COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 1, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on Performance-Based Payments.

Pursuant to section 25.5-4-401.2, C.R.S., on or before November 1, 2017, and on or before November 1 each year thereafter, the Department of Health Care Policy and Financing (the Department) shall prepare a written report describing rules adopted by the state board and contract provisions approved by the Centers for Medicare and Medicaid Services in the preceding calendar year that authorize payments to providers based on performance.

Federally Qualified Health Centers (FQHC) and Primary Care Medical Providers (PCMP) Value-Based Alternative Payment Methodology (APM)

The Value-Based Alternate Payment Model (APM) is a point-based system with a payment structure specific to participating Federally Qualified Health Centers (FQHCs) and Primary Care Medical Providers (PCMPs). The FQHCs and PCMPs are responsible for selecting quality measures to focus on with each measure having an assigned point value. The program model consists of both structural and performance measures. Structural measures are characteristics of a practice and are determined - pass or fail - by the Regional Accountable Entity (RAE) at the FQHC and PCMP site annually. Performance measures are clinical processes or outcomes and are evaluated based on claims or electronic clinical quality measure (eCQM) reporting on an annual basis. The goal of the Value-Based APM is to reward improved quality of care while managing costs. The Department is committed to aligning performance incentives across the entire delivery system to ensure program participants can be successful within the APM.

The Department is currently in the process of reviewing and updating the measure set for calendar year 2022. The measure set updates include aligning APM 1 quality measures with CMS core measures; expanding choices for eCQMs aligning with other payers in Colorado to

reduce provider burden; and, ensuring weighting is reflective of the difficulty to implement and report on the measures selected. This process involves extensive stakeholder feedback. A description of more recent changes can be found in the SB18-226 report, which is currently being drafted by the Department.

Value-Based APM Specific to the FQHCs

Pursuant to a rule approved by the Medical Services Board, effective June 30, 2018, a portion of FQHC physical health and specialty behavioral health rates are at risk based on the FQHCs quality modifier. An FQHC quality modifier is determined by the FQHCs performance on quality indicators in the previous calendar year. The first rate modification was effective July 1, 2020.

The Value-Based APM incentivizes FQHCs to: improve data collection; analyze data to create plans to improve performance on identified measures; and, modify clinical work to improve outcomes. The anticipated impact of this program includes, for example: better chronic care management as well as increased screening for cancer, depression, and sexually transmitted infections. Providing claims data and feedback on progress to PCMPs help providers improve their processes and become - or maintain status as - high-achieving medical homes.

PCMP Value-Based APM

The PCMP Value-Based APM's performance measures were developed using elements from other national programs, such as the State Innovation Model (SIM), Uniform Data System (UDS), National Commission on Quality Assurances' (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), 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.

There were no rule or contract changes for the PCMP Value-Based APM in calendar year 2020; however, in 2020, a stakeholder engagement process was conducted to make minor alterations to the measure set. The eligibility requirements to address billing issues with PCMP IDs changed, and a system change request (SCR) was instituted to further address this issue.

Value-Based Payments for Primary Care and Chronic Care Management

The next APM program is in the creation phase and will go live January 2022, pending CMS approval. Participating PCMPs will be paid a per member per month (PMPM) fee for attributed members and will receive upside only, gainsharing payments for managing defined chronic condition episodes. The goal of the program is to provide financial flexibility for providers by allowing them to receive a portion of their revenue as a PMPM payment.

Extensive stakeholder engagement, actuarial data analysis, and Medical Services Board rule approval have occurred. The final step is federal approval from CMS, which is expected to take place in late 2021.

Pay for Performance in the Accountable Care Collaborative (ACC)

In 2018, CMS approved various performance-based payment programs offered through the Accountable Care Collaborative (ACC). The ACC features:

- Key Performance Indicators: A set of measures that reward the RAEs' and their provider networks for achieving progress toward building a coordinated community-based approach to meet member health needs while reducing costs.
- Behavioral Health Incentive Program: A set of measures tied to the capitated behavioral health benefit to encourage the RAEs and their provider networks to make meaningful changes within the behavioral health system.
- Payment Reform Initiatives: Under Section 215.5-5-415, C.R.S., the Department has implemented two payment reform initiatives as part of the ACC: Rocky Mountain Health Plans Prime and Denver Health Medicaid Choice.

