Federally Qualified Health Center / Rural Health Clinic Prospective Payment System Plus Reimbursement Methodology

Data Collection Pilot Findings and Implications

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EXECUTIVE SUMMARY

In late 2010, the Department of Health Care Policy and Financing (the Department) received a grant from the Centers for Medicaid and Medicare services to assist with implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requirements related to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) reimbursement. Additionally, the Department sought to take the opportunity associated with implementing the requirement to develop a value-based payment methodology for FQHCs and RHCs in CHP+ and Medicaid. The Department contracted with JSI Research and Training Institute (JSI) to assist in developing a payment methodology for FQHCs and RHCs, which would go beyond the current Prospective Payment System (PPS) to provide quality/outcome incentives in the state CHP+ and Medicaid programs.

One component of the project was a data collection pilot designed to 1) identify and provide recommendations to the Department regarding the use of cost, access, and quality measures for a future value-based payment methodology, and 2) assess and define considerations related to implementation of a value-based payment methodology. Three FQHCs, one RHC and a CHP+ managed care organization (MCO) participated in the pilot, providing information about their ability to capture, report on, and validate nine measures related to cost, quality, or access.

Pilot Findings

The data collection pilot demonstrated that the pilot FQHCs/RHCs are, with a few exceptions, capturing the data elements needed for the selected access (Ambulatory Care) and quality measures. Two of the selected value and cost measures (Emergency Room Utilization, Hospital Readmissions) are hospital focused, and thus the data elements are not captured by the clinics. Data elements for the third value measure, Generic Drug Substitution, were less consistently captured by clinics. The conceptual focus of the Generic Drug Substitution measure was also found to be less relevant for FQHCs, given their participation in the 340B drug program, and problematic to implement for both FQHCs/RHCs due to challenges linking pharmacy claims with clinics or primary care dates of service. All of the pilot participants have EHR (electronic health records) systems in place, and most have integrated practice management and EHR systems. Thus, these results do not necessarily hold true across all FQHCs and RHCs, especially those not using EHRs.

While clinics are capturing most of the data elements for the measures, not all are captured in data fields that lend themselves to inclusion in claims forms, and therefore cannot be calculated exclusively through administrative data. Because FQHCs/RHCs have historically submitted institutional claim forms to be paid on an encounter basis, there has not been a compelling reason for clinics to include all procedure codes, or detailed modifiers, on claims information. At this time, generation of the clinical measures could not rely solely on administrative information, but would require a chart audit or development of separate systems that could capture and report clinical information, especially for any measure requiring a counseling component.

A number of system and process gaps and challenges were documented through the data collection pilot. The implementation of an FQHC/RHC specific measure will involve refinement of data systems and/or processes at the Department, MCO and clinic level. Just as stakeholder input was very valuable in the development and execution of the data collection pilot, it will be critical to further refinement and roll-out of measures specific to a value-based payment methodology for FQHCs/RHCs.

Considerations for Payment Methodology Design

Considerations for the structure and implementation of a future value-based payment methodology for FQHCs and RHCs relative to their Medicaid and CHP+ patients are based on current and emerging best practices, stakeholder and Department input, and findings from the data collection pilot. Key findings include:

Scope

Value-based payment methodologies are most successful when they impact a sufficiently large percent of a practice's patient mix. The small size of the CHP+ program relative to Medicaid, both at the state level and at the clinic level, poses a challenge for generating statistically valid measures and providing incentive payments large enough to affect change. Aggregation of Medicaid and CHP+ data for measure generation and value-based payments could be a way to address the small numbers in CHP+

Incentive Structure

The key consideration for selection of incentives is the desired outcome of the methodology. If the desired outcome is to transform the care delivery model, a lump sum payment, or a per member per month payment for attainment of the desired characteristics provide the predictability necessary to support system changes. If the desired outcome is clinical performance, a supplemental retrospective payment based on attainment of benchmarks and/or improvement is the most common structure. The incentive could be based on either progress against a baseline or the achievement of pre-established benchmarks on process, quality and/or value indicators The Department should use the most straightforward incentive structure possible to achieve the stated goals in order to increase transparency and reduce any administrative burden for the Department, MCOs and providers. Given the diversity of FQHCs and RHCs in Colorado, it may make most sense to use a phased implementation model that allows clinics to participate in additional incentive components over time.

Indicators

The measures selected for the pilot were consistent with the Department's priorities for improving care for adults and children, although only one measure (Body Mass Index 2 through 18 Years of Age) was specific to children. Within individual FQHCs/RHCs, especially rural or smaller clinics, actual volume of patients with targeted conditions may be low, making it difficult to generate reliable measures. The Department may want to consider the relative importance of measuring and incentivizing quality within a subset of providers (FQHCs/RHCs), to measuring and incentivizing it across providers. As indicators are

chosen for FQHC/RHC providers they should be consistent with and/or build on those used by other Department initiatives. Furthermore, nationally defined measures are designed for a managed care environment, and may require modification when applying them to fee-for-service (FFS) populations.

Financing

Given the absence of new state dollars to support value-based incentives at the present time, the Department must consider other financing mechanisms. One alternative is to document and share savings to the Medicaid/CHP+ programs resulting from internal efficiencies achieved by providers, or from savings in the overall cost of care resulting from effective provision of primary care. One challenge is to ensure that shared savings are not "double counted" by the various incentives being developed within the state. Another source of financing is the use of public or private grant programs focused on delivery system innovation.

Summary

The implementation of a value-based purchasing methodology with Colorado FQHCs/RHCs has the potential for furthering the Department's strategic goals and achievement of the Triple Aim, and is consistent with payment reform efforts by the Centers for Medicare and Medicaid Services and other public and private payer payment efforts. While federal requirements limit the degree to which FQHC/RHC PPS payments can be put at risk, there are opportunities to combine PPS payments with other payment methodologies that support value-based care. The pilot findings indicate that it would be difficult to implement one single methodology universally across all FQHCs and RHCs for both CHP+ and Medicaid services, given the variation in clinic size and number of enrollees, and the separate delivery systems for the two programs. The data collection pilot clarified specific gaps, challenges, and considerations that will be critical to the development and implementation of an effective value-based payment methodology. These gaps and challenges can be overcome but will require resources at the state, MCO and clinic levels.

INTRODUCTION

The purpose of this report is to present the Department of Health Care Policy and Financing with a summary of findings and implications from the data collection pilot conducted to inform the development of a value-based payment methodology for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The data collection pilot was conducted in 2011 as part of a broader effort to identify payment methodologies that might be implemented by FQHCs/RHCs. This report analyzes the system gaps and challenges in state operations, payment systems, and data processes related to a set of measures chosen through the project. The report also provides considerations for the design of future payment methodologies and identifies structures most feasible for implementing desired changes.

Background

The Department of Health Care Policy and Financing's (the Department's) mission is to improve access to cost-effective, quality health care services for Coloradans. The Department has adopted the Institute for Healthcare Improvement's Triple Aims[1] to guide its payment and delivery system reforms, which include:

- Improving the health of a defined population;
- Enhancing the patient care experience (including quality, access, and reliability); and
- Reducing or least controlling the costs of care.

Colorado's Blue Ribbon Commission for Health Care Reform was charged with identifying strategies to expand health care coverage and reducing health care costs, and made recommendations to that effect in January 2008. Over the past several years the Department has built on those recommendations and laid the foundation for linking health care expenditures with health outcomes and value. The Department has implemented a number of initiatives focused on improving value including a Medical Home Initiative for children, the Healthy Living initiative, the establishment of the Center for Improving Value in Health Care, and the launching of the Accountable Care Collaborative. These efforts, coupled with planning for the implementation of provisions from the Affordable Care Act, have laid the foundation for other value-based initiatives within Colorado.

In late 2010, the Department received a grant from the Centers for Medicaid and Medicare services to assist with implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requirements related to FQHC and RHC reimbursement. Additionally, the Department wished to take the opportunity associated with implementing the requirement to develop a value-based payment methodology for FQHCs and RHCs in both CHP+ and Medicaid.

[1] Institute for Healthcare Improvement. (2010). *The Triple Aim*. Available online at http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

The Department contracted with JSI to assist in developing a payment methodology for FQHCs and RHCs, which would go beyond the current Prospective Payment System (PPS) used in Medicaid to provide quality/outcome incentives in the state CHP+ and Medicaid programs. JSI conducted a review of pertinent reports and articles; researched Colorado's existing payment methodologies, quality initiatives, and value-based strategies; gathered input from stakeholders and key informant interviews with national experts, state Medicaid/CHIP programs, and key Department staff; and reviewed federal and state requirements related to PPS and CHIPRA PPS implementation. Findings of this research were submitted to the Department a *Review and Research Report* and an *Options and Gaps Report* in order to inform the state's decision making. The *Review and Research Report* presented research on PPS requirements, CHIPRA PPS implementation, value-based purchasing, and Colorado's current programs and systems.

Based on this research, JSI presented the Department with four options for moving from the existing PPS payment model to value-based purchasing in order to meet both federal requirements for FQHC/RHC payment methodologies and the Department's objectives.[2] Financing for the methodology options included the potential use of shared savings to fund new incentives, a restructuring of current FQHC/RHC payments, or the use of new funds. However, recent cuts to provider rates, combined with the federal requirements for FQHC/RHC reimbursement and the lack of new dollars available to immediately fund any new incentive, made the implementation of a value-based payment methodology not practical at this time. In addition, the earlier stages of the project had identified substantial gaps in current systems that would need to be addressed before implementing a new payment methodology. The Department recognized the need for a better understanding of data flow through Department and clinic data systems and of clinics' capacity to gather and share data points prior to moving forward with methodology design. Thus the Department, with input from stakeholders, made the decision postpone implementation of a methodology and instead conduct a data collection pilot to ascertain the feasibility of using specific measures for value based purchasing.

This report provides an analysis of findings from the data collection pilot and their implications for the design and implementation of future value-based payment methodologies. It first describes the pilot process developed for collecting information and soliciting feedback from pilot participants. It then presents the pilot findings on the gaps and challenges related to the availability of data points for extraction, measure generation, measure validation, state operations, payment systems, and other processes related to use of selected indicators. Following the description of the pilot findings, this report presents considerations for structuring future payment methodologies including discussion of scope, measurement areas and indicators, potential incentives, and financing considerations.

[2] The *Options and Gaps Report* submitted in February 2011 details each option's scope, payment model, quality and efficiency indicators, incentive structures, and financing.

PILOT FOCUS AND PROCESS

The purpose of the data collection pilot was to identify and provide recommendations to the Department regarding the use of cost, access, and quality measures for a future value-based payment methodology, and assess and define considerations related to implementation of a value-based payment methodology.

The objectives of the data collection pilot were as follows:

- To identify potential cost and quality measures for implementation in a future value-based payment methodology;
- To assess the availability of data elements related to the measures throughout Department, MCO, and clinic level systems;
- To identify gaps and challenges associated with the generation and validation of the proposed pilot measures; and
- To collect feedback from the Department, the pilot participants, and interested stakeholders on the data collection pilot processes, focus, and mechanisms for input.

