Primary Care Payment Structure in ACC Phase III
PCMP Education Session
Webinar Questions and Responses

November 19, 2024
4:00 P.M. to 5:30 P.M.

In this session, the Colorado Department of Health Care Policy and Financing (HCPF) provided forthcoming program updates to value based payment programs for primary care medical providers (PCMPs) and Accountable Care Collaborative (ACC) Phase III quality programs, including the refresh of Alternative Payment Model 2 (APM 2) and the Payment Alternatives for Colorado Kids (PACK) programs. The following questions and answers were shared during the webinar.

When will PACK go live? Could we get an update on the status of PACK, its recommendations, and planned adoption?

A: PACK is embedded within the ACC's Primary Care Payment Structure and includes payments additive to primary care services payments: 1) Access Stabilization Payment, and 2) site-specific pay-for-performance on up to six pediatric quality measures. PACK will not be a separate program.

If you qualify for all measures in Track 1, then do you choose which to be measured on?

A: If you qualify for all measures based on denominator size, you would first be assigned the three measures listed in in Step 1 (Well-Child Visits in the First 30 months of Life, Glycemic Status Assessment for Patients with Diabetes, and Controlling High Blood Pressure). Then, in Step 2, you would be assigned remaining measures in order of measures for which the PCMP has the largest denominator size. Details on these steps, including measures associated which each step, are on Slides 24-27 of the [meeting presentation.]

Can PCMPs that qualify for Track 1 still choose Track 2?

A: All PCMPs will automatically be placed in Track 1. PCMPs only qualify for Track 2 if they do NOT qualify for Track 1.

How often will you be evaluating where the thresholds are set?

A: Thresholds will continue to be reviewed annually.

Can you clarify if the measure is not met— does that mean number of patients is less than 30, or, if you are below threshold? If, for example you know you cannot

meet an immunization measure, can you opt to do a Quality Improvement (QI) activity, such as a Plan-Do-Study-Act Plan?

A: You would be evaluated before the performance period started. You cannot change which measures you are accountable for mid-year.

If you know you cannot achieve a specific measure, such as an immunization measure, can you proactively select a Quality Improvement (QI) activity in place of the measure?

A: If a practice has 30 or more Health First Colorado members in the denominator for a measure, and met the overall eligibility requirements for Track 1, they would be responsible for their performance for that measure and would not be able to choose a QI activity in its place.

Which PCMPs qualify for this model? Rural Health Clinics? Obstetrician-gynecologists (OBGYNs) clinics?

A: All Medical PCMPs qualify for the Quality Model, including OBGYNs who identify as PCMPs. With regards to the Access Stabilization Payment, OBGYNs could potentially qualify as either rural or small, if they are enrolled as a PCMP. Federally Qualified Health Center (FQHC), Rural Health Centers (RHC), and Indian Health Service (IHS) PCMPs are not eligible for Access Stabilization Payment.

For Federally Qualified Health Centers, will measure selection be site-specific by individual clinics, or by health system as it has been for APM 1?

A: HCPF is still reviewing how measures will be reported. More will be presented on this in a future meeting.

In the Small PCMPs criteria for Access Stabilization Payment, does "one to five providers" refer to total providers or full-time equivalents (FTE)?

A: The number of providers refers to up to five total providers who have their National Provider Identifier (NPI) registered at an individual PCMP site. HCPF does not have PCMP FTE information.

If a practice is not eligible for three or more measures, can they qualify for Track 2?

A: Yes, PCMPs that do not qualify for at least four measures are eligible for Track 2 in the Quality Model.

Could you clarify what impact the new Primary Care Services Payment changes will have on reimbursement specifically for Federally Qualified Health Centers (FQHCs)?

A: HCPF will continue to work with FQHCs and Colorado Community Health Network (CCHN) to design a primary care services payment methodology. This will be a voluntary change for FQHCs who elect to these changes.

If a practice chooses not to participate, are they at risk of a 4% penalty, as is the case with the current APM 1 program?

A: All PCMPs are automatically enrolled in this new Primary Care Payment Structure through their relationship with the ACC. Quality Payments in this structure are upside risk only.

Can you talk more about the APM 1 program through the 2025 calendar year - and clarify the different phases of work/measures associated with the programs/and what impacts that will have on payment?

A: There will be some overlap between the launch of ACC Phase III, beginning July 1, 2025 and APM 1 taking place in calendar year 2025. However, when the ACC structure initially launches, it will be a pay-for-engagement period. APM 1 measure selection is anticipated to begin in January 2025. The close the gap methodology for APM 1 will continue through calendar year 2025.

If a PCMP elects to receive their Primary Care Services Payment as a prospective payment, will the payment come from HCPF or their RAE?

A: HCPF will continue to pay prospective payments, as well as fee-for-service (FFS), for primary care services payments.

When will FQHC measure selection occur for APM 1?

A: Measure selection is anticipated to occur at its usual timeline in January 2025. There is a chance that measure selection will be delayed due to ongoing program alignment, however, HCPF is striving to keep measure selection on the same timeline.

Is the APM 1 measure set going to be the same 11 measures starting in January 2025?

A: APM 1 clinical measure selection will be limited to the 11 clinical measures that overlap between APM 1 and the new Primary Care Payment Structure under ACC Phase III.

Will FQHCs still get points for reporting on minimum denominator size for measures in APM 1 Program Year 2025 (PY 2025)? And will the measure selection process stay the same as PY 2024?

A: APM 1 PY 2025 will look the same as prior program years with measure selection being limited to the CMS measures provided. HCPF will follow up about the denominator size for the affected measures.