Detailed information on the ACC pay for performance programs can be found in the annual legislative reports on both the ACC and ACC Payment Reform Programs located on the Department's website (https://www.colorado.gov/hcpf/legislator-resource-center).

Maternity Bundled Payment

The Maternity Bundled Payment program was launched in Nov. 2020 with three obstetrical practices joining the program voluntarily. A program rule details operational specifications and how incentive payments will be determined and distributed based on an annual evaluation of participating providers performance on meeting quality goals. The rule was developed in a collaborative process with stakeholders who helped the Department to focus on health equity, the patient experience, and including the voice of Medicaid members who are people of color who have received Medicaid covered maternity services into the program. The rule importantly ties provider payment to closing health disparities and outcomes-based metrics to improve outcomes for pregnant people and newborns covered by Medicaid.

As the second program year starts in Nov. 2021, the Department is in the process of the following activities for program improvement and expansion:

- First, finalizing program quality measures selection by collecting internal and external stakeholder feedback. The final set of program quality measures will be used to evaluate a provider's annual performance.
- Second, finalizing performance reporting and incentive payment calculation for existing providers based on improvements to outcomes and health equity.

- Third, recruiting more providers to join the program.
- Fourth, selecting and purchasing a data sharing solution for the upcoming program years to timely share program performance data with participating providers.
- Fifth, updating the program rule to reflect program stakeholder feedback in terms of: refining program operational details, including adding incentives to encourage holistic screening, referral, and follow through to treatment for mental health conditions; delaying the program downside risk implementation; and, a revised program application process, utilizing the program webpage and an electronic application.

As a final step before the rule is reviewed by the medical services board, the Department is collaborating with stakeholders to craft updates aimed at further strengthening program levers to close health disparities and incentivize the use of Medicaid covered midwifery care through the bundle framework. The rule is aiming to be effective in early 2022.

Hospital Transformation Program (HTP)

On July 26, the Centers for Medicare and Medicaid Services (CMS) approved the Department's State Plan Amendment (SPA) for the pay-for-reporting component of Hospital Transformation Program (HTP) leveraging future Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. The SPA also approves the federal fiscal year (FFY) 2020-21 CHASE supplemental payments authorizing $1.48 billion in funding for Colorado hospitals, including $12 million for rural hospitals in need of support in their efforts to succeed in HTP.

The goals of HTP are to improve the quality of hospital care provided to Health First Colorado (Colorado Medicaid) members and support the state's efforts to improve affordability of health care for all Coloradans by tying provider fee-funded hospital payments to quality-based initiatives.

Over the course of the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure in an effort to improve quality, demonstrate meaningful community engagement and improve health outcomes over time.

Under the program, hospitals must implement quality-based initiatives, meaningfully engage community leaders and organizations, and improve health outcomes. Key activities and quality measures for HTP are consistent across the state, yet flexible enough to allow hospitals to work with their communities on the best interventions and approaches that serve them. The ultimate goal of HTP is to serve as a volume-to-value glide path to and inform future value-based models in the state, which will support and complement the state's efforts to improve affordability for all Coloradans by lowering the cost of hospital

care - the largest contributor of health care spending for both Medicaid and commercial payers. The specific goals that the HTP has set forth to achieve these outcomes are as follows:

1) Improve patient outcomes through care redesign and integration of care across settings.
2) Improve patient experience in the delivery system by ensuring appropriate care in appropriate settings.
3) Lower Medicaid costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery.
4) Accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
5) Increase collaboration between hospitals and other providers, particularly Regional Accountable Entities (RAEs).

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-2573.

Sincerely,

Kim Bimestefer
Executive Director
Health Care Policy and Financing

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