COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

November 1, 2022

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find a legislative report to the Senate Health & Human Services 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.

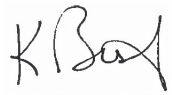
Value-based payments are a mechanism to reimburse health care providers for cost-effective, high-quality, person-centered care that achieves shared goals. The Center for Medicare and Medicaid and Services has challenged states to have 50% of Medicaid provider payments through value-based payments by 2025. Hitting this goal is imperative for the Department and is a cornerstone of our strategy to improve outcomes for members, close persistent health disparities, and control costs through innovative provider collaborative arrangements in light of the looming fiscal cliff.

This report provides an update of the Department's value-based payment programs in primary care, perinatal care, and the Prescription Drug Tool.

Detailed information on the ACC pay-for-performance programs and the Hospital Transformation Program (HTP) - two broader value-based payment models - can be found in their respective annual legislative reports located on the Department's website (https://www.colorado.gov/hcpf/legislator-resource-center).

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 720-610-7796.

Sincerely,



Kim Bimestefer
Executive Director

Enclosure(s): 2022 Report on Value-Based Payments

Cc: Senator Joann Ginal, Vice Chair, Senate Health and Human Services Committee
Senator Janet Buckner, Senate Health and Human Services Committee
Senator Sonya Jaquez Lewis, Senate Health and Human Services Committee
Senator Barbara Kirkmeyer, Senate Health and Human Services Committee
Senator Cleave Simpson, Senate Health and Human Services Committee
Senator Jim Smallwood, Senate Health and Human Services Committee
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Ralph Choate, Medicaid Operations Office Director, HCPF
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health & Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

Enclosed please find a legislative report to the Senate Health & Human Services Committee from the Department of Health Care Policy and Financing on Performance-Based Payments.

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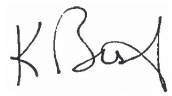

Kim Bimestefer
Executive Director

Enclosure(s): 2022 Report on Value-Based Payments

Cc:

Representative Emily Sirota, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
Representative Ron Hanks, House Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, House Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, House Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, House Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, House Public & Behavioral Health & Human Services Committee
Representative Dave Williams, House Public & Behavioral Health & Human Services Committee
Representative Mary Young, House Public & Behavioral Health & Human Services Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

The Honorable Susan Lontine, Chair
House Health & Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Susan Lontine:

Enclosed please find a legislative report to the Senate Health & Human Services 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.

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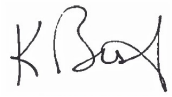

Kim Bimestefer
Executive Director

Enclosure(s): 2022 Report on Value-Based Payments
Cc:

Representative David Ortiz, Vice Chair, House Health & Insurance Committee
Representative Mark Baisley, House Health & Insurance Committee
Representative Chris Kennedy, House Health & Insurance Committee
Representative Karen McCormick, House Health & Insurance Committee
Representative Kyle Mullica, House Health & Insurance Committee
Representative Patrick Neville, House Health & Insurance Committee
Representative Emily Sirota, House Health & Insurance Committee
Representative Matt Soper, House Health & Insurance Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2022

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

Dear Representative McCluskie:

Enclosed please find a legislative report to the Senate Health & Human Services 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.

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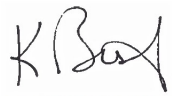

Kim Bimestefer
Executive Director

Enclosure(s): 2022 Report on Value-Based Payments

Cc:

Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
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Value-Based Payments Legislative Report

Nov. 1, 2022

Submitted to: The Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

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Department of Health Care Policy & Financing

I. Introduction

Value-based payments are a mechanism to reimburse health care providers for cost-effective, high-quality, person-centered care to achieve shared goals. The Centers for Medicare and Medicaid and Services (CMS) has challenged states to have 50% of Medicaid provider payments through value-based payments by 2025, and has announced their intention to have the majority of Medicaid beneficiaries in an accountable care relationship through value-based payments by 2030[1]. Achieving this goal is imperative for the Department and is a cornerstone of our strategy to improve quality outcomes for members, close persistent health disparities, and control costs through innovative, collaborative provider arrangements given the emerging fiscal cliff. If the Department does not shift to value-based payments, the Department's ability to improve member outcomes, reduce health disparities and drive affordability will be considerably limited. Further, as Medicaid costs continue to grow without innovations to better manage them, the General Assembly may be forced to either reduce member benefits or provider reimbursement rates, which would undermine the Department's mission to improve health care equity, access, and outcomes.