The data collection pilot began in June 2011. Prior to the month of June, the Department gathered input through discussions at monthly stakeholder meetings to arrive at consensus on the measures and specifications utilized in the data collection pilot, listed below. Stakeholders identified the following principles as important in measure selection:

- Measures selected should be nationally recognized, such as those defined by the National Quality Forum, in order to facilitate benchmarking and comparison.
- Measures selected should be consistent with those required of FQHCs and RHCs under other programs or initiatives. For example, those required by the Centers for Medicaid and Medicare Services to meet Meaningful Use criteria, or required of FQHCs for the Bureau of Primary Health Care Uniform Data System report. In addition, measures should be reconciled with future initiatives or those currently being developed, for example, the Accountable Care Collaborative.
- Measures should not be limited to those that could be used to identify reduced costs. Measures should focus on quality of care and access, (i.e., ambulatory care visits), to ensure that focus on shared savings does not dis-incentivize appropriate use of care. Additionally, the indicators chosen for their ability to identify cost savings also have a quality/value component. This approach is consistent with the Department's desire to work within the Triple Aim framework.[3]

[3] Institute for Healthcare Improvement. (2010). *The Triple Aim*. Available online at http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

The following table summarizes the measures agreed upon for the pilot.

Proposed Measure	Focus	Steward/ Source for Specifications	Measure Type
Emergency Room Utilization	Cost/ Appropriate care	NCQA: AMB – B	Administrative
Hospital Readmissions (all cause)	Cost/ Appropriate care	HCPF	Administrative
Outpatient Visits	Appropriate care	NCQA: AMB-A	Administrative
Generic Drug Substitution	Cost/ Appropriate care	To be developed	Administrative
Diabetes: Hemoglobin A1c Testing	Quality	NQF #: 0057 Steward: NCQA	Administrative (for test done)
Diabetes: Blood Pressure Management	Quality	NQF #: 0061 Steward: NCQA	Hybrid
Hypertension: Controlling High Blood Pressure	Quality	NQF#: 0018 Steward: NCQA	Hybrid
Body Mass Index (BMI) 2 through 18 Years of Age; Adult Weight Screening and Follow-Up	Quality	NQF #: 0024 Steward: NCQA; NQF #: 0421 Steward: CMS	Administrative (for BMI assessment); Hybrid for counseling
Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Quality	NQF #: 0028 Steward: AMA	Administrative & Hybrid

Measures generated as part of the data collection pilot have not been finalized as official measures on which future value-based payments will be made. Rather, the measures were selected because they represent areas of interest for both the Department and stakeholders. Understanding the considerations and challenges related to the availability of data elements, measure generation, and measure validation for these measures provides valuable information to inform selection of measures as part of a future payment methodology.

The Department requested clinics and MCOs to volunteer for the pilot, and encouraged a diverse representation of clinics from different geographical and technological capacities. The eligibility specifications, developed with input from stakeholders, required that participating FQHCs and RHCs provide services for both Medicaid and CHP+ clients, and furthermore, that the FQHC/RHC be

contracted with at least one MCO participating in the pilot. The specifications also required that the MCO partaking in the pilot activities participate in CHP+ and maintain a variety of both FQHCs and RHCs in their network of providers. Three FQHCs, one RHC, and one MCO to participated in the data collection pilot, listed below.

- Colorado Access (MCO)
- Denver Health Community Health Services (FQHC)
- Metro Community Provider Network (FQHC)
- Mountain Family Health Services (FQHC)
- Rocky Ford Family Health Center (RHC)

The Department had hoped for participation from at least one more RHC. Since such participation was not forthcoming, it was decided that two other RHCs would be engaged to provide focused feedback on aspects of the pilot. Pediatric Associates of Montrose and Yuma Clinic participated in this capacity.

FQHC/RHC Involvement

Each FQHC/RHC participant established a designated point person to represent the participating entity. Over the course of the pilot, the point person for each FQHC/RHC was expected to facilitate and participate in pilot activities on behalf of the participating entity. These activities included completion of tools regarding their data capture, reporting capacity, and processes; participation in meetings with JSI to document pilot findings and obtain feedback regarding any challenges that arose; and participation in pilot group meetings of all interested stakeholders held monthly in June through November that focused on identifying shared data collection strategies, reporting gaps and barriers, and, where possible, identifying strategies to resolve them.

At the onset of the pilot, FQHC/RHC participants collaborated with the Department and to finalize the parameters used for the selected measures. During subsequent months, FQHC/RHC participants reported on the ways in which data elements for the selected measures are collected and recorded within the participant's data systems, as well as any challenges and barriers to doing so. JSI documented the information provided by each FQHC/RHC through a series of interviews conducted over the phone. Pilot tools, consisting of two tailored feedback guides for the FQHC/RHC participants, were utilized during these conference calls in order to both guide and standardize the information gathering process. The first pilot tool, a data collection questionnaire, focused on how data is captured in clinics' practice management system, billing, and electronic health records systems. The second, a data matrix in the form of an Excel spreadsheet, focused on whether specific patient and claims variables are captured in the participants' systems, and if so, whether they can be extracted and reported on by the participants. These tools are included in Appendices C and D, respectively.

In the following months, FQHC/RHC participants were provided with reports generated by the participating MCO with clinic-specific information on the following pilot measures using CHP+ claims for 2010 calendar year:

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Ambulatory Care Utilization Visits
- Childhood Body Mass Index (BMI) Screening and Follow-Up

FQHC/RHC participants were asked to provide validation to the extent reasonable and practical on the reports generated by Colorado Access. Two of the three participating FQHCs (Denver Health and Mountain Family Health Center) and the participating RHC (Rocky Ford Family Health Centers) provided feedback on the content and format of the reports, as well as the validation process. This feedback was documented by JSI through a series of phone interviews with the designated point person at each participating entity.

A tailored interview guide developed by JSI was again utilized in order to both guide and standardize the information gathering process; this interview guide can be found in Appendix H.

MCO Involvement

The MCO, along with other stakeholders, collaborated with the Department and JSI to finalize the parameters used for the selected measures, including related attribution methodologies. The MCO also utilized customized versions of the two pilot tools described above to document how data elements for the selected measures are collected from their contracted clinics and are captured within their data systems.

The MCO was then asked to create data reports, to the extent possible and feasible, on the data elements specific to the measure parameters agreed upon with the Department for each of the FQHCs/RHCs participating in the pilot. These measures include Emergency Room Utilization, hospital readmissions (any cause), Ambulatory Care Utilization Visits, Childhood Body Mass Index (BMI) Screening And Follow-Up. The measure numerator and denominator were reported on an entity-specific level for each of the participating FQHC/RHC providers and as a roll-up across the participant using CHP+ claims from the 2010 calendar year. The MCO worked with JSI and the Department to finalize these reports and document any system challenges or specifications that proved challenging to respond to.

The designated point person was asked to provide feedback on the process of defining and running the measures, including observations regarding:

- Identification of numerator and denominators
- Generation of data at the clinic provider level
- Challenges encountered in generating the measures; specifically, measure criteria/specifications that are challenging to respond to

- Suggestions for improvements in the process
- System challenges that prohibited reporting on the measures and specifics to address that challenge

HCPF Involvement

As the aggregator of claims data through MMIS, the Department served as a participant in the data collection pilot. The Department's Data Section was engaged in the completion of the two pilot tools, customized to assess the Department's ability to process claims, capture claims-level detail, and store data for retrieval and analysis at the individual provider level. The Department's Data Sections also filled out a customized, detailed data matrix tool delineating where specific claims variables related to the proposed pilot measures are captured, and met with JSI to provide a detailed understanding of data flow through MMIS.

As a pilot participant, the Department's Data Section was also engaged in the generation of measure reports at the entity-specific level for each of the participating FQHC/RHC providers. The Department was able to generate denominators in member months for Emergency Room Utilization, Outpatient Visits, the Diabetes Measures, Hypertension, and BMI down to the provider level. For the Diabetes, Hypertension, and BMI measures, the Department does not have access to the test results that the indicators require in order to generate a numerator. The Tobacco Use measure proved impossible to generate because the Department does not have the information to accurately determine if a patient is a tobacco user merely from claims data. Furthermore, the Generic Drug Substitution and Hospital Readmissions measures required more resources and time than the Data Section had available to undertake within the timeframe of the pilot. The Department point person was asked to respond to the same questions regarding measure generation as outlined for the MCO above.

Stakeholder Involvement

Throughout the pilot the Department gathered input from both pilot participants and interested stakeholders through monthly group meetings. These meetings provided interested stakeholders with progress updates in the pilot and the opportunity to provide input on the pilot processes. The monthly group meetings also served as forum for group decision making, focusing on discussion of prominent gaps and barriers, and, where possible, strategies to resolve them. A list of meetings and attendees can be found in Appendix E.

PILOT FINDINGS

In order to determine whether the above measures (or one substantially similar) could be produced for use in a future value-based purchasing initiative, a multi-step assessment process was developed with the objectives of determining:

1) Whether clinics capture the data elements required to calculate the measure,
2) Whether those data elements can be readily extracted from clinic records, and
3) Whether the data elements are transmitted by clinics to a central data repository (the Department, an MCO or data warehouse) and available for analysis.

Accurate generation of measures requires that the data be available at the clinic level. The format in which those data are available (e.g. if data are in a format that is readily retrieved through a standardized query, or are in a text fields that do not lend themselves to queries and would require manual chart review) has implications for extraction and reporting methodologies. The way data is reported from clinics to managed care organizations or the Department, in turn, has implications for how measures can be generated, and the degree to which current systems can (or cannot) support the generation of the selected measures.

When considering the pilot findings it is important to note that the pilot clinics are not a representative sample of FQHCs and RHCs, but rather, clinics interested in the pilot and willing to participate. Only one RHC participated fully in the pilot, although two additional RHCs were interviewed by JSI using the protocol identified above. The Colorado Rural Health Center has noted that many RHCs are not as advanced in their ability to capture, and in particular, query and report data beyond that required for billing. Of the over 50 RHCs in the state, 36 are participating in the CRHC REC (Rural Extension Center) which provides assistance to RHCs in meeting Meaningful Use criteria. Of those, 29 have existing EHRs, and five have already completed their meaningful use attestation. An additional seven are expected to attest by January 2012, and the vast majority of remaining clinics are in some stage of implementing systems to achieve meaningful use.[4] Thus, there appears to be considerable variation in data capture and reporting capabilities across RHCs in Colorado.

As described above, each participating clinic completed an Excel spreadsheet detailing if and how data elements needed (based on the national guidelines) are captured and able to be extracted. They completed a questionnaire which informed a conversation with JSI about their data systems (practice management system, billing, EHR) and any relevant concerns or issues with the chosen measures.
Colorado Access also produced reports on four of the measures, which were then validated by the participating clinics to the extent feasible within time and resource constraints. The format for the reports is included in Appendix F. The following table summarizes the availability of the data needed to produce the selected measures.

[4] (Angela Marino, Colorado Rural Health Center, email communication, November 12, 2011).

