery Domain	Number of Criteria Passed	Number of Criteria	
12		TOTAL NUMBER OF MUST PASS CRITERIA:	-	8	
13		Physical Health Care Delivery Domain	Points Received	Points Available	
14		TOTAL POINTS:	-	100	
15					
16		NCQA PCMH Certified	-	100	
18		1. Leadership (1 Criteria)			
19		1.1 Practice Leadership for Quality Improvement Initiatives			
20		1.1.1 Deploys a quality improvement champion	-	Must Pass	
21		2. Data Driven Quality Improvement (5 Criteria)			
22		2.1 Quality Measure Tracking and Assessment			
23		2.1.1 Tracks performance on quality metrics	-	Must Pass	
24		2.2 Quality Improvement Implementation			
25		2.2.1 Improves quality using data	-	1	
26		2.2.2 Has a quality improvement team	-	1	
27		2.3 Data Collection			
28		2.3.1 Connects to EHR	-	1	
29		2.3.2 Connects to HIE	-	3	
30		3. Empanelment (2 Criteria)			
31		3.1 Personal Clinician Assignment			
32		3.1.1 Process to assign patients to clinician	-	1	
33		3.1.2 Assignment of 75% patients to clinician	-	1	
34		4. Team Based Care (5) Criteria)			
35		4.1 Roles and Responsibilities of Team			
36		4.1.1 Defines team roles	-	1	
37		4.2 Communication Within Team			
38		4.2.1 Holds care team meetings & implements team-based communicati	-	1	

1 Leadership | 2 Data Quality Improvement | 3 Empanelment | 4 Team Based Care | 5 Patient & Family Engagement | 6 Population Managem

4. Q&A

5. What's Next?

Upcoming Education Sessions

Session 1: Medical Home Payments	Today
Session 2: Quality Payments	Wednesday, April 9th 12:00pm – 1:30pm
Session 3: Primary Care Services Payments	Wednesday, April 23rd 12:00pm – 1:30pm
Session 4: Shared Savings	Wednesday, May 7th 12:00pm – 1:30pm

Questions? email: HCPF_VBPStakeholderEngagement@state.co.us


Thank You!