To achieve the goal of transitioning to value-based payments, the Department has submitted, as part of the Governor's Nov. 1, 2022 Budget, budget request R-6 "Supporting Primary Care Medical Providers' (PCMPs) Transition with Value Based Payments." This request builds off the Department's approved FY 2021-22 budget request R-6 "Value Based Payments" and requests to increase reimbursement to non-federally qualified health center (FQHC) PCMPs through the primary care partial capitation in APM 2. The Department believes that by investing in lower cost, high-value services such as those delivered by PCMPs, the Department and the health care system at large can move towards a better future where PCMPs are supported to improve outcomes, close health disparities, and improve affordability by better maintaining and managing member health while leveraging emerging and innovative state-based tools that enable them to do so. This report highlights four value-based payment models

[1] https://innovation.cms.gov/strategic-direction

pursuant to section 25.5-4-401.2, C.R.S. Unless otherwise specified, details of the Department's value-based payment work is through calendar year 2021.

Section 25.5-4-401.2, C.R.S. requires the Department to submit an annual report "…describing rules adopted by the state board and contract provisions approved by the Centers for Medicare and Medicaid Services (CMS) in the preceding calendar year that authorize payments to providers based on performance." This statute requires that the Department include:

- A description of performance-based payments included in state board rules, including which performance standards are targeted with each performance-based payment;
- A description of the goals and objectives of the performance-based payments, and how those goals and objectives align with other quality improvement initiatives;
- A summary of the research-based evidence for the performance-based payments, to the extent such evidence is available;
- A summary of the anticipated impact and clinical and nonclinical outcomes of implementing the performance-based payments;
- A description of how the impact or outcomes will be evaluated;
- An explanation of steps taken by the state department to limit the administrative burden on providers;
- A summary of the stakeholder engagement process with respect to each performance-based payment, including major concerns raised through the stakeholder process and how those concerns were remediated;
- When available, evaluation results for performance-based payments that were implemented in prior years; and
- A description of proposed modifications to current performance-based payments.

The programs detailed in this report include:

1. **Alternative Payment Model 1 (APM1):** a value-based system in which primary care medical providers earn points by reporting on quality measures (structural, administrative, and clinical) and demonstrating high performance or improvement. The number of points earned by each provider determines the impact on payment rates for that practice.

2. **Alternative Payment Model 2 (APM2):** similar to APM 1, with the addition of partial capitation payments and incentive payments for chronic care management.

3. **Prescriber Tool Alternative Payment Model:** this model shares savings with providers for using the Prescriber Tool, which shows patient-specific prescription drug benefit and cost information at the point of care via a Real-Time Benefits Inquiry module. This payment model encourages providers to be part of the affordability solution by prescribing cost-effective, lower cost alternatives to higher cost drugs, which is especially important given that prescription drugs are the largest driver of rising health care costs.

4. **Maternity Bundle:** this model is an episode-based incentive payment program that covers all prenatal care, care related to labor and delivery, and postpartum care for Health First Colorado (Colorado's Medicaid program) pregnant and birthing parents.

   Not included in this report are the Accountable Care Collaborative (ACC) pay-for-performance programs, skilled nursing facility pay-for-performance program, and the Hospital Transformation Program (HTP) - three broader value-based payment models - which can be found in their respective annual legislative reports located on the Department's website.

   The Department is committed to improving member quality outcomes, reducing health disparities, and increasing affordability through value-based payments. The Department is working on creating value-based payments in partnership with stakeholders for high value areas such as behavioral health, pediatrics, home health, a new maternity APM to transform the maternity bundle, and Colorado Providers of Distinction for facilities. The Department will report on these programs in future iterations of this report when they meet the reporting requirements outlined in section 25.5-4-401.2, C.R.S.

II. Alternative Payment Model 1

Alternative Payment Model 1 (APM 1) represents the Department's gradual transition to a reimbursement methodology that rewards the quality of care delivered instead of the volume of member encounters in the primary care setting. In response to CMS' policy guidance[2] and an increasing body of literature that demonstrates improved patient experience and clinical outcomes, the Department has continued to leverage stakeholder feedback to contour APM 1 so that it is mutually beneficial to providers, Health First Colorado members, and the Department.