Availability of Needed Data

	Captured by Pilot FQ/RHC	Available for Extract at FQHCs/RHCs	Accumulated (across providers)	Available for Analysis	Gaps, Exceptions, Considerations
ER Utilization					
Medicaid	No	From hospital claims data	HCPF data warehouse	HCPF data warehouse	Requires methodology to attribute patients with ER visits to FQHC/RHC
CHP+	No	From hospital claims data	MCO and Actuary	Actuary (combining all MCOs)	
Hospital Readmission					
Medicaid	No	From hospital claims data	HCPF data warehouse	HCPF data warehouse	Requires methodology to attribute patients with ER visits to FQHC/RHC
CHP+	No	From hospital claims data	MCOs and Actuary	At actuary (combining all MCOs)	
Outpatient Visits					
Medicaid	Yes	From claims data and clinic record	HCPF data warehouse	HCPF data warehouse	Requires methodology to attribute patients to FQHC/RHC
CHP+	Yes	From claims data and clinic record	MCOs and Actuary	At actuary (combining all MCOs)	
Generic Drug Utilization					
Medicaid	Yes for prescribed, For dispensed only if dispensed at FQHCs	At FQHC: Only where dispensed in-house	No	No	Pharmacy claims don't always have provider indicated, nor are they linked to a facility. Not clear measure rationale is applicable where 340B drug pricing is used.
CHP+	Yes for prescribed; For dispensed, only if dispensed at FQHCs	At FQHC: Only where dispensed in-house	Yes, at MCOs	At MCO level. Could be made available to actuary/HCPF	Not clear measure rationale is applicable where 340B drug pricing is used.
Diabetes: HBA1c testing					
Medicaid	Yes	Varies: values captured in varying formats	HCPF data warehouse for procedure; No for results	with hybrid method only	NDC codes/medicines prescribed to ID diabetes not consistently available. MMIS does not accept "f" codes for test value
CHP+	N/A	N/A	N/A	N/A	
Diabetes: Blood Pressure Management					
Medicaid	Yes	Yes	HCPF Data warehouse for procedure*; No for results	with hybrid method only	NDC codes/medicines prescribed to ID diabetes not consistently available
CHP+	N/A	N/A	N/A	N/A	
Hypertension: Blood Pressure Management					
Medicaid	Yes	Yes (see Considerations)	HCPF Data warehouse for procedure*; No for results	with hybrid method only	ICD-9 for hypertension available; BP results available on chart review
CHP+	N/A	N/A	N/A	N/A	
BMI Screening and Follow-Up/Nutrition Counseling					
Medicaid	Yes	Varies	HCPF Data warehouse for procedure*; No for results	HCPF data warehouse	Documentation of follow-up at clinic level varies.
CHP+	Yes	Varies	MCOs	Yes	
Tobacco Use and Assessment					
Medicaid	Yes	Varies	HCPF Data warehouse for procedure*; No for results	HCPF data warehouse	Denver Health: documentation for counseling/advice not able to extract Rocky Ford: query, advice to quit, counseling not able to report
CHP+	N/A	N/A	N/A	N/A	

Availability of Data at the Clinic Level

The five pilot clinics were capturing the data needed to report on the following measures:

- Outpatient visits
- Hemoglobin A1C Testing for Diabetics
- Blood Pressure management for Diabetics
- Blood Pressure management for Hypertensive individuals

Clinics, however, do not have historic eligibility data that would allow them to readily identify patients who both meet the clinical criteria for inclusion and who had the required Medicaid or CHP+ eligibility span.[5] For the remaining clinical indicators (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents; Adult Weight Screening and Follow-Up; and Tobacco Use Assessment and Tobacco Cessation Intervention) all of the clinics are capturing related data if the assessment was done, but are not consistently capturing whether follow-up counseling was provided. In addition, the specific BMI values captured varies from clinic to clinic, with some recording the BMI percentile and others the values.

The clinics are not able to capture the data required for the Generic Drug Substitution measure, although they are capturing data on drugs prescribed to patients. All of the pilot clinics had electronic interfaces with laboratory companies that ensure lab results are readily (or, in some cases, automatically) incorporated into the patient record in designated data fields, making lab data available where it can be used to determine the universe for the measure. As would be expected, none of the pilot clinics were capturing data on emergency room visits or hospital readmissions. However, all had the ability to access hospital records for their patients on an as-needed basis through data exchange agreements with partner hospitals.

Gaps

1. *Variation in Capture Method.* Most participating clinics captured the required data elements as a discrete field within the electronic health record that could be queried. However, this was not the case across all clinics or for all measures. For example, some clinics captured in the EHR the performance of HBA1C screens, but the results were in text notes within the clinical notes, and not readily available for extract. All clinics had the ability to capture "f" codes, as called for in the measure specifications, but not all are using that ability.

2. *Insufficient Detail to Generate the Measure.* The tobacco measure, like other prominent nationally utilized quality measures, includes a counseling component. While all clinics captured information

[5] In the case of these measures, enrollment in Medicaid or CHP+ for 12 months, with no enrollment gap of over 45 days.

regarding whether the patient was screened for tobacco use, not all clinics captured whether or not cessation counseling was conducted. Similarly, all clinics were recording body mass index (BMI) assessments in the patient record. However, some clinics were not recording the BMI percentile or values. Additionally, some others were either not capturing whether follow-up was provided, or were only capturing the information in text fields that are not readily queried. Nonetheless, several had modified their EHR to ensure that the required data elements were captured.

3. *Insufficient Detail to Identify Denominator (Eligible Population) for Measure*. Some of the measures allow for the use of national drug codes or prescribed medicines to assist in identifying patients to include in the measure, (i.e., insulin to identify diabetics). Not all clinics, however, capture history of dispensed medication within the clinical record. While other data elements (such as diagnosis codes) can be used to identify the eligible population, variation in data elements captured across clinics could be problematic when identifying measure denominators.

4. *Generic Drug Prescribing.* All of the clinics capture information about prescriptions written by their providers, but most were unable to reconcile medications prescribed with those filled. For example, the clinics would not know if the pharmacy substituted a generic for brand name prescribed in accordance with Medicaid formulary requirements or if patients did not fill the prescription. Clinics with in-house pharmacies have the ability to reconcile prescribed medications with dispensed medications, but only for those medications filled in-house, and not on a real-time basis.

5. *Eligibility Span Information*. Because the measures are specific to Medicaid and CHP+ enrolled individuals, some of the clinical measures include an eligibility span (one year's eligibility with no gap greater than 45 days). However, clinics capture eligibility information at the time of visit only, and do not have access to information about the patient's entire eligibility span, except based on enrollment reports provided for CHP+ by the MCO. Additionally, historical enrollment information is not typically stored in a way that is readily linked to the patient's clinical record. In some cases historical eligibility is not captured. Therefore, clinic information would have to be matched with state eligibility information (for example, through the state provision of an eligibility file that includes retroactive enrollment) in order to identify the universe of patients to be included in requirements.

Challenges

1. *Modifications for Data Capture.* If clinics are not currently capturing the data needed for a specific measure, it can be challenging and costly to modify systems to do so. The actual costs vary widely depending on the system used by the clinic and the internal information technology capacity. Adding additional data elements to data templates can also impact clinic work flow, and require ongoing maintenance as measures or data templates are updated.

Availability of Data at Clinic Level for Extraction and Reporting

Most of the clinic pilot sites were capturing data in a manner that facilitates the generation of internal reports for quality assurance processes, i.e., the recording of procedures and of test values in EHR data fields that are readily queried. However, the ability to report specific values to external entities is much more varied. Three of the four FQHCs participating in the pilot are reporting clinical data to the Colorado Associated Community Health Information Enterprise (CACHIE), an external data warehouse and data analytics entity developed in collaboration with FQHCs, which has the capability to generate custom reports. While all FQHCs in the state could participate fully in CACHIE, the three pilot FQHCs were the only ones doing so at the time of the pilot. CACHIE was designed initially to support quality improvement processes and reported. Currently the data submitted is for a specific set of clinical measures, and does not contain all the data elements that would be required (such as eligibility for Medicaid/CHP+) for generating measures. CACHIE extracts data from clinical records through data mining, which reduces the need for clinics to all capture data in the same fields or sections of the medical record. There is not an equivalent data warehouse and analytics organization serving RHCs and it is unlikely that such an organization would be created.

Each FQHC and RHC clinic submits data to the Department and CHP+ MCO through the established billing mechanisms. Because certain fields are required for billing, and in some cases only certain fields are allowed, the data available through claims systems is limited. The pilot MCO, Colorado Access, reported that its systems would be capable of accepting and reporting on any of the data elements required for the selected variables, should that be required as a condition of their contract. The Medicaid MMIS system is less readily modified[6] and is constrained to some degree by the way that FQHC/RHC claims have historically been submitted.

The situation is different for MCO billing through Colorado Access. In this case, most FQHCs/RHCs submit information on a professional (rather than institutional) billing form, which is able to capture multiple procedure and diagnosis codes for a given clinic visit/encounter.

Gaps

1. *Limitations of MMIS and Effects on FQHC/RHC Medicaid Billing Submissions.* Because FQHCs/RHCs are paid at an encounter rate, the MMIS system had historically been programmed to reject CPT codes beyond the first code which triggers the encounter payment. Most FQHCs have now modified their systems to be able to process the denied codes. However, because the amount paid is not tied to the information submitted, there is no financial driver for including all information needed to generate measures on the claim form. While clinics are capturing data for use in internal quality improvement efforts, that same information is not necessarily captured on billing forms, such as the

[6] (Meeting with Department Medicaid Rate section staff, April 20, 2011).

super bill. Furthermore, in cases where data from the super bill or claim form must be hand entered into a separate billing system, clinics may prioritize entry of only the data essential to claims processing and thus may not include items not linked to payment.

Challenges

1. *Variations in Data Capture.* The variation in the way data elements captured, discussed above, poses challenges in how readily they can be exported. If data values are to be compiled from across clinics using billing data (also referred to as administrative data), clinics will need to report the data in a uniform manner. If needed data elements are captured in non-exportable fields, or fields that cannot be queried, then a chart audit would be needed to retrieve the necessary data. Conversely, the Department could explore a data mining approach, such as that used by CACHIE, to locate the data elements regardless of the way in which it is captured. Because CACHIE uses a data mining (vs. data reporting) framework, it would require less up-front modifications to data capture systems within individual clinics.

2. *Ensuring Consistent Data Capture.* To ensure accurate measurement of services provided, clinics must consistently capture the data elements needed for selected measures. In order to reduce reliance on chart audits to generate any clinical measures, data elements could be transmitted through billing systems. This approach would require training of both billing and provider staff, and potentially changes to the EHR templates used by clinics, including when they are billing on institutional (rather than professional) claim forms. Another possibility for FQHCs would be to use the data submitted through CACHIE on clinical indicators, and link it to eligibility information provided by the Department.

3. *MMIS Limitations.* Another challenge is ensuring that the MMIS system is able to accept all the claims level data without generating denials, including all the procedure and diagnosis codes, HCPCs, and "v" and "G" codes used in some measures. Almost all FQHCs have modified their systems to ignore the denials that are auto-generated by MMIS for codes beyond the first procedure code. However, it is not clear the degree to which RHCs have made similar changes. The changes needed to make MMIS more flexible in regard to FQHC and RHC claims may take years to implement due to competing priorities for changes to MMIS. As the Department explores the development of a new system that is capable of combining billing and quality data, it will be important that the billing requirements specific to FQHCs/RHCs are taken into account so FQHC/RHC data can be captured and analyzed at the same level as that submitted by other providers.

Availability of Data in a Central Location for Analysis and Measure Generation

Due to the use of separate delivery systems for Medicaid and CHP+ program in Colorado, there is not currently a central location in which Medicaid and CHP+ data are combined. The Department, through the MMIS system, has data for all Medicaid claims. CHP+ data from across all MCOs and the State

Managed Care Network is compiled by the CHP+ Actuary, under contract with the Department. MMIS, primarily a claims processing system, is designed to capture diagnosis and procedure codes, but not clinical outcomes or test values.

The pilot MCO, Colorado Access, was able to generate the hospital (ER Utilization and Readmissions), Outpatient, and child BMI measures for CHP+ enrollees at a clinic-specific level for the pilot. The hospital and outpatient measures were generated from claims data. The BMI measure, however, requires information regarding counseling for nutrition and physical activity that are not routinely included on claim forms, and would thus require a chart audit. Because the time and resource constraints of the pilot did not allow for a clinic-specific chart audit, the BMI measure was generated by breaking down Colorado Access' 2010 HEDIS data to the clinic-specific level. Thus, the number of eligible children for the measure was identified at the clinic level, but client level data was available only for those individuals that were selected as part of Colorado Access's random sample of chart audits conducted in 2010. Colorado Access attributed patients to specific FQHCs/RHCs based on the provider that the MCO patient was assigned to. In the future it would be necessary to either gather the BMI data elements entirely through administrative data, or to define a chart audit methodology that includes adequate sampling from all FQHCs and RHCs.

