

Contents

Introduction	3
Design of the APM	3
APM Goal	4
Purpose of the Survival Guide	4
Eligibility Criteria	4
Exclusion Criteria	5
Payment Model	5
How to Earn Enhanced Payments	5
Impact on Payment	6
Timeline	7
Payment Timeline	7
Structural and Performance Measures	8
Measure Selection	8
Submission of Measure Selection	9
Point Values	9
Close the Gap Concept	9
Maintenance of Goals	10
Current PCMP Performance	10
Structural Measures	10
Claims-based Performance Measures	10
eCQM	10
How will the PCMPs be Supported in APM?	10
RCCO/RAE Support	10
The RAE is responsible for supporting PCMPs by:	10
Contact	11
Resources	11



Introduction

The Department of Health Care Policy and Financing's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. The Medicaid program currently serves 1.33 million Coloradans, many of whom have complex health needs either because of life circumstances or disability. To meet the unique needs of those we serve, the Department has a long history of innovation to improve access, health care quality and the health of its members.

The Accountable Care Collaborative (ACC) is the core of the state's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way. The ACC provides the framework in which other health care initiatives, such as payment reform, can thrive. This guide focuses on the Alternative Payment Model for Primary Care (APM) and is intended to help primary care medical providers and their staff successfully implement the APM in their practices.

The Department is transforming payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is committed to aligning performance incentives across the entire delivery system so primary care providers can be successful in the APM. For example, the Department has created incentive payment programs for Behavioral Health Organizations (BHOs) to support primary care in meeting the demand for services with greater emphasis on screening and detection in the primary care setting. In addition, the Department is working with hospitals on payment models incentivizing transitions of care, data sharing, and support of integrated care, has engaged with the Colorado State Innovation Model (SIM) and the Multi-Payer Collaborative to expand and support primary care transitions across the state, and has engaged with commercial payers to seek alignment on APM measures.

Design of the APM

The Affordable Care Act provided federal funding, known as the 1202 bump, for a temporary increase in primary care rates starting in 2013. When the federal funding expired on December 31st of 2014, the General Assembly of Colorado chose to continue the 1202 bump with State General Fund dollars. **The APM is a transformation of the 1202 bump.**

The Department's budget request for fiscal year 2017-18 asked for a continuation of the 1202 bump with the addition of a value proposition. **The APM is that value proposition.**

Starting in the Fall of 2016, the Department engaged with [six workgroups](#) consisting of primary care physicians, primary care practice coordinators and office managers, along with Regional Care Collaborative Organizations (RCCOs) to design the APM. Workgroups had input on almost every aspect of the APM including selection of measures and design of the payment structure. The Department expects to continue working with stakeholders on implementing and operationalizing the new payment model.



APM Goal

In collaboration with the workgroups, the Department created the following goals for the APM:

1. Provide long-term, sustainable investments into primary care;
2. Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to PCMPs, and;
3. Align with other payment reforms across the delivery system.

Purpose of the Survival Guide

This Survival Guide is meant to inform and help primary care medical providers (PCMPs) and their staff implement the Department of Health Care Policy and Financing's (Department) new APM for primary care.¹

Eligibility Criteria

A PCMP is a primary care provider contracted with a Regional Care Collaborative Organization (Regional Accountable Entity or RAE beginning July 1, 2018) to participate in the ACC as a Network Provider. PCMPs serve as the Medical Home for Members, providing whole-person, coordinated, and culturally competent care.

The APM applies to providers designated as a PCMP in the ACC. To be designated as a PCMP, a provider must meet the following requirements:

- Be a medical practitioner with a focus on primary care (family medicine, internal medicine, pediatrics, geriatrics, obstetrics or gynecology).
- Enrolled as a Health First Colorado (Colorado's Medicaid) provider.
- Licensed and able to practice in the State of Colorado.
- Holds a MD, DO, or NP provider license.
- Licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.
- Community mental health centers and HIV/infectious disease practitioners may qualify as PCMPs if all PCMP criteria are met and with approval from the RCCO (RAE July 1, 2018).

Not all PCMPs will have the claims volume to participate in the APM. The Department will calculate PCMP eligibility (including new providers and solo billers) in the APM by reviewing claims data from March to March annually. In May of each year, the Department will announce eligibility for the APM for the following calendar year. Smaller PCMPs that were previously excluded because of

¹ This guide will be updated regularly and should be considered an iterative document.



low claims volume may become eligible for the APM in the following year, if the PCMP's Medicaid claims volume grows.