APM 1 began development in 2016 and went live in 2018. It is designed to provide investment, reward performance, and introduce accountability for all PCMPs, including FQHCs. It is a points-based system in which PCMPs earn points by reporting on quality measures and demonstrating high performance or performance improvement. The number of points earned by each PCMP determines the impact on payment for that practice. Points are assessed based on the APM 1 Measure Set[3], which are categorized by: 1) structural measures, 2) administrative measures, and 3) electronic clinical quality measures (eCQMs). PCMPs report on 10 quality measures from the APM Measure Set: three mandatory measures and seven measures selected by the PCMP.

Measures included in the APM 1 Measure Set are intentionally aligned with other value-based payment programs or federal reporting requirements. Structural measures align with the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition program. Administrative measures and eCQMs align with the CMS Child and Adult Core Sets and the Medicare Quality Payment Program (QPP).

In collaboration with stakeholders, the Department has developed three goals for APM 1.

1. Provide long-term, sustainable investments into primary care,

[2] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf
[3] https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%20Measure%20Set%20PY2022.pdf

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

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

These goals tightly align with those of the Department's Accountable Care Collaborative (ACC) by aiming to improve member health, drive value, reduce costs, and bolster care coordination.

There are myriad outcomes in APM 1 - both clinical and non-clinical - that benefit members, providers, and the Department. Participating primary care practices receive an enhanced reimbursement rate on a subset of their fee-for-service billing codes. This increased investment supports PCMPs in providing high quality care to Medicaid members. Further, practices that meet or exceed their performance standards, determined by scoring enough points on quality measures, are eligible for an increase in their enhanced reimbursement rate. By providing PCMPs the flexibility to tailor quality measures to fit the needs and capacity of their particular practice, members who are attributed to and receive care from a participating PCMP are subject to rigorous, standardized screening protocols, which encourage preventive care that improves outcomes.

All PCMPs received the enhanced rate in 2021 with no rate change based on quality, due to the impacts of COVID-19. For program year 2021, 95% of PCMPs achieved/exceeded the quality threshold and are eligible to receive an additional rate increase. PCMPs who achieved the threshold either achieved Department goals or showed improvement on some or all their quality measures.

A collaborative and comprehensive stakeholder engagement process occurred throughout 2021. To ensure the Department adequately captured the comments, concerns, and suggestions of practices throughout the state, stakeholder engagement sessions took the form of webinars, phone calls, emails, and surveys. The APM 1 quality measure framework was developed in conjunction with stakeholder feedback and mindful that it is the providers on the front-line providing care. Every practice has different barriers to achieving particular quality outcomes, such as: populations served, geography where the clinic is located (urban, rural, frontier), staffing difficulties (hiring and

retention), and access to capital (often associated with the size of a practice and/or its association with a health system). Thus, stakeholder engagement was essential to ensure the Department could promulgate an equitable model and not unfairly penalize smaller or less-resourced practices. The evolving host of quality measures that practices could choose was emblematic of this process. As practices adopted APM 1, the Department ensured that they had the tools and resources available to succeed. Technical assistance was provided to practices via webinars, one-on-one calls and outreach, as well as a guidebook[4] posted on the Department's website. To incentivize participation in APM 1, practices were allowed to pilot the program without any downside risk, meaning that they would not be penalized for not meeting their quality measure goals.

III. Alternative Payment Model 2

APM 2 was developed in 2021 and went live on Jan. 1, 2022. This program builds on what the Department learned from APM 1 and empowers PCMPs to better support members by changing the way they receive payments. This model is designed to improve member outcomes and reduce health disparities by continuing to invest in primary care through a reimbursement methodology that cultivates flexibility and innovation. Participating practices are reimbursed through a combination of flexible partial capitation, fee-for-service payments, and incentive payments. Flexible partial capitation allows practices to select between 0-100% of their revenue to be received as a per member per month (PMPM) payment. Incentive payments are upside-only payments to practices to incentivize chronic care management in which any realized savings will be shared 50/50 between practices and the Department. To allow additional programmatic flexibility and encourage participation, practices that require additional time to review and adopt the partial capitation model can join APM 2 as incentive-only participants, until they are prepared to take any percentage of PMPM.