The Department was able to generate denominators (number of Medicaid members eligible for a given measure) for all of the measures except generic drug substitution and tobacco assessment. No numerators were generated. The denominators were generated at the clinic level, and based on the measure criteria, although with some deviation.[7] Because Medicaid is a FFS program and does not assign members, the Department attributed patients to specific FQHCs/RHC based on which provider the client saw for the most number of well-care visits.

The denominators (eligible population) generated for the measures varied greatly across the pilot clinics, reflecting differences in their patient volume. For example, one pilot clinic had 204 member months for the ER Admissions and Outpatient measure. Another had over 120,000, and the smallest pilot clinic (the RHC) had none. Because the clinical measures have additional inclusion criteria (such as disease diagnosis or age) their denominators were even smaller. For the participating RHC, no qualifying member months were identified for the child BMI measure. For the FQHCs, the denominator (member months) ranged from 2,846 to over 46,000. The denominators for the Diabetes measure were even smaller, ranging from 12 for the participating RHC, to 82 and 524 for two of the participating FQHCs, and 3,436 for the third FQHC. Lack of administrative information within the MMIS system regarding disease diagnosis may impact the generation of these denominators.

[7] The Department applied the 12 month eligibility criteria to all the measures, but it is called for in only a subset. Additionally, the CPT and ICD9 codes used by the Department did not match the national measure guidelines precisely.

Gaps

1. *Limited Capture of Outcome Data on Billing Forms.* The institutional claim form on which FQHCs/RHCs report bill is not rich in detail and doesn't systematically capture procedure codes or have a designated way of capturing outcomes. Several of the selected measures require reporting of codes such as "v" or "G" codes, which can be used to report test results or ranges. The Department has released guidelines for reporting of Healthy Living measures that include listing of diagnosis codes, as well as "v" codes for specific procedures as a secondary diagnosis code, and could build on the need to more regularly accept those codes while avoiding the need for chart audit to compute the measures.

   The CHP+ actuary has access to the CHP+ data (from across all MCOs), however, not all items required for measure calculation are currently submitted to Colorado Access (or, presumably, other MCOs). In order to generate clinic-level measures across MCOs using billing data, all MCOs would need to be collecting the required variables and submitting them to the actuary (or other central warehouse/analytic entity). Such a requirement would need to be explicitly stated in MCO contracts. Furthermore, the exact specifications and process would need to be clearly communicated to all CHP+ MCOs in order to ensure consistency in reporting.

2. *Limited Sampling of FQHCs/RHCs for HEDIS Measures:* The Department contracts with an external entity to produce its Medicaid and HEDIS measures each year, and each CHP+ MCO is responsible for producing HEDIS measures as well. Currently the measures are generated at a program level, and many require the use of chart audits because the necessary information is not available on submitted claims or through routine EHR data extraction. The current chart audits are conducted with a random sample selected from the entire patient population, and do not include a big enough sample to provide meaningful data at the FQHC/RHC entity level. A distinct sampling methodology and additional resources would be needed to ensure chart audits are representative. For FQHCs, another alternative would be to obtain the needed clinical information through CACHIE.

3. *Variable Attribution Methodologies*: The national quality measures do not typically include an attribution methodology, primarily because they are designed for application within a managed care environment. The Department and pilot MCO used very different attribution methodologies. The MCO assigned all patients meeting the inclusion criteria for the measure to the clinic Colorado Access had assigned them to for primary care (regardless of visit history). The Department assigned patients to the primary care provider they had seen most often during the measurement period. These distinct methodologies resulted in very different populations being included, and would have to be reconciled for any measure applied across CHP+ and Medicaid, or across MCOs within CHP+. The stakeholders agreed that finalization of an attribution methodology was outside the scope of the project and would need to be agreed upon in the future through a collaborative process, and further

noted that it should be compatible with those being developed under other Department initiatives such as the Accountable Care Collaborative.

Challenges

1. *Resource Investment Needed for Effective Aggregation and Analysis of Data*. For both the Department and the MCO, generation of these measures at the clinic-level will require additional staff time, and potentially system changes.
   - Colorado Access expressed a willingness to produce measures such as those requested, as long as there is clear guidance from the Department to clinics about the purpose and structure of the measures, and contractual clarification of the expectation. Willingness and ability of other contracted MCOs to perform these same tasks was not assessed in the pilot.
   - Department Data Section staff are capable of defining and running queries needed to generate the measures, to the extent that the required data is part of the claims data; however, additional Department staff resources would be needed to generate the measures. Given limited staff availability, such analysis would need to be prioritized with respect to other data requests. The Department would be able to generate numerators for ambulatory care, admissions and readmissions measures relatively easily, as these methodologies have been established within the Department and could be applied to the FQHC/RHC provider groups.

2. *Consistent Application of Measure Parameters.* The Department and participating MCOs each had to make assumptions when using the measure definitions to generate the denominator for the measure. Examples include the identification eligibility spans, and the look-back period used to identify patients with specific disease conditions. Thus, the provision of clear and detailed specifications for measure generation will be critical to accurate measure generation and to the perceived reliability of the data.

3. *Aggregation of Data within CHP+*. Each CHP+ MCO has its own process for obtaining claims and clinical data from its contracted FQHCs and RHCs. If the Department were to ask MCOs to report FQHC/RHC data, or to ensure that specific data elements were included in reporting to the actuary, very clear and consistent specifications would need to be provided in order to ensure accuracy of the data.

4. *Aggregation of Data Across CHP+ and Medicaid.* As discussed above, it is not clear that there is sufficient FQHC/RHC patient volume within CHP+ for the selected measures to create valid results. Combining CHP+ and Medicaid data would result in a more substantive patient base for the measures, especially those related to hospitalizations and readmissions. In doing so, however, it would be critical to ensure that the measure definitions and parameters be applied consistently in both programs.

5. *Variation in Size of Eligible Population Across Clinics.* The denominators generated by both the Department and the MCO indicate that smaller clinics may have limited populations for whom certain measures apply, and pose challenges for valid measurement.

Data Validation

Pilot clinics were asked to validate, to the extent practical, the data generated for their clinic by Colorado Access. Clinics were not asked to validate data reports generated by the Department because they included the patient universe only, and were not available within the initial pilot timeframe that the clinics agreed to.

Some of the pilot clinics have internal staff available to assist with data extraction and reporting, and have developed standardized quality improvement reports that apply to the clinical measures. Other clinics, particularly the smaller ones, tended to rely on their software vendor to assist with data extraction and/or creation of reports. In cases where the specific data element was captured by the clinic but not currently in a field that can be queried, clinics noted that they could, with advance notice, modify the templates in their systems or create fields in order to ensure capture of the data. The major exception to this is Denver Health's FQHC, which captures clinic notes as an electronic attachment in the EHR but has defined specific fields for specific clinical values and indicators that can be queried.

Two of the FQHCs and the RHC were able to validate the data provided by Colorado Access. These clinics found the reports as designed to be clear and helpful, providing most of what was needed to validate the data.[8] Clinics in the pilot were able to validate dates of service and receipt of specific types of service, provided that those happened within their walls.

Gaps

1. Inability to Validate Member Months. Two of the three clinics reported that they were not able to fully validate the member months identified by Colorado Access in their reports. Several clinics reported that this discrepancy could be due to the way their systems captured CHP+ MCO vs. State Managed Care Network patients, or their inability to do so. While member months could theoretically be validated through capitation reports, doing so is a labor intensive and challenging process, given that patients who later are retroactively enrolled in CHP+ would not have shown up on a clinic's report from Colorado Access. For the one FQHC that does not have a capitation contract with Colorado Access, validation of member months would have required several custom data requests.

[8] One additional piece of information requested was client social security number, which would be helpful in identifying clients with common last and first names.

2. *Relationship Between Members Included on the Reports and Clinic CO Access CHP+ Patients.* All three clinics noted that some measure reports included patients they did not consider to be theirs. One clinic noted that the reports seemed to be missing patients that they would have expected to see on the reports. This is due in part to the fact that Colorado Access assigns all enrollees to a specific provider, but the enrollee may not seek care, or may choose to seek care at a different provider. This was especially true for the Ambulatory Care and ER Utilization measures. The reports clearly demonstrated that a substantial portion of members go to a location other than their assigned provider, or to multiple locations (within or outside of FQHC) for care. Pilot sites were interested in seeing the degree to which members saw other providers, as this information could provide valuable insight into quality improvement strategies.

3. *Difficulty Accessing Historical Information on Eligibility*. As noted above, clinics typically collect eligibility data as it relates to specific visits. They are able to look up eligibility as of a specific date in the state systems, but not eligibility spans. Thus, they have imperfect data against which to validate any group of eligible patients. While they may have enrollment lists from CHP+ MCOs, such lists would represent a series of point in time eligibilities, and would not reflect any adjustments in eligibility (such as retroactive eligibility). In the current systems for Medicaid, clinics would be reliant, to some degree, on MCOs or the Department to provide eligibility data and could only partially validate that data.

4. *Inability to Distinguish between State Managed Care Network and MCO CHP+ Members*. Most of the participating clinics did not differentiate between CHP+ eligibility types (e.g. state managed care plan or MCO), especially for patients enrolled in Colorado Access. While some of their systems had the capacity to do so, they were not set up in that way currently. Thus, some clinics had difficulty validating the member months included on the Colorado Access reports.

5. *Lack of Information to Validate ER Utilization and Readmission Data*. Participating clinics have been putting in place systems to strengthen the data they receive from Hospitals regarding inpatient or ER visits for their patients. However, most of these systems work on a one-on-one basis (e.g. clinics can request data for individual patients once they are aware they have had a hospital visit or if the hospital refers a patient to the clinic for follow-up care). Thus, they are not routinely informed of their patient's hospital visits, and it is challenging for clinics to validate hospital data.

6. *Patient Attribution is Distinct from Concept of Active Patient*. As noted above, the assignment of patients to providers by Colorado Access does not mean that patients will seek care at the assigned provider. Thus, clinics identified patients included in the measure with which they had not had contact. Clinics were not able to identify whether there are Colorado Access CHP+ patients they do see who were not included in the report, in part because of the challenges with differentiating between CHP+ product lines, as discussed above.

Challenges

1. The small size of the CHP+ program relative to Medicaid, both at the state level and at the clinic level, poses a challenge for measure generation. As identified in pilot, the actual number of CHP+ patients who qualify for inclusion in a measure denominator may be very small, especially for smaller or rural clinics and those which do not have a large pediatric population.

2. Aggregation of Medicaid and CHP+ data for measure generation could be a way to address the small numbers in CHP+. In order to do so, a system would need to be developed that would be capable of aggregating the Medicaid data available through MMIS and the CHP+ data that is currently reported to the actuary.
    - The lack of administrative data to calculate HEDIS measures has, in the past, necessitated the use of chart audits to supplement the administrative data. However, the national measure specifications provide mechanisms for using billing codes to report the needed variables. Reliance on administrative data would require that providers submit codes they are not submitting now (including "v" and "G" codes, depending on the measure), and that the measures be generated at a clinic-specific (rather than program) level. Challenges capturing full data for clinical measures, especially the BMI measure.
        - The BMI denominator (e.g. patients identified for the measure) was very low to some clinics compared to the population they expected to have enrolled in CHP+ through Colorado Access, and the reason for this requires further investigation.
        - Because the HEDIS data used by Colorado Access was data from the 2010 audit, which is based on random selection of CHP+ members regardless of assigned provider, representation of FQHC/RHC clinics in the audited files was very low. Should the HEDIS audit process be used to support data collection on clinical measures, a different sampling methodology would be required
    - Many members did not have administrative data related to compliance, but during the validation process (which included closer examination of the chart), were found to be in compliance with the measure.