Will pediatric patients who are eligible for Medicaid through Cover All Coloradans in January be included in the attribution for prospective payment methodology? Will they be included in the performance measure denominators?

A: Cover all Coloradans will not be part of prospective payment or measure calculations in Calendar Year 2025. HCPF will be monitoring performance for that population separately and will work with stakeholders prior to including them in the measure calculations.

It sounds like the only component of PACK that is substantively different from the adult model is the Access Stabilization Payments. Can you further clarify the PACK components that will be included within this new model?

A: HCPF understands that stakeholders may have expected to see PACK as a distinct model from this Primary Care Payment Structure under ACC Phase III. HCPF felt it was important to include PACK within this aligned structure to reduce needless fragmentation and discoordination. PACK is now embedded within the Primary Care Payment Structure. In this structure, pediatric PCMPs can elect to receive their Primary Care Payment Services revenue prospectively or fee-for-service. They are eligible for the 16% R6 funds via Access Stabilization and they are eligible for pay for performance Quality payments with pediatric quality measures included.

As part of the pediatric payment strategy, HCPF has put extra thought into the constraints that pediatric PCMPs face. They have specific quality measures in Phase III which HCPF believes will be favorable with the pediatric community. We hope this helps to support these providers by reducing administrative burden while preserving the use of quality measures that meet the needs of the pediatric population.

Will measures for APM 1 Program Year 2025 (PY 2025) be available in both electronic clinical quality measures (eCQMs) and administrative?

A: Measures will be offered in both eCQM and administrative for PY 2025.

Will PCMPs still select 10 measures for APM 1 Program Year 2025?

A: Yes, this is correct.

Is there is an estimate of how many practices will be able to receive Access Stabilization Payment? For example, how many rural, small PCMPs, and pediatricians?

A: HCPF is currently conducting analyses as they fine-tune criteria. More information will be shared publicly once available.

Will the RAEs continue to get key performance indicator (KPI)/performance pool money? Or will it all transition to the PCMP level?

A: In the proposed model, RAEs are being held accountable for RAE-specific metrics. There are regional-specific metrics specifically for the RAEs. RAEs are also held accountable for performance of their PCMP metric. RAEs will be paid for performance as well, but the details of this payment are not covered in today's discussion, which was focused on PCMPs.

Will RAEs continue to pass through the Key Performance Indicator payments to PCMPs?

A: For the metrics discussed today, PCMPs will receive payments from the RAE, but RAEs will be told how and what to pay. There is a 33% passthrough requirement in the current contract. They will continue to do this according to a schedule HCPF is providing them. The intent is to keep the PCMP as whole as possible in this model, while bringing multiple programs into a comprehensive payment, rather than siloed programs.

Will the attribution list used as the Health First Colorado patient members? If so, will the attribution list be updated more frequently? Also, will RAEs be required to be transparent with all PCMP payments?

A: In ACC Phase III, the attribution lists will be updated quarterly rather than every 6 months. The RAEs will be required to share a transparent scorecard of a PCMP's payment.

When would Access Stabilization Payment begin?

A: Access Stabilization Payment, if approved by the JBC, would go live July 1, 2025.

Historically, contracts are provided on June 1st from RAEs with an expectation they must be signed on July 1st, which is not enough time. Can HCPF send details over earlier to accommodate ramp-up time to modify what PCMPs are doing to fit the model?

A: The models are different, but HCPF has been thoughtful in looking at sustaining PCMPs. We understand that PCMPs need details and would prefer to see them earlier

and will strive to accommodate this. HCPF wants to make sure that revenues are comprehensive across the organization and will do our best to do as asked.

Some practices in APM 1 have geographically attributed members which helps them meet the 30-denominator threshold for measures. When attribution changes on July 1, it might impact those providers which could affect their payment. If that happens, is there an opportunity for practices to select another measure or quality improvement activity?

A: HCPF will work with practices if they can no longer report on the measures they selected for APM 1.

How does this model address components of high-quality primary care such as addressing social determinants of health and care coordination?

A: This conversation focused on quality and access stabilization but there are other payments that RAEs will be making to PCMPs. RAEs can consider acuity and complexity of members as they pay out to their network. More information to come on this.

What is the Medical Home criteria? We were a Medical Home years ago and I thought that program was dissolved.

A: Medical Home Payments refers to a specific payment mechanism within the Primary Care Payment Structure from the RAEs to PCMPs to support non-reimbursable activities. These payments will continue from RAEs in ACC Phase III and more information is to come on this part of the model. This terminology is also sometimes used to refer to specific “Medical Home” programs like Patient Centered Medical Homes (PCMHs), which can lead to some confusion.

When will APM 1 Program Year 2025 (PY 2025) end?

A: APM 1 will follow the typical program year in 2025 and is planned to end on December 31, 2025.

I recall in a review with HCPF there was an expectation that APM per member per month (PMPM) rates would have to go down effective January 1, but I didn't hear anything about that today. Can I assume rates won't decline on January 1?

A: HCPF has rebased APM rates based on most current utilization and found an issue with overpayment and HCPF does not have authorization to spend above FFS rates. The HCPF APM 2 Team will be reaching out shortly to discuss changes in rates with PCMPs. The team will also support and prioritize conversations with practices that need support reviewing their rate workbooks.

Can a program take part in APM 1 and 2?

A: APM 1 is the quality model for APM 2 so for a practice to participate in APM 2, they must be in APM 1. This model will continue for the first part of 2025 but APM 1 will sunset as the quality model beginning in 2026.