



Primary Care Alternative Payment Criteria

As part of the Department of Health Care Policy & Financing’s (Department) efforts to shift providers from volume to value, the Department is developing a structure to make differential fee-for-service payments to give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system. Under the proposed model, providers can earn higher reimbursement (when designated as meeting specific criteria) as they implement and achieve more advanced criteria. Movement along this framework not only encourages higher organizational performance but also helps the Accountable Care Collaborative achieve its respective programmatic goals.

In developing the proposed framework, the Department cross-referenced with Departmental initiatives, such as CPC, CPC+, EPCMP, and SIM, as well as with National Committee for Quality Assurance (NCQA) standards for Patient-Centered Medical Homes (PCMHs). Please note this is a proposed framework intended for discussion. Also note that additional work is being done to align with CPC+ Track 2 – the framework described does not apply to that methodology.

Primary Care Alternative Payment Framework

Care Delivery Domain	Payment Category			Outcomes/ Areas of Impact
	<i>Basic</i>	<i>Enhanced</i>	<i>Advanced</i>	
Access to and Continuity of Care	<ol style="list-style-type: none"> 24 hour phone access Primary care focus Extended hours Same day appts 	<ol style="list-style-type: none"> Provider Empanelment (75%) Accept new patients 24 hour EHR access 	<ol style="list-style-type: none"> Asynchronous communication Provider Empanelment (95%) 	<ol style="list-style-type: none"> Well child care Depression screening ER utilization Other preventive screenings
Care Management	<ol style="list-style-type: none"> Preventive health screening Medication management Release of previous records 	<ol style="list-style-type: none"> Population stratification: methods Population stratification: care protocols Registries Shared care plan: patient E-prescribing 	<ol style="list-style-type: none"> Self-management goals 	<ol style="list-style-type: none"> Appropriate asthma medications HbA1c testing Well child care Depression screening SUD screening
Team Based Care	<ol style="list-style-type: none"> Care team roles Care team structure Standing orders 	<ol style="list-style-type: none"> Care team empanelment (75%) Patient engagement trainings Population health management trainings 	<ol style="list-style-type: none"> Care team empanelment (95%) QI trainings Shared care plans: provider 	<ol style="list-style-type: none"> HbA1c testing Well child care Depression screening SUD screening ED Visits for ambulatory care-sensitive conditions CAHPS survey



		4. Care team huddling		7. ECHO survey 8. National Core Indicators survey
Health Neighborhood Care Coordination	1. Care compact: medical providers	1. Referral tracking 2. eConsult	1. Hospital F/U 2. ER F/U 3. Care compact: community partners	1. ED Visits for ambulatory care-sensitive conditions 2. Total cost of care
Behavioral Health Integration	1. BH preventive health screening 2. BH referrals	1. BH registry 2. BH share care plan: patient 3. BH shared decision making tool 4. Care compact: behavioral health providers 5. BH agency strategic measures 6. BH referral tracking	1. BH co-location 2. BH providers	1. Well child care 2. Depression screening 3. SUD screening
Patient Engagement and Experience	1. Process for soliciting patient feedback	1. Shared decision making tools 2. Patient satisfaction survey	3. Patient advisory group	1. CAHPS survey 2. ECHO survey 3. National Core Indicators Survey
Quality Improvement	1. Performs practice improvement activities	1. Agency strategic measures 2. Agency QI plan	1. Agency QI projects 2. Family and patient engagement in QI projects 3. QI project progress and communication	

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Access and Continuity	24 hour phone access	Practices will provide patients with 24 hour, 7 day a week access to a provider or clinician.	Basic	Well Child Care; Depression Screening	CPC, CPC+, SIM	1B2
Access and Continuity	Primary care focus	Practices will focus their care models on wellness and prevention and will provide their patients access to primary care providers from the following specialties: Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn.	Basic	Well Child Care; Depression Screening	ACC 1.0	
Access and Continuity	Extended hours	Practices will provide patients with access to care and their provider/care teams outside of the standard working hours. At least one alternatively scheduled day a week.	Basic	Well Child Care; Depression Screening	CPC+, ACC 1.0	1A2
Access and Continuity	Provider empanelment (75%)	Practices will assign 75% patients to a provider who will serve as their primary point of care.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2
Access and Continuity	Same day appointments	Practices will ensure timely access to care through integration and use of same day appointments.	Basic	Well Child Care; Depression Screening		1A1
Access and Continuity	24 hour EHR access	Practices will provide patients with 24 hour, 7 day a week access to a provider or clinician who has real-time access to their medical records.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	1B3
Access and Continuity	Provider empanelment (95%)	Practices will assign 95% patients to a provider who will serve as their primary point of care.	Advanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2