Other Findings

Through the course of the data collection pilot it was determined that the Generic Drug Substitution measure is not a viable measure to collect, nor is it viable for use demonstrating or achieving cost savings. This is due to the following:

- For FQHCs and RHCs accessing the 340B drug program, it is often possible to secure name brand drugs at a lower cost than the generic equivalent. Thus, prescription of generic drugs would not correlate with lower costs.
- 340-B covered entities may negotiate additional discounts, or sub-ceiling prices, that are lower than the maximum allowable statutory price. In particular, covered entities are encouraged to join a prime vendor program run by Apexus Inc., which negotiates deep discounts off the 340B

Ceiling Price for outpatient drug purchases on behalf of participating entities. Therefore, the negotiation methods by which 340B wholesale prices are determined, the actual sub-ceiling discounts realized at the pharmacy, and the timing by which prices fluctuate are not readily apparent.

- Within the Medicaid program, it is not possible to match drug claims to the prescribing provider entity because claims are submitted under the providers license ID, and it is not feasible to match all licensed providers with the provider under which they prescribed.
- Because drugs may be dispensed on a different day than they are prescribed it is not feasible to tie specific drugs to a particular provider entity or visit type, making it challenging to attribute the cost of the drug to an FQHC/RHC.

Feedback on Pilot Processes

JSI and the Department conducted a debriefing of the pilot with participants and other interested stakeholders for evaluative purposes. JSI solicited feedback through an online survey created in SurveyMonkey that was sent to participants in an email after final pilot check-in meeting. A total of eight responses were collected, four of which were from staff members at a participating FQHC, RHC, or MCO. Of the remaining responses, three were submitted from HCPF staff members, and one was submitted from an interested stakeholder that was not participating in the pilot.

Overall, all of the respondents felt that the pilot was designed in a way that responded to stakeholder input; that the focus of the pilot was appropriate for the current stage of development of a payment methodology; that the pilot included appropriate mechanisms for input from pilot sites and other stakeholders; that the monthly pilot meetings were helpful and informative; and that the pilot has successfully identified gaps and challenges that will be helpful to the Department as it considers future value-based payment strategies. In addition, the majority of respondents felt the structure and timeline for the pilot were appropriate for the stated goals; measures selected for the pilot were appropriate for the pilot goals; the tools employed in the pilot elicited valuable information; and that overall, the pilot was helpful in understanding possible implications/requirements related to future value-based payment strategies.

Written feedback from the online survey revealed that two respondents felt the timeline for the pilot was too short to meet the stated goals, particularly those related to generating test-run data reports of the proposed measures. These respondents requested clearer communications from JSI and the Department regarding expectations of participants, timeframes, and the overall project plan. Another survey respondent recommended collecting more of the information from pilot participants in interview format, rather than in written responses, in order to minimize the workload of the pilot participants.

On the other hand, one respondent stated in written feedback that the identification of data flow, reporting and payment issues, and sharing of information with the Department were particularly effective parts of

the pilot. Another respondent commended the Department for their efforts to encourage stakeholder involvement and incorporate their feedback in the decision-making process.

CONSIDERATIONS FOR DEVELOPING AND IMPLEMENTING A VALUE-BASED PAYMENT METHODOLOGY

This section of the report discusses considerations for the structure and implementation of a future value-based payment methodology for FQHCs and RHCs relative to their Medicaid and CHP+ patients. These considerations are based upon 1) research on the current best and emerging practices for developing and implementation value-based payment methodologies relative to all payers and populations, 2) the findings from stakeholder meetings and the data collection pilot, and 3) the stated goals and future direction of the Department, including the potential relationship between an FQHC/RHC-specific strategy and other value-based initiatives being implemented by the Department.

The Department has embraced the Triple Aim,[9] as reflected in The Department's mission, which is "to improve access to cost-effective, quality health care services for Coloradans." Implementation of value-based payment methodology is consistent with this vision and with three of the five goals in the Department's five-year (2011-2016) strategic plan: [10]

- Improving health outcomes,
- Increasing access to health care, and
- Containing health care costs.

The Department's strategic plan calls for provider payments to be increasingly linked to outcomes. The target percentage of provider payments linked to outcomes in FY2010-11 is .75 percent, while the target by FY2014-15 is 5 percent.

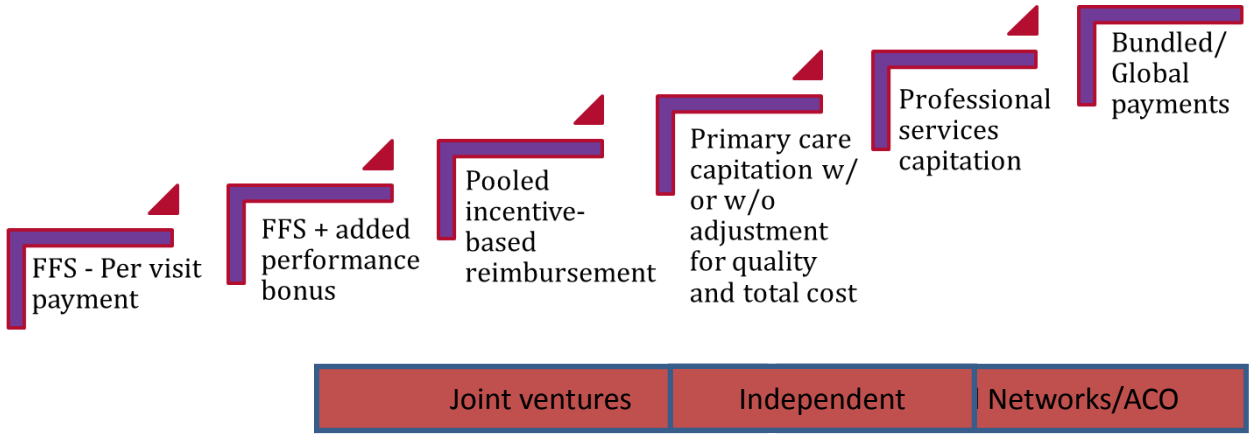
A discussion of current value-based purchasing practice in state Medicaid Departments was presented in depth in the *Review and Research Report* submitted by JSI on February 14th, 2011, and is summarized briefly in the next section. General considerations for payment methodology design were addressed in the *Options and Gaps Report* submitted by JSI on February 22nd, 2011. Following the summary of payment methodology alternatives and trends, this section highlights considerations for designing an FQHC/RHC value-based payment methodology in light of the Department's mission and goals, findings of the data collection pilot, and the background research conducted throughout this project.

[9] Institute for Healthcare Improvement. (2010). *The Triple Aim*. Available online at http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

[10] Department of Health Care Policy and Financing. Department of Health Care Policy and Financing Five-Year Strategic Plan – Goals and Performance Measures. Accessed online on 1/18/2012, at www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251758363127&ssbinary=true

Payment Methodology Alternatives and Trends

The graphic below depicts a continuum of payment models ranging from fee-for-service (FFS), where individual services are reimbursed on a per-unit volume basis, to global payment, where one single payment is made to a health system on behalf of a beneficiary. These models are described in more detail in Appendix I. Each step in the continuum involves increasing emphasis on payment for value compared to payment for volume. As one moves up each stair step of the continuum, providers move from bearing no risk in F arrangements to only upside risk with incentive models, and to increasing amounts of upside and downside risk in the capitation models. While the current FQHC/RHC PPS methodology is actually a bundled payment for a host of clinical and enabling services, we consider PPS to be in the FFS step of the continuum because FQHCs/RHCs are paid on per-face-to-face visit with a provider.



Payment System Components
The traditional payment model for Medicaid is FSS, which does not include a value-based component, but is volume driven: payment is made for services rendered. The major payment alternatives to the FFS system are incentive-based payment systems, capitation, and global payment. These payment models can either be combined with or layered on top of fee-for-service payment models, or can replace FFS models altogether. Each payment methodology consists of a set of design elements, described briefly below. These design elements do not function independently, but must be consistent with each other in order for the methodology to be successful. These are briefly described below.

- *Scope***.** The programs and clients that will be covered by the payment methodology. The Department's stated objective is to implement a payment model that will apply to FQHC and RHC patients in Medicaid and CHP+.

- *Incentive Structure***.** The incentive design describes under what conditions and how the payment will be made. Common incentive designs include:

  - Lump sum payments made from the available dollars on a quarterly or annual basis, based on attainment of indicator targets (either a fixed amount or a per-member amount),
  - Per-member-per-month payments made once a FQHC/RHC has attained a certain benchmark or certification, and
  - Incentive dollars distributed based on attainment of indicator targets. One example would be an increase in the encounter rate for medical home certification or achievement of benchmarks related to certification.

- *Indicators***.** These are the measures upon which payments will be based. A variety of indicators can be used, including quality indicators (either outcome measures, i.e., reduction in HBA1C levels among diabetics, or measures of evidence based clinical care, i.e., administration of HBA1C tests); cost indicators; and value indicators such as access and patient satisfaction. Many initiatives use the Triple Aim framework to ensure indicators reflect quality, cost, and patient experience.
- *Financing***.** These are the dollars that will be used to make the incentive payments. Major options for financing include:
  - State dollars designated for this purpose,
  - The difference (or some portion of the difference) between the BIPA PPS minimum and the APM for each FQHC/RHC using state funds already dedicated to APM (currently applicable to Medicaid only, as CHP+ reimbursement for FQHCs/RHCs is at the federal minimum),
  - Savings resulting to the health care system from the provision of more comprehensive care,
  - Savings resulting from internal efficiencies achieved by primary care providers within their scope of practice through service delivery design, or from use of lower-cost effective care mechanisms, such as group visits or Telehealth, and
  - Federal grant dollars such as increased federal match for Chronic Care Medical Home implementation, or other funds made available through the Affordable Care Act implementation. For example, Section 2703 of the Affordable Care Act offers an opportunity for Colorado to address the growing burden of chronic illness by receiving a 90/10 federal match for eight calendar quarters, under a state plan amendment (SPA), for the provision of health home services to individuals with chronic conditions.

CONSIDERATIONS FOR PAYMENT METHODOLOGY DESIGN

As described above, a wide range of payment methodologies exist, and new payment models continue to evolve. A recent analysis by the California HealthCare Foundation indicates that that the transition to future payment models will involve ongoing evolution, rather than one-time radical transformations.[11] This observation is consistent with the findings of the data collection pilot, and informs the considerations presented below for the development of an FQHC/RHCs payment methodology

Payment Methodology

Theoretically, the entire range of payment methodologies outlined above (from FFS to global payment) is available to the Department to use with FQHCs/RHCs. However, federal requirements for FQHC/RHC payment and the current state fiscal situation have implications for the selection of an appropriate methodology.

Considerations

- Federal law requires that FQHCs and RHCs be paid at least the equivalent of the BIPA minimum rate established under the perspective payment system (PPS). Currently, the Department uses an alternative payment methodology (APM) based on actual costs to establish, compares the APM rate to the BIPA rate, and pays the midpoint between the APM and the BIPA minimum, or the BIPA minimum (whichever is higher). The federal PPS requirements essentially establish a base payment that cannot be put at risk without a state plan amendment waiver. Thus, the Department should consider an approach that will ensure compliance with federal requirements but also provide additional incentives for value.

- The ability to employ global payment methods for an FQHC/RHC methodology is limited by the fact that FQHCs/RHCs represent only one part of the full spectrum of care, whereas global payment models rely on an integrated system.