Exclusion Criteria

- **To be eligible for participation in the APM, PCMPs must have more than \$30,000 in annual paid claims associated with services defined in the APM Code Set.** PCMPs who fall below this low volume threshold will be excluded from the APM and will not experience an increase or decrease in their rates. PCMPs who are eligible to participate in the APM but choose not to do so will see a decrease in their rates.
- Providers who are contracted as PCMPs in the ACC but have claims volume below the low volume threshold are not able to opt-in to the APM. Providers who are not contracted as PCMPs in the ACC are not able to opt-in to the APM.



To be eligible for participation in the APM, PCMPs must have more than \$30,000 in annual paid claims associated with services defined in the APM Code Set.

Payment Model

How to Earn Enhanced Payments

The APM model is a point-based system. PCMPs are responsible for selecting the quality measures they will focus on. Each measure is assigned a point value. If PCMPs achieve their goal for their selected measures and earn enough points, they will receive enhanced payment on codes defined in the [APM Code Set](#). The Department assigned point values in collaboration with the APM workgroups.

The APM model consists of a set of structural measures which are characteristics of a practice and will be determined pass or fail by the RAE at the PCMP Site annually. Performance measures are clinical processes or outcomes and will be evaluated based on claims or electronic clinical quality measure (eCQM) reporting on an annual basis.



The percentage of fee-for-service rate reimbursement is based on the APM Quality Score. The APM Quality Score is determined by PCMP performance on selected measures. The percentage of fee-for-service rate reimbursement will be applied to any utilization of APM codes billed under the participating PCMP's ID.

The table below specifies the APM score ranges and the corresponding levels of reimbursement:

APM Quality Score range	% FFS Enhancement
0 - 46	< 1%
47 - 93	1% - < 2%
94 - 140	2% - < 3%
141 - 190+	3% - 4%+

Impact on Payment

Fiscal Year	Event	High Performing Practices	If You Do Nothing	Excluded Practices (Low Volume)
FY 2016-2017	Current Year	100%	100%	100%
FY 2017-2018	No Change	100%	100%	100%
FY 2018-2019	Redistribution of 1202 Funds to APM Codeset	101.10%	101.10%	101.10%
FY 2019-2020	No Change - Performance Measure Year	101.10%	101.10%	101.10%
FY 2020-2021	Payment Adjustment - 4.0% at risk	102.60*%	97.10%	101.10%
FY 2021-2022	Payment Adjustment - 5.5% at risk	104.60*%	95.60%	101.10%
FY 2022-2023	Payment Adjustment - 7.0% at risk	104.60+*%	94.10%	101.10%
FY 2023-2024	Payment Adjustment - 8.5% at risk	104.60+*%	92.60%	101.10%
FY 2024-2025	Payment Adjustment - 10.0% at risk	104.60+*%	91.10%	101.10%





