Primary Care Alternative Payment Model

Frequently Asked Questions updated 12/01/2017

What is the goal of the alternative payment model?

The Department of Health Care Policy and Financing (Department) is transforming payment design across the entire delivery system - from incentive payments for Behavioral Health Organizations to separate alternative payment models for Federally Qualified Health Centers - to reward improved quality of care while containing costs.

The Department's approach to primary care provider payments is evolving with the implementation of the value-based Primary Care Alternative Payment Model (APM). The new APM will incentivize care that improves both health outcomes and coordination in the health care delivery system.

The APM will:

1. provide a long-term, sustainable investments into primary care,

2. reward performance and introduce accountability for outcomes and access to care while granting flexibility to providers, and

3. align with other payment reforms across the delivery system.

What will happen to the 1202 bump?

The APM is essentially a transformation of the 1202 bump. The Affordable Care Act provided federal funding for a temporary increase in primary care rates. When the federal funding expired in 2014, the state chose to continue the 1202 bump with General Fund dollars. The Department’s budget request for fiscal year 2017-18 asked for a continuation of 1202 with the addition of a value proposition. The APM is that value proposition.

Will this replace the PMPM in the ACC?

No. The PMPM will be continuing, the APM is an addition and replaces the 1202 bump.
How did the Department develop the APM model?

The Department created six workgroups consisting of primary care physicians, primary care practice coordinators and office managers, and Regional Care Collaborative Organizations (RCCO) representation. These workgroups provided input on most aspects of the program, such as the determining which quality measures to offer and payment design.

How did the Department utilize or integrate the feedback from workgroup stakeholders?

The Department incorporated feedback from each workgroup into almost all aspects of the model including payment design, performance and structural measures and the final weighting of the measures. As an example, workgroup members told us that the model was unnecessarily complicated with paths or tiers so the final model is a point-based system.

The APM Model:

How does the model work?

The model consists of a set of structural (characteristics of a practice) and performance (clinical processes or outcomes) measures, and each measure has been assigned a point value by the Department. Primary Care Medical Practices (PCMPs) will select which measures they want to be measured on and at the end of the performance year, their performance on each measure will generate an APM score from the APM model. The APM score will, in turn, dictate the percent by which their fee schedule (FS) rates will be enhanced for a defined set of primary care services (see APM Code Set for more details).

The table below specifies APM score ranges and the corresponding levels of enhancement:
Which providers will be eligible to participate in the APM?

Providers that are designated as Primary Care Medical Providers in the Accountable Care Collaborative (ACC). To be designated as a PCMP, a provider must meet the following requirements:

1. A medical practitioner with a focus on primary care (family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology).

2. Enrolled as a Colorado Medicaid provider.

3. Licensed and able to practice in the State of Colorado.

4. Holds an MD, DO, or NP provider license.

5. Licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.

6. Community mental health centers and HIV/infectious disease practitioners may qualify as PCMPs if all PCMP criteria are met and with approval from the Regional Accountable Entity.

PCMPs must have more than $30,000 in annual PAID associated with APM services (see the APM Code Set for more details). PCMPs who do not meet the billing volume threshold will be excluded from the APM program and experience no adjustments to their fee schedule rates.

The APM applies to PCMPs, consequently any rendering provider that bills under a PCMP’s billing ID is included in the APM.
Can physicians in the same PCMP choose different measures?

The unit of measurement for the APM is the brick and mortar PCMP site. Practices will select a single set of measures for all rendering providers in a practice that bills under their PCMP ID.

Is qualifying for the APM PCMP or Tax ID based?

With the implementation of the new claims payment system, each brick and mortar site has its own ID. Therefore, measures chosen will apply to that site.

How will payment be received?

The Department plans to pay based off an enhanced fee schedule through claims processing. It will not be a separate supplemental payment.

How did the Department determine the primary care code set used in the model?

The code set was developed using a three-step process:

1) The Department identified common primary care codes from a variety of sources: ACA Section 1202, Medicare, US Preventive Services Task Force, other Medicaid programs, and commercial payers
2) A modified Delphi panel from the University of Colorado Hospital reviewed and modified that code set to represent primary care
3) The Department reviewed the list from the Delphi panel to ensure it is a Health First Colorado covered benefit and in support of the goals of:
   • Reimbursing for providers’ time to administer the vaccine, birth control, or other devices, rather than reimbursing for the immunization or device itself
   • Reimbursing for providers’ time to collect lab specimens and interpret their results, rather than reimbursing for the lab processing itself
   • Reimbursing for activities that allow for flexibility in where providers deliver care. For example, delivering care in different settings.

Structural and Performance Measures:

How many measures must a PCMP select?

PCMPs must select ten (10) measures, as selecting ten measures increases the
likelihood of a practice achieving full points in the model.

**How were the structural measures determined?**

The Department compiled structural measures from the State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+), and NCQA Patient Centered Medical Home (PCMH) certification. The Department then engaged with workgroup stakeholders through the workgroup process to modify and assign weights to points on the structural measures.

**How will the Department determine if a practice has met the structural measures?**

The new Regional Accountable Entity (RAE) will collect documentation that proves structural measures are met, as well as attestations from the PCMPs. RAEs will also conduct spot checks during the performance period to ensure continued compliance. Achievement of the structural measures will be input into the APM model as a binary yes/no answer. For example, the RAE will determine if a PCMP has care compacts in place or not.