- In designing a payment methodology, it is important to consider the degree to which transformation of the delivery system is a goal of the reform efforts. It will take additional investment in primary care and patient-centered medical homes in order to realize overall health system savings because PCMH services include additional services beyond the enabling services that health centers provide today. In particular, investments will need to center on developing the workforce for medical homes, improving coordination of care transitions, and better integrating behavioral health and primary care. In order to encourage delivery system transformation, payment reform must also give FQHCs and RHCs the flexibility to invest their payments to support efficient, high value care. The Department should

[11] Health Care Payment in Transition: A California Perspective. California HealthCare Foundation. January 2012.

consider ways to incentivize FQHC/RHC implementation of medical homes, such as through participation in the existing Medical Home Initiative by accepting national medical home recognition as a proxy for Colorado's recognition criteria.

- Given the above considerations, and the fact that the Department's goals are not only to reduce cost, but to also improve access, outcomes and the patient's experience of care, an approach that combines multiple payment methodologies may be the most effective. In such an approach PPS would be the base payment, and additional payments would be made to support specific medical services demonstrated to increase value (such as medical homes) and to reward performance on high-value measures (such as reducing emergency room utilization). Such an approach would be consistent with the Colorado's Accountable Care Collaborative, which has provided a PMPM for infrastructure development, and will transition to a shared savings approach over time.

- Providers and Patients must be acting in concert with one another to realize the promise of medical homes or accountable care organizations. In fact, for both medical home and payment reform to optimally succeed in meeting the Triple Aim, patients must be tightly bound to a provider as their medical home. This is a challenge for Colorado given the fact that Medicaid operates within a FFS system, and CHP+ MCOs do not require patients to see their assigned provider. This was evidenced in the ambulatory care measure produced by Colorado Access for the Pilot. Each participating clinic found that a number of their assigned patients had sought care with other primary care providers. In fact, in validating the data, clinics reported that they did not have a patient relationship with at least some of the "assigned" patients who were included on Ambulatory Care, Hospital Readmission and Emergency Room Utilization reports. The methodology used by the Department for the pilot was based on the 12 months of the measurement period and 3 months before and after the most frequent provider of well care for the patient, and attributed the patient to that provider. While this methodology provided a tighter linkage, it did not include any patients who were not seen for well care, thus limiting the scope to patients with an established primary care relationship.

- A payment model should be clearly defined in its relationship to other Colorado initiatives and its ability to leverage them. For example, FQHCs/RHCs are participating in RCCOs, which in itself is a broader integrated system moving toward global payment. The ACC model clearly requires that a medical home be provided within the RCCO, and that providers be able to function as a medical home. A FQHC/RHC-specific payment methodology could further support medical home capacity building. By fostering the development of medical homes, the state is promoting broad system transformation, not just specific clinical improvements.

Scope

Value based payment methodologies are most successful when they impact a large percentage of a practice's patient mix. This is true both because the costs of any systems the practice must put into place

are spread across a broader number of patients, and also because there is a greater incentive at stake. The data collection pilot confirmed that the CHP+ patient base makes up a small portion of FQHC/RHC patients. For FQHCs in particular, Medicaid patients greatly outnumber CHP+ patients. Similarly, CHP+ patients make up a very small portion of most RHC practices. In fact, it was difficult to identify RHC practices with substantial enough CHP+ membership to engage in the data collection pilot.

The data collection pilot results indicated that the volume within the CHP+ is too low to support measure generation for hospital indicators at the FQHC/RHC entity level. For two of the measures, ER Utilization and readmissions, the number of occurrences was too low to support generation of the measure value. However, all four of the pilot participants for whom measures were generated exist in CHP+ choice counties (counties where more than one MCO provides CHP+), or had multiple sites, some of which were in counties not served by Colorado Access. As a result, the Colorado Access reports may provide data on only a subset of the clinic's total CHP+ patient population. Furthermore, at least one pilot site indicated that the provided reports were missing patients they felt should be included. Thus, it is possible that combining data from all CHP+ MCOs, or further refining the report parameters, would result in more occurrences, and thus allow for generation of the measure.

Considerations

For small, single-site FQHCs and for RHCs, a payment methodology with scope limited to CHP+ would likely not be effective. The CHP+ population is too small when broken out by clinic, especially for smaller FQHCs or RHCs.

- Stakeholders noted that clinics manage population health for all of their patients, without consideration of their payer status. A value-based payment strategy that is applied across Medicaid and CHP+ would reaffirm this approach, and be consistent with the Department's movement toward impacting population health.
    - Inclusion of both CHP+ and Medicaid in a methodology could be implemented in two ways: by implementing the measures and payment incentives separately in both programs, or by aggregating data from both programs to produce one consolidated measure, and applying incentives to the aggregated data.
    - Aggregating the data would require first aggregating the indicator numerators and denominators for each CHP+ MCO, and then aggregating the data with Medicaid data. This would be greatly facilitated through a shared data warehouse, for example, by incorporating of CHP+ data in existing data warehouse and analytic solutions such as the ACC State Data Analytics Contractor (SDAC) or, in the future, the all-payer database being developed by Colorado's Center for Improving Value in Health Care.

- It is important to distinguish between the CHP+ State Managed Care Network and CHP+ delivered through MCOs. The State Managed Care Network includes CHP+ eligible individuals

in the pre-enrollment period, and pregnant women and enrollees in counties without an MCO option. Through the data collection pilot Colorado Access generated reports on selected indicators for MCO patients served through the pilot FQHCs/RHCs, and not on patients served through the State Managed Care Network. However, the State Managed Care Network provides important access to care in rural areas, and should be considered for inclusion in any future value-based payment methodology.

- Increasingly, national delivery system redesign efforts are focusing on a subset of the total population, such as those with multiple chronic conditions or other identifiable cost drivers, rather than the whole population. Any future methodology developed in Colorado should be consistent with the ACC focus on supporting care for complex patients.

Incentive Structure

The key consideration for selection of incentives is the desired outcome of the methodology. If the desired outcome is to transform the care delivery model, a lump sum payment, or a per member per month payment for attainment of the desired characteristics provide the predictability necessary to support system changes. If the desired outcome is clinical performance, a supplemental retrospective payment based on attainment of benchmarks and/or improvement is the most common structure. The incentive could be based on either progress against a baseline or the achievement of pre-established benchmarks on process, quality and/or value indicators. Given the diversity of FQHCs and RHCs in Colorado, it may make most sense to use a phased implementation model that allows clinics to participate in additional incentive components over time.

Considerations

- Payment incentives will need to be substantial to support any required practice changes or administrative requirements. For clinics with limited infrastructure, some up-front investment may be needed prior to earned incentives. A lump-sum incentive paid upfront has the benefit of providing necessary funds to finance delivery system transformation. The advantage of these payments is they are negotiated once, and there is no ongoing need for data analysis.
- Another consideration is whether each FQHC/RHC will be compensated proportionally to its stake in the process, or whether all incentive dollars available will be pooled and distributed based on some other criteria (i.e., percent of total patients). This is an important consideration if the Department considers financing any incentives with the difference between the BIPA PPS minimum and the APM (or some portion of it), because this differential varies significantly across FQHCs and RHCs. Pooling allows for the practices with the highest quality to be more highly rewarded, and additionally allows equal opportunities for providers to earn comparable incentives for meeting a given target. However, pooling also could have significant negative implications for those providers with the greatest difference between the BIPA PPS minimum and their APM, should they not be able to achieve the targets required to earn the incentives.

- The Department should use the most straightforward incentive structure possible to achieve the stated goals in order to increase transparency and reduce any administrative burden for the Department, MCOs and providers. For example, risk might be adjusted based on removing the outliers in a patient population from the data, rather than risk-adjusting the whole population based on demographics, diagnosis or claim history. Similarly, the Department should avoid complex weighted indices that combine multiple measures. Rather than including ambulatory care access or even some of the quality indicators in the index used for incentive distribution, they could be 1) monitored against a threshold to ensure that efforts to reduce costs are not impacting patient access and care, or 2) used as a pre-qualifier for eligibility to receive an incentive based on achievement of reduced cost.

- It may be helpful to consider how incentives can be layered to accomplish the Department's objectives. The existing PPS serves as a base payment that could be combined with lump-sum payments for implementation of desired service delivery models (such as medical home) and retrospective incentives for achieving benchmarks on quality indicators.

Measurement Areas and Indicators

The measures selected for the pilot were consistent with Department priorities for adults and children, although only one (BMI for children) was specific to children. These measures were also consistent with those being used by other states. The Department was able to generate a clinic-specific denominator for all of the measures except hospital readmissions, generic drug utilization, and tobacco within the time frame for the pilot. The Department already generates a readmission measure for Medicaid that could in the future be applied to FQHCs/RHCs. The Department could also generate a Generic Drug Substitution measure, but for reasons discussed above such a measure does not make sense for FQHCs given the limitations in data regarding filled prescriptions, and the impact of the 340B drug program discussed above. Colorado was Access was able to develop clinic-specific measures for the hospital, ambulatory care and childhood BMI measures. The pilot brought to light several considerations for the selection of measures for use value-based purchasing.

Considerations

- The data collection pilot focused primarily on indicators applicable to adult populations. Only four of the nine indicators were applicable to child populations (ER Utilization, Hospital Readmissions, Generic Drug Substitution, Ambulatory Care Visits, and BMI), and only the BMI measure was specific to children. Pilot measure results indicated that the volume of ER use and readmissions within CHP+ is not significant, at least among Colorado Access MCO members. If the Department wishes to focus on child health in the future, it will be important to further explore whether ER use and hospital admissions among children are significant cost drivers in Medicaid, or identify other cost drivers for care provided to children.

- Within individual FQHCs/RHCs, especially rural or smaller clinics, actual volume of patients with targeted conditions may be low, making it difficult to generate reliable measures. The Department may want to consider the importance of measuring and incentivizing quality within a subset of providers (FQHCs/RHCs) relative to the importance of measuring and incentivizing it across providers.

- None of the measures selected for the pilot directly addresses patient experience, although ambulatory care utilization can be used to monitor patient access, which is related to, but is not a direct measure of patient experience. Given the Department's commitment to the Triple Aim, it may be appropriate to explore more robust patient experience measures as a component of payment and service delivery reform.

- The data collection pilot included nine indicators, and at least one indicator for three of the four quality/value areas identified by the Department (health outcomes, patient access, patient satisfaction, and cost containment), the exception being patient satisfaction. However, it is important to indicate that the employment of too many indicators can result in a lack of focus. Similarly, some indicators may be very complex to measure, and the real/opportunity cost of incorporating multiple measures may end up acting as a disincentive to provider participation. Selected measures should support the payment methodology. For example, if the Department wished to use a shared savings model it would want to focus on the one or two highest impact cost (or value) measures, and just enough quality and access measures to monitor quality and access.

- Use of nationally recognized measures requires flexibility over time because the measures are regularly updated or modified. The pilot revealed that it can be challenging to match the national measure definitions exactly. For example, the Department used a single ICD-9 code to identify hypertensive individuals for the blood pressure management measure that did not result in the identification of any individuals for inclusion in the measure, while the national measure includes additional ICD-9 codes that can be used to identify hypertensive individuals. To the extent that a future payment methodology requires each MCO to produce denominators and numerators for the measure, or requires combining numerators and denominators derived from different data sets, it will be critical that detailed technical specifications are provided to all entities involved in entering or processing data.

- Providers should also be made aware of the specifications being used so that they can ensure that the appropriate data elements are being included. Should the measures deviate from those developed nationally, there should be conversations with stakeholders about the conflict, and a clear rationale agreed upon for any modification.