Partial capitation and incentive payments as a revenue stream have multiple goals, a key goal being to provide stable revenue for practices that allows investments in means of care that are not currently reimbursed, such as

[4] https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Methodology%20Guidebook%202022.2.pdf

outreach, care coordination, case management, implementation of current innovations (i.e.: Prescriber Tool) and emerging state innovations (eConsults, cost and quality tools, social determinants of health navigation tools) and health information analytics. This allows practices to holistically manage clinical care by broadening the scope of the care team involved in a member's care outside of the clinical realm. These mediums of care and coordination are not typically reimbursable in a fee-for-service model but are enabled due to predictable revenue that stems from the APM 2 framework. Practices can earn a more predictable revenue stream that is not based on the number of patient encounters. Predictable revenue is especially salient for practices given the ebb and flow of volume that has occurred throughout COVID-19, which generally reduced the margins of many primary care practices. Furthermore, incentive payments for chronic care management prevent unnecessary spending on diagnostics, imaging, lab work, and hospitalizations by incentivizing providers to address upstream determinants of chronic disease. The Department identified 12 chronic conditions that were both major cost drivers to the state and align with improved patient outcomes with primary care intervention. This program seeks to reward practices that improve outcomes for members with one or more of these conditions.

There is not yet data to report as APM 2 was not launched until 2022 (Jan. 1 for non-FQHCs and July 1 for FQHCs). As the program continues to grow, the Department plans to evaluate outcomes through a reconciliation process that involves comparing PMPM payments to comparative fee-for-service reimbursements that would have been received in the absence of the APM 2 program. The difference will help illustrate the financial benefit providers have to gain by meeting performance standards. Participation in APM 2 requires participation in APM 1; therefore, provider scoring on quality measures will continue to be assessed. Meeting the Department's APM 1 goals on quality measures is a requirement for the provider to be eligible for an upside reconciliation in the case that fee-for-service reimbursements would have exceeded the PMPM payments.

The Department is mindful of the key role that stakeholders play in the development of a successful rollout of APM 2. Therefore, many stakeholders - providers, advocates and members - were consulted to inform the

programmatic nuances of partial capitation and gainsharing. Specifically, in February and March 2021, the Department held two provider sessions, two advocate sessions, and one member session to gather perceptions and solicit feedback. These insights, in addition to a model design team (that included advocates and providers) met seven times in March 2021 through June 2021 to help develop the framework. Additional stakeholder outreach was conducted as part of the initial recruitment process for interested practices who elected to join APM 2 at the go-live date.

To facilitate alignment between Medicaid and the commercial market in primary care APMs, the Department is an active participant in the Primary Care Payment Reform Collaborative facilitated by the Division of Insurance in the Department of Regulatory Agencies and the implementation of HB 22-1325 to ensure that APM 1 and APM 2 are aligned with the commercial market.[5]

IV. Prescriber Tool Alternative Payment Model

The Department released a Prescriber Tool shared across Medicaid and commercial plans that empowers health care prescribers with real-time prescription drug cost information, so that prescribers can be a part of the affordability solution. The Prescriber Tool is accessible to prescribers through most electronic health record (EHR) systems and consists of the following modules: electronic prescribing (eRX), electronic prior authorization (ePA), Real-Time Benefits Inquiry (RTBI), and an opioid risk module (OpiSafe). The tool provides member-specific benefit and drug price information to prescribers at the point of care in the outpatient setting. It further eases administrative burden for prescribers, improves service to members and reduces the chance of over-prescribing opioids, thereby improving quality of care. This pioneering work will make it easier for providers to make prescription therapy more affordable, which in turn will have downstream cost-savings for Coloradans, employers, other payers, the Department, and the state budget.

The Prescriber Tool APM begins on July 1, 2023, and centers around the RTBI module of the tool, rewarding providers based on two metrics: the frequency

[5] https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform

of RTBI utilization and the frequency of Medicaid formulary compliance. A key goal of the RTBI module of the Prescriber Tool is to provide feedback to providers about the cost-effectiveness of a medication compared to up to three alternatives in the same therapeutic class. This information will help facilitate changes in prescribing behavior, where clinically appropriate, to reduce annual Medicaid expenditure on pharmaceuticals. Similar to the Department's other APMs, the Prescriber Tool APM employs upside risk to incentivize the adoption and utilization of the RTBI module. The Department's Pharmacy Benefit Manager (PBM) calculates the cost savings generated from the RTBI module, which will be used to inform the final model design of the Prescriber Tool APM. Historically, providers have not had any Medicaid pricing insights when prescribing drug therapy to Health First Colorado members, nor were they incentivized to be part of the affordability solution. The advent of the Prescriber Tool and the innovation of this value-based payment transforms that for the betterment of Health First Colorado members, providers, the Department and the state.