**How will the performance measures be scored?**

It is important to understand that the APM model rewards achievement based on a practice's performance, so a practice is being measured against itself over time, rather than against other PCMPs during the same period. Each practice will be required to "close the gap" by 10% between their own performance and the statewide target benchmarks that are determined by the Department (and informed by HEDIS benchmarks). For example:

- The benchmark is 80%
- The practice baseline is 50%
- The gap between the benchmark and baseline is 30%
- The goal to close the gap is 10%
- 10% of 30 is 3%
- The practice would need to close the gap by 3% or hit 53% to earn full point value

**How were the point values for the measures assigned?**

In collaboration with workgroups, the Department assessed the potential value gained by improvement on the measure, the resource intensity, and difficulty of achieving improvement. Measures that required greater resource intensity and were more difficult to implement or achieve improvement on were weighted more heavily.
How were the State’s goals established?

Goals were set based on Department review of our claims data compared to NCQA, national Medicaid goals, and recommendations from the Centers for Medicare and Medicaid Services. There are a few measures that do not currently have goals established. The Department will collect and review data submitted by SIM practices as well as national measure benchmarks to determine those goals. Goals for those measures will be established and disseminated by the end of calendar year 2018.

Can a practice change the measures it selected?

Yes, a practice may select different measures during or at the end of the baseline year. A practice cannot change measures during the performance year.

A practice will choose their first set of measures by January 31, 2018. Practices will have the opportunity to change measures at the end of the baseline year (2018) and cannot change measures during the performance year (2019).

What if a PCMP is at or above the goal for a measure?

PCMPs that are at or above a goal for a measure will get full credit for that measure. The Department is still determining policy for how long a PCMP will get full credit for maintaining a goal.

Is it possible to earn negative points?

No. If actual performance is worse than a PCMPs baseline, it is not possible to earn negative points, a PCMP would simply not receive any points for that measure.

How long will the Department pay for meeting structural measures?

The Department considers structural measures an important component of the APM. Structural measures are meant to encourage PCMPs to improve business models, enhance client care and engagement, and improve clinical outcomes. Over time, the Department anticipates phasing out all but a select few structural measures, such possibilities would be: accepting new Medicaid clients, Behavioral Health integration, emergency department and hospital discharge follow-up. Once a practice has achieved a structural measure they will receive credit, depending on the measure, for one or two years. The length of payment for Structural Measures can be found on the detailed specification sheets.

What are the requirements/guidelines for choosing measures?
PCMPs will need to earn at least 190 points to receive the maximum possible enhancement. PCMPs must select ten measures. To minimize administrative burden, PCMPs should select measures that are aligned with internal initiatives and obligations to other payers.

Can a PCMP select only structural or only performance measures or both?

A PCMP may select any 10 measures, regardless if they are all structural or performance measures.

Can a PCMP select measures that total more than 190 points?

Yes. In fact, PCMPs can or should select measures that total more than 190 points to increase the likelihood that they will earn the enhanced reimbursement.

What data or information can PCMPs look at before selecting measures?

PCMPs should keep these in mind regarding measure selection:

1. Structural measures: PCMPs will know if they meet the measure or not because it is based on practice characteristics and PCMPs processes. For example, PCMPs know if they have team-based care or are working on quality improvement projects.

2. eCQM measures are paid for reporting the first year. PCMPs that report at the end of 2019 will get credit for those measures regardless of where they landed on that measure.

3. Claims measures: initially the Department will not have claims data for release for individual PCMPs. The goals for the claims measures will be available and PCMPs can use that to gauge their performance. The Department will provide rolling feedback to PCMPs in late summer 2018 on claims measures.

In future years, what percentage of reimbursement will be tied to performance?

Per the table below, each fiscal year the Department will increase the percent of rate enhancement that can be earned through the APM model.
How do SIM, CPC+ and PCMH recognized PCMPs fit into the APM?

The Department will award “credit” in the APM model for PCMPs that are in good standing with SIM and/or CPC+ and that are certified or recognized as a PCMH practice.

SIM:

The Department will award “credit” in the APM model for PCMPs that are in good standing with SIM. All SIM cohorts will receive credit in the APM until July 1, 2021. All SIM cohorts will select measures in December 2019, 2020 will be the performance year, and APM rate changes for all SIM cohorts will happen July 1, 2021. **SIM practices do not need to select measures until December of 2019.**

CPC+:

The Department will award “credit” in the APM model for PCMPs that are in good standing with CPC+ until July 1, 2022. CPC+ practices will select measures in December 2020, 2021 will be the performance year, and APM rate changes for CPC+ practices will happen July 1, 2022. **CPC+ practices do not need to select measures until December of 2020.**

PCMH:

The Department will award “credit” in the APM model for PCMPs that are certified or recognized as a PCMH. **PCMH practices will have to select measures in December of 2017.**

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What other changes are happening that support primary care in achieving these measures?

The Department is committed to aligning performance incentives across the entire delivery system so that PCMPs can be successful.

The Department has requested additional funding to support primary care providers through the Accountable Care Collaborative. The new Regional Accountable Entity (RAE) will be responsible for investing in primary care and supporting PCMPs. The Department made changes to the risk structure for Behavioral Health to make it easier for primary care PCMPs to provide behavioral health services. The Department has created incentives in Behavioral Health to support primary care in meeting the demand for services when there is a greater emphasis on screening and detection.

The Department is working with hospitals on payment models that incentivize transitions of care, data sharing, and support of integrated care.

The Department is also working to reduce administrative burdens:

- Whenever possible, the Department is aligning with other payers so that there isn’t additional reporting burden.

- The Department has changed its documentation requirements for behavioral health services to limit the time spent filling out paperwork.

- The Department is committed to supporting PCMPs by providing access to data to help manage the member population.

For more information contact

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Primary Care Payment Reform Website

Primary Care APM Survival Guide

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

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