- As indicators are chosen for FQHC/RHC providers, they should be consistent with and/or build on those used by other Department initiatives, such as the ACC and those described in the Healthy Living Performance Measure Tool Kits. For example, the Tool Kit for Nutrition and Fitness is consistent with the national measures used in the data collection pilot, but stops short of asking providers to submit the codes related to the follow-up (counseling) components of the measure. This was a deliberate choice for the Tool Kit, since the Medicaid program is not able to reimburse discretely for the counseling. Nonetheless, reporting of the codes by FQHCs/RHCs within the context of a value-based payment methodology might be appropriate, as it could allow for compliance of all measure components to be assessed through administrative data rather than via chart audits.

- Nationally defined measures may need to be refined for the Colorado environment. Many national measures are designed for a managed care environment, and may require modification when applying to the Medicaid FFS population. For example, the Hypertension, Diabetes and child BMI measures require that only those individuals with enrollment gaps of 45 days or less in the applicable 12 month period be included in the denominator. For the data collection pilot eligibility for Medicaid was used to determine enrollment, but enrollment in an MCO implies a link to a provider that is equivalent to eligibility for a program. The allocation method developed by the Department linked patients to the clinic where they received the most primary care. This is a reasonable approach for Medicaid, but results in a different population being included in the measure than is true for CHP+, where all patients assigned were included in the denominator, regardless of whether they accessed the assigned provider or not.

- As noted above, the Colorado Access reports identified a very low volume of emergency room visits and readmissions relative to the identified member months. Before moving forward with a payment methodology based on these measures of cost (and potential cost saving) the Department should generate these measures for FQHCs/RHCs as they relate to Medicaid patients, and consider whether they are the most appropriate cost areas to target. Increasingly, value based payment methodologies are focusing on assessment of total cost rather than costs related to discrete indicators, as evidenced in the recent Centers for Medicaid and Medicare Services Health Care Innovation Challenge grant opportunity.

Financing

Given the absence of new state dollars to support value-based incentives at this time, the Department must consider other financing mechanisms. One alternative is to document and share savings to the Medicaid/CHP+ programs resulting from internal efficiencies achieved by providers, or from savings in the overall cost of care resulting from effective provision of primary care. Another is the use of public or private grant programs focused on delivery system innovation.

Considerations

- A clinic's own internal savings could be used to support effective and increased care. The current APM methodology in Colorado results in clinic encounter rates being modified on an annual basis to reflect actual costs. Thus, if a clinic achieves internal efficiencies, the net result is a decrease in funding, rather than additional revenue that could be used at the clinic level to provide cost-effective services (such as Telehealth or group visits). The Department should consider supporting a financing mechanism that allows clinics to retain all or some of their internal efficiency savings, as long as quality and access benchmarks are met.

- Similarly, the Department could use savings resulting to the health care system from the provision of better more comprehensive care to fund incentives. This is the basis under which the ambulatory care visit payments are made under the Colorado Medical Home Initiative (MHI), and for funding the per-member-per-month (PMPM) in the Accountable Care Collaborative (ACC). While the same rationale can be applied for PPS Plus, it is important to note that many of the same providers are or will be involved in the ACC. It is important to understand whether the full savings are already being allocated to support ACC or whether the savings are available to support PPS Plus.
- The models that include financing from shared system savings or efficiencies provide an opportunity to expand the available dollars. However, the amount of additional funding available depends on the specific indicators agreed upon and the degree to which savings or efficiencies are realized. Thus, an internal analysis of the potential savings would be an important step in securing clinic interest and participation.

- With the implementation of a phased approach as described in the methodology section above, the Department may be able to work with FQHCs and RHCs to develop an APM that includes putting some of the current Medicaid APM (that portion above the BIPA minimum payment) at risk for value-based indicators. In doing so, it would be important to consider and adjust for (through a pooled or weighted incentive methodology) the fact that the difference between the BIPA minimum and the APM varies widely across clinics, and is irrelevant for some RHCs or clinics already at BIPA minimum. Because an APM must be agreed upon by the impacted clinics, stakeholder involvement would be critical to such an approach. Because the APM must be agreed to by each FQHC/RHC entity, there is also an opportunity to implement a new APM with the clinics that are ready to embrace a new payment strategy, without including those clinics that are not.

- It is important to note that where a portion of existing funds is used to create the incentive (as in a pooling of the difference between the BIPA PPS minimum and APM amounts), both winners and losers could be created. This effect could be reduced by drawing from only a portion of the difference between the BIPA PPS minimum and APM for the incentive pool, up to a specified dollar limit.

- The Department should continue to monitor funding opportunities made possible through the Affordable Care Act. Section 2703 of the Affordable Care Act describes the opportunity for states to submit a state plan amendment (SPA) for provision of health home services for Medicaid and dual eligible enrollees who have two chronic conditions: one chronic condition and are at risk of having a second chronic condition, or one serious and persistent mental health condition. Once the Center for Medicare and Medicaid Services (CMS) approves a SPA, the federal medical assistance percentage (FMAP) is 90% for the first eight calendar quarters that designated health home providers deliver health home services. While three SPAs have been approved as of December 2011 for small sub-populations in Rhode Island and the severely mentally ill population in Missouri, the State of Missouri will soon be the first state to have a SPA approved for a general population with chronic conditions. The SPA also allows for the type of health home providers to be specified, so that a SPA could be designed to focus on care provided by FQHCs and RHCs. A SPA application could support capitated payments for health home services that are to be tracked as separate lines of business from the care delivery resources included on the FQHC/RHC cost reports.

Additional Considerations

- Stakeholders repeatedly stated their appreciation that the Department took the time to understand the systems gaps and limitations of current systems before moving forward with implementation of a value-based methodology. Continued stakeholder involvement as the Department moves forward will be helpful in ensuring that the methodology is appropriate and meaningful.

- Implementation of any new methodology will require additional resources with the Department and, potentially of stakeholders. For example, the Data Section staff will be needed to assist with generating estimates of cost savings or quality indicator reports, and with updating the parameters on a regular basis. Should the Department choose to use a measure that includes chart audits, the existing HEDIS contract will need to include resources to generate measures at the FQHC/RHC entity-level. Similarly, any additional requirements placed on MCOs would need to be reflected in MCO contracts and, potentially, rates.

CONCLUSION

The implementation of a value-based purchasing methodology with Colorado FQHCs/RHCs has the potential for furthering the Department's strategic goals and achievement of the Triple Aim, and is consistent with payment reform efforts by the Centers for Medicare and Medicaid Services and other public and private payer payment efforts. While federal requirements limit the degree to which FQHC/RHC PPS payments can be put at risk, there are opportunities to combine PPS payments with other payment methodologies that support value-based care. The pilot findings indicate that it would be difficult to implement one single methodology universally across all FQHCs and RHCs for both CHP+ and Medicaid services, given the variation in clinic size and number of enrollees, as well as the separate delivery systems for the two programs. The data collection pilot clarified specific gaps, challenges, and considerations that will be critical to the development and implementation of an effective value-based payment methodology. These gaps and challenges can be overcome but will require resources at the state, MCO and clinic levels.

APPENDICES

APPENDIX A: PILOT AGREEMENT

PPS+ Data Collection Pilot for Value-Based Purchasing in CHP+ and Medicaid

Purpose

The pilot will serve to identify and provide recommendations to the Department regarding the use of cost and quality measures for a potential value-based payment methodology in the future, including data collection considerations, gaps and challenges, and considerations related to the methodology design. In addition, the pilot will help to inform financial implications of a value-based payment methodology, such as defining cost savings pools and equitable sharing methods.

Proposed Measures

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Outpatient visits
- Generic Drug Substitution
- Diabetes: Hemoglobin A1c Testing
- Diabetes: Blood Pressure Management
- Controlling High Blood Pressure (Hypertension)
- Body Mass Index (BMI) Screening and Follow-Up
- Tobacco Use Assessment and Cessation Intervention

Pilot Participation

The Department wishes to engage at least one MCO, 3 FQHCs and 2 RHCs in the data collection pilot. Eligible participants include:

- MCOs that participate in CHP+, and have both FQHCs and RHCs in their network of providers.
- FQHCs and RHCs that provide services for both Medicaid and CHP+ and that are contracted with at least one MCO participating in the pilot.
- The Department encourages a diverse representation of clinics from different geographical and technological capacities, and would prefer FQHCs from both rural and urban areas of Colorado.

Participation Expectations

Meetings and Communication:

- Establish a designated point person to represent the participating entity in pilot activities.
- Participate, in person or by phone, in meetings of pilot participants and bi-weekly check-ins with JSI.
    - Group meetings of all Pilot participants will be held monthly in June, July, August and September. These meetings will focus on identifying shared data collection and reporting gaps and barriers, and, where possible, strategies to resolve them.
    - Check-in meetings with JSI. These will be informal meetings on a regular basis (most likely every other week), to obtain feedback on pilot activities and progress, and identify any challenges that need to be addressed.
- Participate in a de-brief meeting in September to provide feedback on the pilot process.

Data Collection:

    - With the Department, participate in a process to finalize the parameters to be used for the selected measures, including related attribution methodologies. A maximum of 8 measures will be used.
    - With JSI's assistance, map the way in which data elements for the selected indicators will be collected within the participant's system and document challenges/barriers to the same.
    - To the extent possible, extract from participant's systems reports on data indicators related to the selected measures.
- For MCOs: create data reports, to the extent possible and feasible, on the data elements to be used for the measures. These reports will be specific to the measure parameters agreed upon with the Department, and should identify the data elements for 1) individual FQHCs/RHCs in the pilot 2) all FQHCs/RHCs in the provider's network as a group and 3) a comparison group
        - If it is not feasible to establish reports, identify the system changes that would be needed in order to develop reports.
    - For FQHCs/RHCs:
        - Provide feedback on data reports and reporting processes developed by the Department and participating MCOs.
        - Where appropriate/feasible, develop reports on data elements requiring manual or automated chart extraction (or not otherwise available through claims data).
    - Based on the available data, assist the Department in identifying possible benchmarks for the selected measures.

Pilot Support

- The Department's contractor, JSI, will check in with pilot participants individually at least every other week to identify and address any challenges to participation and completion of requested activities.
- JSI will provide tools and/or templates to facilitate the tasks requested of participants, including identification of common themes/challenges for exploration in meetings of pilot participants.

Implementation Plan

- June: Finalize measures and measure development, select pilot participants, kick off pilot.
- Mid June- July: Work with pilot participants to determine what reports will look like, develop reports in the system. Work with Department to develop internal reports on Medicaid system.
- August: Run reports, debrief on findings, and obtain participant feedback on the reports.
- September: same as August, and debrief/evaluation meeting.

APPENDIX B: PILOT PARTICIPANTS

The MCO participant in the pilot was Colorado Access MCO.

Colorado Access is Colorado's largest CHP+ MCO, serving over 27,000 enrolled children in 34 counties up and down the Front Range and in the Eastern Plains. In addition to their own line of business, Colorado Access provides claim payment services, provider contract administration, and utilization management for the State Managed Care Network and CHP+ Prenatal Care Program.

The FQHCs participants in the pilot were Mountain Family Health Center, Denver Health Community Health Services, and Metro Community Provider Network.

Denver Health Community Health Services is one of the largest community health center networks in the country and includes eight community health centers, two hospital-based urgent care centers, and 13 school-based health centers located in low-income urban neighborhoods throughout the City and County of Denver. Denver Health Community Health Centers provides primary care services (medical, dental and mental health) to approximately 1 out of 5 Denver residents and 35 percent of Denver's children.

Metro Community Provider Network's service areas encompass Jefferson, Arapahoe, Adams and Park Counties and the City of Lakewood and Aurora. Patient volume in 2010 consisted of approximately 37,800 patients, with 69% of these patients at or below poverty level. Services provided include medical, dental, and mental health, as well as limited pharmacy and lab support.