To ensure a successful launch in 2023, the Department has thoroughly engaged a host of subject matter experts and stakeholders. Primary stakeholder engagement occurred in July and August 2021. Through 11 key informant interviews, six workgroup meetings, and a survey distributed statewide, stakeholders have played an integral role in the development of a value-based payment model that works best for its intended users. A common theme expressed by stakeholders was the need for a robust dashboard with a user-friendly interface. The Department used this feedback to refine the plan for the development of the dashboard, to ensure it enables providers to easily view components of their prescribing practices that will facilitate success in the program. The Department has provided personalized support for the implementation, navigation, and functionality of the RTBI module among practices, statewide. This has also allowed practices to integrate the use of the module into their workflow before the Department begins tracking performance metrics for value-based payments. Opportunities for end-user technical assistance and feedback will be readily available throughout development and launch by both the Department as well as a contracted vendor.

V. Maternity Bundled Payment Program

The Maternity Bundled Payment program is the Department's first episode-based payment program, as well as one of the adopted innovative value-based payment and delivery models that support transition from fee-for-service payments to value-based payments. The program aims to improve perinatal care service quality, pregnant/birthing members' health outcomes, and newborn health outcomes. Mental health and substance use issues are the leading causes of the rising maternal morbidity and mortality in Colorado; the Maternity Bundled Payment program specially addresses substance use disorder (SUD) and mental health issues through the program design to promote quality mental health and substance use screening, referral, and treatment to pregnant and birthing parents. The bundled payment program covers all eligible costs associated with prenatal care, labor and delivery, and postpartum care for Health First Colorado pregnant and birthing parents. Prenatal care providers can serve as principal accountable providers (PAPs) because of their partnership with the patient and their ability to influence the quality and cost of the episode. PAPs can earn incentive payments for improving the quality of care. Episodes covered during each performance year will be retrospectively reconciled against a prospectively calculated target. PAPs will receive incentive payments only if all improvement goals are met. To give providers time to engage and learn how to succeed in the program long term, participation in the program is voluntary, and incentive payments are upside only.

The Maternity Bundled Payment program completed its first year of operation by October 2021 with three OB/GYN practices enrolled, representing approximately 10% of Health First Colorado births in the state. The Department provided quarterly performance reports with each participating provider to provide progress updates and collect feedback on program improvement. The Department also worked with providers as well as program stakeholders to finalize the selection of the quality measures that serve as the gateway for shared savings. The Department will include results from the first performance year in next year's legislative report.

To expand the program and recruit providers, the Department initiated a series of promotional and outreach activities through public webinars and forums, and

targeted feedback sessions to invite eligible providers to join the program. As a result, four more practices joined the program for the second program year (November 2021 - October 2022). These seven enrolled practices cover about 25% of the total annual Medicaid-covered births in Colorado.

Stakeholder engagement and feedback was especially prominent in the development of the Maternity Bundle. The Department collaborated with a diverse group of consumer and member advocates, providers, and subject matter experts through a series of meetings to learn about emerging concerns and care models in maternal care. In response to their collective feedback, the Department agreed that program participation remains voluntary instead of including all obstetrical providers and updated the program's incentive payment model by specifically addressing SUD and mental health issues to promote quality mental health and substance use screening, referral, and treatment to pregnant and birthing parents.

VI. Conclusion

The value-based payment models outlined in this report are indicative of the Department's commitment to a reimbursement model that drives value for Colorado and aligns with our shared goal to achieve 50% of the Department's reimbursement through value-based payments by 2025. Stakeholders are the key to the development and implementation of successful value-based payment programs that promote equity, access, and improved outcomes. Providers and their respective practices hold the key to early identification, intervention, and prevention by expanding the traditional model of care delivery and reimbursement to a model that incentivizes patient-centered care and upstream interventions. The Department strives to be a market leader in the shift to value-based payments by ensuring providers have the tools and resources they need to be successful in improving member outcomes, closing health disparities, and improving affordability.