Timeline

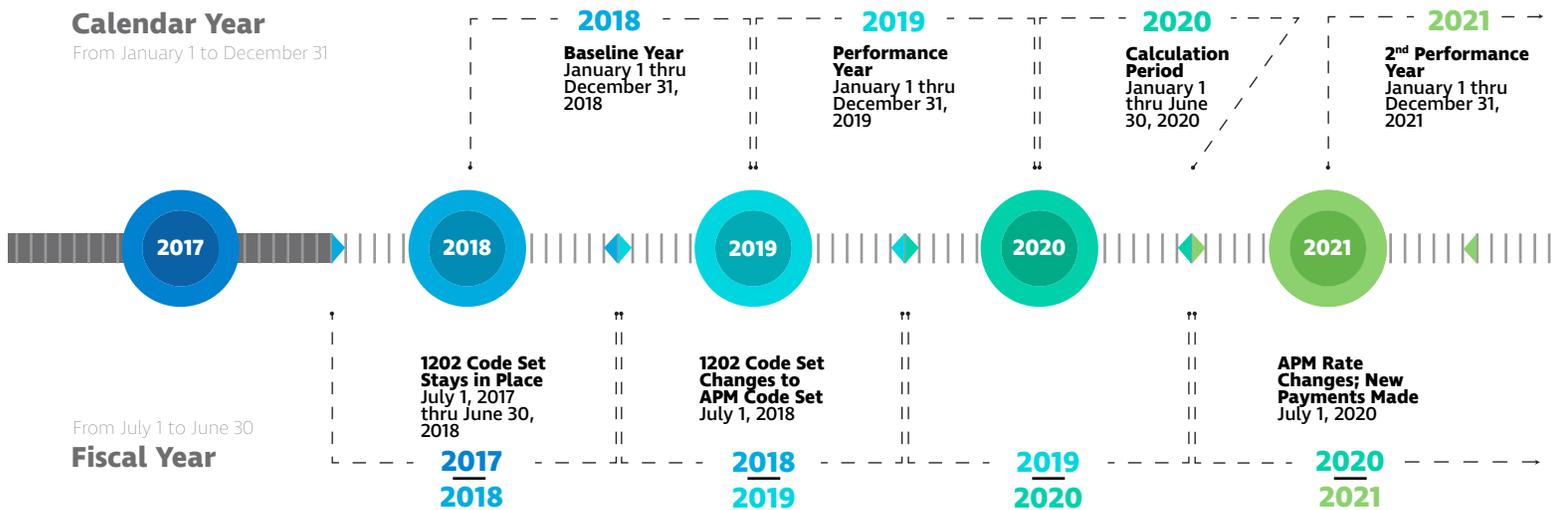
Calendar year 2018 is the baseline year of the APM. The Department will use data from this year to measure PCMP performance during the performance year of 2019. During the baseline year, PCMPs will want to validate they selected the right measures. Measures can only be changed during the baseline year. RCCOs will be supporting PCMPs with measure selection for the baseline year and the RAEs will be responsible for supporting PCMPs on improving measures during the performance year.

To ensure credit in the APM for performance on claims-based measures, proper coding is essential. PCMPs should always refer to the [claims performance measure specification sheets](#), and [APM Code Set](#) for proper coding information.



To ensure credit in the APM for performance on claims-based measures, proper coding is essential.

Payment Timeline





Structural and Performance Measures

In collaboration with the APM workgroups, the Department created structural and performance measures.

- Performance focus on clinical processes and outcomes, such as screening for maternal depression or controlling high blood pressure.
- Structural focus on practice characteristics, such as integrating behavioral health care, providing alternative types of encounters or implementing quality improvement activities.

It was the Department's priority, along with the APM workgroups, to ensure alignment with other value-based payment efforts to reduce or avoid as much administrative burden on PCMPs as possible.

The final performance measures were developed using elements from other national programs such as the State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+), and the Quality Payment Program (QPP). The structural measures were developed using the required elements from SIM, CPC+ and the NCQA's Patient Centered Medical Home (PCMH) recognition program.

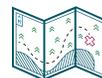
Measure Selection

PCMPs must select ten measures from either performance, structural, or a combination of both. The Department suggests the following questions to consider when a PCMP is selecting measures:

- What are you working on for other payers?
- What are you working on for yourself?
- What are the needs of the population you serve?
- Where can you realistically make change?

PCMPs should also keep in mind:

- Structural measures are pass/fail and should be easy for a PCMP site to determine how many structural measures they can meet.
- Claims measures will be run for all participants in the APM regardless of individual PCMP measure selection.
- eCQM performance measures are paid for reporting the first year. PCMPs will report eCQM data by March 1st, 2019 of the performance year and get full credit in the model for those measures when performance is determined and payment adjusted in July of 2020.



Submission of Measure Selection

PCMPs are expected to submit their initial measure selection by electronic survey between December 1st, 2017 and January 31st, 2018. The Department will coordinate with the RAEs to support PCMPs with measure selection for the 2019 Performance Year. PCMPs may change their measure selections during the baseline year of 2018. **Measures cannot be changed during the performance year of 2019.**

If PCMPs do not select measures before the performance year, they will not receive a score for the performance period and reimbursement will be reduced.