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Access and Continuity	Accept new patients	Practices will take on new Medicaid patients as their care team capacity permits.	Enhanced	Well Child Care; Depression Screening	ACC 1.0	
Access and Continuity	Asynchronous communication	Practices will implement at least one form of asynchronous communication (patient portal, email, text messaging, etc) and will set appropriate and timely follow-up standards.	Advanced	Well Child Care; Depression Screening	CPC, SIM	1A3, 1B3, 1C5
Care Management	Preventive health screening	Practices will regular screen patients for preventive health issues.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	ACC 1.0	
Care Management	Medication management	Practices will proactively manage and review each patient's respective medications.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM	4C
Care Management	Release of previous records	Practices will develop protocols and processes whereby they can request, receive, and send patient records from previous providers.	Basic	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening		5C
Care Management	Population stratification: methods	Practices will employ data-driven methods and tools (including BDIM) to risk stratify all empaneled patients.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM, ACC 1.0	3D; 4A1



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Care Management	Population stratification: care protocols	Practices will develop and implement care protocols for the specific risk pools within their population.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM, ACC 1.0	4A
Care Management	Registries	Practices will develop and implement patient registries to manage the care and outcomes of at least three specific patient populations.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	SIM, ACC 1.0	4A
Care Management	Shared care plan: patient	Practices will develop and monitor care plans with each patient that address relevant needs and that are shared across each patient's care team members.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC, CPC+, SIM, ACC 1.0	4B5
Care Management	E-prescribing	Practices will develop and implement technologies and partnerships that allow for electronic transmission of patients' prescriptions.	Enhanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	CPC	4D
Care Management	Self-management goals	Practices will develop and monitor self-management goals with their respective patients.	Advanced	Appropriate Asthma medications; HbA1c testing; Well Child Care; Depression Screening; SUD Screening	SIM	4B
Team Based Care	Care team roles	Practices will define the specific roles for care teams and integrate patient engagement, population health management, and quality improvement responsibilities in each role. These	Basic		SIM	2D

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		roles will ensure that all members are working to the top of their licenses.				
Team Based Care	Care team structure	Practices will define the composition of their agency's care teams. Care team members can include but are not limited to a provider, medical assistant, care coordinator, nurse, social worker, or behavioral health consultant.	Basic		SIM	2D
Team Based Care	Care team huddling	Practices will create spaces for care teams to meet and perform pre-visit planning. Meetings will include the care team members and any relevant staff, will discuss anticipated needs for the day or patient, and will occur on a consistent basis.	Enhanced	Well Child Care; Depression Screening; SUD Screening; HbA1c testing; ED Visits for Ambulatory Care Sensitive Conditions	SIM	2D
Team Based Care	Standing orders	Practices will develop and implement written protocols approved by an authorized practitioner that allow qualified clinicians to assess and administer certain clinical services, including vaccines, laboratory tests, and screenings.	Basic	Well Child Care; Depression Screening; SUD Screening; HbA1c testing	SIM	2D
Team Based Care	Care team empanelment (75%)	Practices will assign 75% patients to an interdisciplinary care team who will serve as their primary point of care. Care team members must include but are not limited to: medical provider, care coordinator, and behavioral health provider.	Enhanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2



Care Delivery Domain	Measure	Definition	Payment Category	Outcomes/ Areas of Impact	Other Department Initiatives	NCQA Standard
Team Based Care	Patient engagement trainings	Practices will employ a common patient engagement curriculum across their agencies and provide consistent trainings for all staff in said curriculum. Curriculums must include topics on shared care plan development, motivational interviewing, patient feedback surveys, etc.	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	SIM	2D
Team Based Care	Population health management trainings	Practices will employ a common population health curriculum across their agencies and provide consistent trainings for all staff in said curriculum. Curriculums must include topics on tools (registries, dashboards, etc), delivery systems (integrated care teams, care coordination, etc), and systems integration (community partnerships, integrated care models with external providers, etc).	Enhanced	Well Child Care; Depression Screening; SUD Screening; HbA1c testing; ED Visits for Ambulatory Care Sensitive Conditions	SIM	2D
Team Based Care	Care team empanelment (95%)	Practices will assign 95% patients to an interdisciplinary care team who will serve as their primary point of care. Care team members must include but are not limited to: medical provider, care coordinator, and behavioral health provider.	Advanced	Well Child Care; Depression Screening	CPC, CPC+, SIM	2A2
Team Based Care	QI trainings	Practices will employ a common performance improvement methodology across their agencies and provide consistent opportunities to train all staff in said methodology. Methodologies can be based on PDSAs, Lean/Six Sigma, Microsystems, etc.	Advanced		SIM	2D
Team Based Care	Shared care plans: provider	Practices will enact compacts with relevant partner practices, including	Advanced	Appropriate Asthma medications; HbA1c	SIM	2A4; 4B2/3