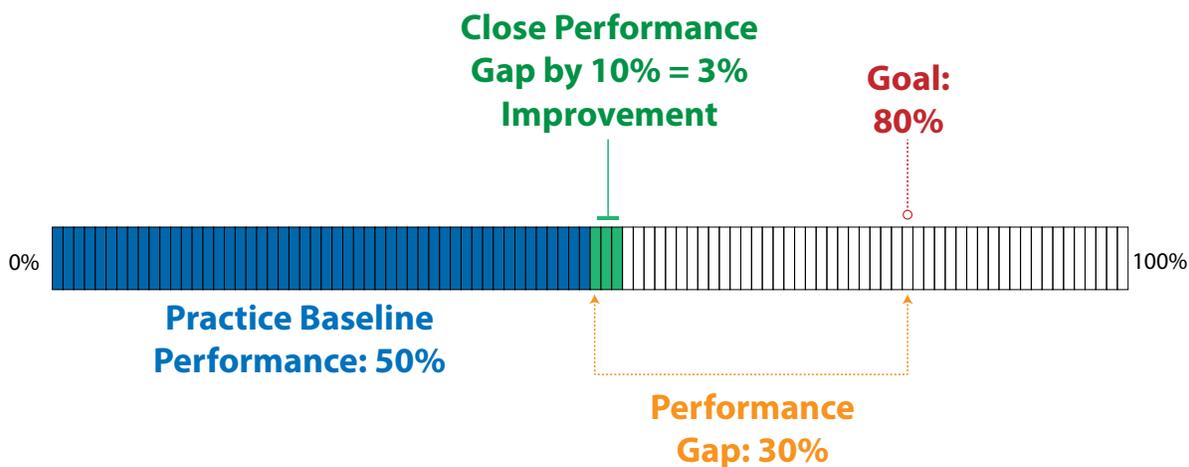
Point Values

In collaboration with our workgroups, the Department assessed the potential value gained by improvement on each measure along with the resource intensity and difficulty of achieving improvement. Measures requiring greater resource intensity and are more difficult to implement or achieve improvement on are given a higher point value.

Close the Gap Concept

Performance measures are awarded achievement based on a PCMP’s demonstration of improvement. Using national HEDIS data, the Department has developed statewide goals for each performance measure. PCMPs are expected to demonstrate improvement by “closing the gap” between their own baseline performance and the Department’s statewide goal by 10%. Thus, PCMPs are measured against their own historical baseline, rather than against other PCMPs during the same period.

For example:





Maintenance of Goals

If a PCMP's baseline for a performance measure is at or above the statewide goal, the PCMP will receive full points for that measure.

Once a PCMP has achieved a structural measure they will receive points for that measure, for one to two years. Structural measures remaining in the APM may evolve to include more rigorous requirements.

Current PCMP Performance

Structural Measures

PCMPs should be able to keep track of their own progress on selected [structural measures](#) based on the definition and documentation requirements outlined. If the practice has any questions about whether they are meeting a Structural measure, they should contact their RCCO/RAE representative to review.

Claims-based Performance Measures

The Department will measure all [claims-based performance measures](#) and **provide feedback to all PCMPs beginning in mid-to-late summer of 2018**. This allows PCMPs to change their measures based on data feedback before they enter the performance year.

eCQM

Practices who have Certified EHR Technology (CEHRT) reporting capabilities should be able to check their own progress on eCQM measures on an ongoing basis. To verify frequency of data refreshing, they should contact their EHR vendor or support company. The Department will work with SIM and CPC+ to gather eCQM data for PCMPs participating in those initiatives.

How will the PCMPs be Supported in APM?

RCCO/RAE Support

PCMPs should work with their RCCO (and soon to be RAE) to implement practice transformation and process improvement efforts.

The RAE is responsible for supporting PCMPs by:

- Designating a single point of contact for practices for questions and support with the APM. The RAE will communicate this contact information to practices.
- Helping PCMPs select appropriate measures for participating in the APM. This decision should account for the PCMP's client panel and/or community, as well as leverage efficiencies by aligning with other initiatives the practices are working on.



- Tracking which measures were selected by each participating PCMP.
- Ongoing education and support to PCMPs to help ensure successful participation in the APM.
- Confirming and reporting SIM/CPC+ participation & good standing.
- Confirming and reporting PCMH recognition/certification/accreditation from one of the following three entities:
 - National Council for Quality Assurance
 - Joint Commission
 - Utilization Review Accreditation Commission

Contact

Email questions to: HCPF_primarycarepaymentreform@hcpf.state.co.us

Resources

[Primary Care Payment Reform Website](#)

[eCQI Resource Center \(eligible professional/eligible clinician eQOMs\)](#)

[Colorado State Innovation Model](#)

[Centers for Medicare and Medicaid Quality Payment Program](#)