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		one behavioral health practice, to grant access to their respective EHRs and their patients' respective medical records and care plans.		testing; Well Child Care; Depression Screening; SUD Screening		
Health Neighborhood Care Coordination	Care compact: medical providers	Practices will enact care compacts with 1-3 relevant partner providers to track and coordinate care.	Basic	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	4C; 5B
Health Neighborhood Care Coordination	Referral tracking	Practices will monitor the status of patient referrals between the practice and its respective partners.	Enhanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	SIM, ACC 1.0	5B2
Health Neighborhood Care Coordination	Hospital F/U	Practices will follow up with 75% of hospitalized patients within 72 hours of discharge.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	5C
Health Neighborhood Care Coordination	ER F/U	Practices will follow up with 75% of emergency room patients within one week of discharge.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	CPC, CPC+, SIM	5C
Health Neighborhood Care Coordination	Care compact: community partners	Practices will enact care compacts with 1-3 relevant community partners to refer and coordinate care.	Advanced	ED Visits for Ambulatory Care Sensitive Conditions; Total Cost of Care	ACC 1.0?	4E
Behavioral Health Integration	BH preventive health screening	Practices will regular screen patients for behavioral health issues using a nationally recognized screening tool.	Basic	Well Child Care; Depression Screening; SUD Screening	SIM	3C



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Behavioral Health Integration	BH referrals	Practices will provide access to behavioral health services through referrals to partner providers or internal services.	Basic	Well Child Care; Depression Screening; SUD Screening	SIM	5B/C
Behavioral Health Integration	BH registry	Practices will develop and implement patient registries to manage the care and outcomes of patients with behavioral health needs.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4A
Behavioral Health Integration	BH shared care plan: patient	Practices will develop and monitor care plans with each patient that address behavioral health needs and that are shared across each patient's care team members.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4B5
Behavioral Health Integration	BH shared decision making tool	Practices will employ shared decision making tools for patients with behavioral health needs.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4E
Behavioral Health Integration	Care compact: behavioral health providers	Practices will enact care compacts with relevant behavioral health providers to track and coordinate care.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	4C; 5B
Behavioral Health Integration	BH agency strategic measures	Practices will identify and monitor at least one clinical quality measure relevant to behavioral health.	Enhanced	Well Child Care; Depression Screening; SUD Screening		6A
Behavioral Health Integration	BH referral tracking	Practices will monitor the status of patient referrals between the practice and its respective behavioral health partners.	Enhanced	Well Child Care; Depression Screening; SUD Screening	SIM	5B
Behavioral Health Integration	BH co-location	Practices will provide on-site behavioral health services through a contracted or in-house provider.	Advanced	Well Child Care; Depression Screening; SUD Screening	SIM	2

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Behavioral Health Integration	BH providers	Practices will employ behavioral health providers as part of their service portfolio.	Advanced	Well Child Care; Depression Screening; SUD Screening	SIM?	2
Patient Engagement and Experience	Solicit patient input		Basic	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, SIM	
Patient Engagement and Experience	Patient satisfaction survey	Practices will enact and publish results from a patient satisfaction survey on a bi-annual basis.	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, SIM	6C
Patient Engagement and Experience	Shared decision making tools	Practices will employ shared decision making tools for at least two primary care conditions.	Enhanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, CPC+, SIM	4E
Patient Engagement and Experience	Patient advisory group	Practices will convene a patient and family advisory council and publish relevant minutes on a quarterly basis.	Advanced	CAHPS Survey; ECHO Survey; National Core Indicators Survey	CPC, CPC+, SIM	6C4
Quality Improvement	Agency QI plan	Practices will develop and implement an agency quality improvement plan that is reviewed annually and linked to the strategic and operational direction of the practice.	Enhanced		ACC 1.0	6
Quality Improvement	Agency strategic measures	Practices will identify and monitor at least three clinical quality measures relevant to their specific patient populations or the RAE's strategic initiatives and goals or the State's designated key performance indicators.	Enhanced		CPC, CPC+	6A



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Quality Improvement	Agency QI projects	Practices will implement 1-3 performance improvement projects, using relevant performance improvement tactics and clinical and operational data, to improve their respective clinical quality measures.	Advanced		CPC, CPC+, SIM	6D
Quality Improvement	Family and patient engagement in QI projects	Practices will solicit and include feedback from patients and families regarding the development and implementation of QI projects.	Advanced		CPC, CPC+, SIM	6C
Quality Improvement	QI project progress and communication	Practices will publicly publish their progress and outcomes from their respective quality improvement initiatives.	Advanced		CPC, CPC+, SIM	6E/F