Mountain Family Health Center is located in Colorado's High Country, and operates four locations in Glenwood Springs, Rifle, Black Hawk, and Basalt, Colorado. Mountain Family Health Center provides primary care, laboratory, dental, and mental health services to over 8,000 people in its service region.

The RHC participant was Rocky Ford Family Health Center. While the Department's goal was to engage at least two RHCs in the data collection pilot, the data collection pilot ultimately consisted of only one RHC participant due to time and resource constraints among interested RHCs.

The RHCs participating in the full breadth of pilot activities described above was Rocky Ford Family Health Center, a provider that offers primary care services in the rural town of Rocky Ford, located in Otero County, Colorado.

The Department and JSI recruited two additional RHCS, Yuma Rural Health Clinic and Montrose Pediatrics for partial participating in the pilot. Both clinics completed the RHC questionnaire tool in Appendix C, to provide information on how data is captured clinics' practice management system, billing, and electronic health records systems.

Yuma Clinic provides primary care services for Yuma, Colorado, approximately 140 miles east of Denver. Yuma Clinic also has access to laboratory, radiology, and limited pharmacy services through their affiliate hospital. Montrose Pediatrics provides pediatric care for Montrose, Colorado.

APPENDIX C: PILOT TOOLS - QUESTIONNAIRES

APPENDIX C1: Data Collection Pilot Questionnaire for FQHC/RHC

General Information:

1. Organization Name:

2. Site(s) Name:

3. Interview Participants (include name and position/responsibility; recommended participants include fiscal managers, billing managers, clinical leadership, and IT managers):

4. Interview date(s):

5. Provide a list of services provided on site. Probe: primary care, specialty care services (identify), laboratory, radiology, pharmacy, other.
    a. For those with onsite pharmacy - is the pharmacy operated by the health center or by an outside vendor?
    b. How are pharmaceutical charges handled? Do you submit claims for pharmacy?
    c. Do you operate a 340B pharmacy? Do you operate it directly or via contract? Is it on site or off site? Do Medicaid and CHP+ patients have access to 340B priced drugs, or are the 340B for uninsured patients only?

Are you able to compare the cost of 340B drugs to generic equivalents?

Practice Management System (PMS) – for organizations that have internal PMS

1. Briefly describe your Practice Management System – vendor name, product name, modules/applications.

2. Describe how patient data is entered into the system, probe – on line registration, paper forms entered into system, etc. How is patient eligibility data input into the system? Probe – upload enrollment files from health plan/HCPF, input as part of registration process (initial plus each visit). How often is eligibility updated?

Medicaid:

CHP+/MCO:

State Managed Care Network (SMCN):

3. How is historical eligibility information maintained? Probe - full history is maintained, eligibility is tied to encounter not patient record, eligibility is overwritten with each change, etc. For CHP+,

to what degree is it possible to identify and capture in the system whether CHP+ patients are in the SMCN or in an MCO?

4. Describe contractual relationship with outside providers and how the PMS interfaces with their systems, for each area, probe what data/information is exchanged, if interface is electronic data exchange or manual input, frequency of download (real time, daily, other).

Outside laboratory -

Acute care hospital -

Retail pharmacy -

Long term care facility -

Other (specify) -

5. Describe ability to extract data and/or produce user-defined reports.
    a. Able to extract data and/or produce reports – yes or no
    b. What data extractions are performed? How often? For what purpose?
    c. What reports are produced? How often? For what purpose?

For those organizations that use outside billing service for capturing encounter data and processing claims

1. Briefly describe arrangement with PMS vendor – name of vendor and system used by the vendor (if known), what applications/processes are supported by the vendor. Describe how patient information and claims data are submitted to the vendor. Probe – direct connection to vendor, web-based application, submit paper encounter forms, etc.

2. Describe how the practice or outside vendor interfaces with outside systems, for each area, probe what data/information is exchanged, if interface is electronic data exchange or manual input, frequency of download (real time, daily, other).

Outside laboratory -

Acute care hospital -

Retail pharmacy -

Long term care facility -

Other (specify) -

3. Describe ability to extract data and/or produce user-defined reports. Can you produce reports or must they be requested from the vendor? If requested, what is the usual turnaround time? Is there an added cost for reports?

    a. Able to extract data and/or produce reports – yes or no

    b. What data extractions are performed? How often? For what purpose?

    d. What reports are produced? How often? For what purpose?

Electronic Medical Record – EMR

1. Does your organization have an electronic medical record? Yes No

2. If no, are there plans for implementing an EMR in the foreseeable future? If so, what is the estimated time frame for implementation?

3. Describe briefly your EMR – vendor name, product name, modules installed, etc.

    a. Is the EMR installed at all sites? If no, which ones have EMR and which ones do not? What is the plan for implementing at the other sites?

    b. Do you have a patient portal where patients are able to access their medical information? If yes, describe briefly. Probe – able to view medical chart, secure email with provider, able to add to personal health record, etc.

4. Describe how the EMR interfaces with outside systems, for each area, probe what data/information is exchanged, if interface is electronic data exchange or manual input, frequency of download (real time, daily, other).

Outside laboratory -

Acute care hospital -

Retail pharmacy -

Long term care facility -

Other (specify) -

5. Describe ability to extract data and/or produce user-defined reports.

    a. Able to extract data and/or produce reports – yes or no

    b. What data extractions are performed? How often? For what purpose?

    c. What reports are produced? How often? For what purpose?

6. For those organizations that have an in-house PMS and EMR – describe the integration between the two systems. Probe – are they fully integrated with free flow of information between the two systems, the systems are linked but data flow is one way only, the two systems are separate and require manually combining data/information to produce reports that require data/information from both, other form of integration.

General Questions – for all FQHCs/RHCs regardless of system used

1. Do you submit UB4 to MMIS for Medicaid claims? If yes, how many procedure codes and diagnosis codes are you able to submit with one claim? Have you made changes to your system to mitigate limitations on MMIS to process detailed claims? For example, set up algorithm to clear denied claims for individual procedure codes.

2. Within your systems (PMS and/or EMR), are you able to differentiate between services provided to patients when enrolled in State Managed Care Network versus when enrolled in MCO?

3. Describe any stand-alone system used for data warehousing and analysis? Is the data warehouse maintained on site or by an outside vendor? What systems feed into the data warehouse?

4. Does your organization participate in CORHIO or Quality Health Network? If yes, describe.

5. Does your organization participate in CACHIE now? If no, are there plans to do so in the future?

6. Does your organization currently produce any of the indicators (or variation on the indicator) included in the pilot? If so, which ones? What is the process for obtaining the necessary data and computing the indicators?
    a. What would be the resource considerations for your organization if it were to produce the measures chosen for the Data Collection Pilot?

7. Are there any issues related to applying the measure (as defined) to the FQHC/RHC population that would reduce its validity and/or reliability?

    a. Any qualifiers or inclusion/exclusion of subpopulations?

    b. Issues/recommendations related to attribution for services provided outside of the FQHC/RHC (hospital admissions, ER Utilization, pharmaceuticals).

i. How is "patient ownership" defined by your organization?

c. Issues/recommendations related to attribution when patient is seen by more than one FQHC/RHC within the measurement period.

8. Complete data matrix (Excel worksheet provided as a separate document). List any questions/qualifiers that arose when completing data matrix.

APPENDIX C2: Data Collection Pilot Questionnaire for MCO

Organization Name:

Interview Participants (include name and position responsibility; recommended participants include those responsible for setting up providers in system, for patient eligibility, for quality assurance and decision support, and for RCCO participation.)

Interview date(s):

Names of contracted FQHCs/RHCs:

1. Provide a broad overview of processing data system capabilities related to: ability to capture claims level detail, ability to store data for retrieval and analysis by individual provider/ provider site/ provider organization and by defined groups of patients, for:

    - FQHC provided services
    - RHC provided services
    - Hospital-based services (inpatients and emergency department)
    - Pharmaceuticals – prescribed and filled
    - Other provider organizations

Note: we do not need to understand every step of the process, but the overall flow in terms of where data is collected, housed, and tapped for analysis.
Please discuss the current process.

What would be the impact on how you capture, store and retrieve claims level detail with a switch to encounter-based payment?

2. Describe process for processing claims for services provided to patients enrolled in State Managed Care Network. Probe- how are they differentiated, are service level data merged after patient in enrolled in MCO, etc.

3. Describe process for determining MCO enrollment/CHP+ eligibility status for claims processing. How is historical enrollment data maintained within the system? Is it possible to create an eligibility span and service and provider history inclusive of both SMCN and MCO enrollment?

4. Describe any stand-alone systems used for data analysis and reporting, for example, data warehouse, maintained on site or through a vendor/affiliated organization.

5. Does your organization currently produce any of the indicators (or variations of the indicators) included in the pilot? If so, which ones? What is the process for computing the indicators? What is the level of analysis – MCO level, by provider type, by individual provider, etc.

What would be the resource considerations for your organization if it were to produce the indicators?

6. Are there any issues related to applying the measure (as defined) to the FQHC/RHC population that would reduce its validity and/or reliability?

a. Any qualifiers or inclusion/exclusion of subpopulations?

b. Issues/recommendations related to attribution for services provided outside of the FHQC/RHC (hospital admissions, ER utilization, pharmaceuticals).

c. Issues/recommendations related to attribution when patient is seen by more than one FQHC/RHC within the measurement period.

7. Complete data matrix (Excel worksheet provided as a separate document).

APPENDIX C3: Data Collection Pilot Questionnaire for HCPF

(To be completed on site at HCPF to allow for viewing/walk through of data system as needed).

Interview Participants (include name, department/division with HCPF, position/responsibility; recommended participants include data system staff from MMIS and ACC contract)

Interview Date(s):

Questions related to Medicaid FFS Claims (MMIS)

1. Describe claims processing data system (MMIS) capabilities related to: ability to capture claims level detail, ability to store data for retrieval and analysis by individual provider/ provider site/ provider organization and by defined groups of patients, for:

    - FQHC services
    - RHC services
    - Hospital-based services (inpatients and emergency department)
    - Pharmaceuticals – prescribed and filled
    - Other providers (specify)

Probe: It is our understanding that claims level detail is "lost" when FQHC/RHC claims are paid on a per encounter basis. What happens to the data – captured but deleted, not captured, etc.? What system/workflow changes would be needed to capture and retain claims level data for Medicaid claims? For example, implementing "zero pay" for procedures/services included in encounter payment.

2. Describe process for determining eligibility status for claims processing. How is historical enrollment data maintained within the system?

3. Describe any stand-alone systems used for data analysis and reporting, for example, data warehouse, maintained on site or through a vendor/affiliated organization (include SDAC) . Probe: what is the role of the actuary contracted by HCPF? Is the actuary used for CHP+ only or for CHP+ and Medicaid? Could the actuary produce the necessary reports with indicators or with data to compute indicators?
4.

How is data transmitted to the actuary? Probe – data source, mode of transmission, etc. What would be the staff and/or hard costs of using the actuary to product a report on the indicators? How feasible would it be to use the actuary?

What is the role of the SDAC for analysis and reporting?
What would be the staff and/or hard costs of using SDAC to product a report on the indicators? How feasible would it be to use the SDAC?

5. Does the Department currently produce any of the indicators (or variations of the indicators) included in the pilot for Medicaid enrollees or subgroup of enrollees? If so, which ones? What is the process for computing the indicators? What is the level of analysis – state level, MCO level, by provider type, by individual provider, etc. What challenges exist for producing this data at the provider (FQHC/RHC entity) level?

What would be the added cost (staff time and hard cost) if the Department were to calculate the indicators?

6. Complete data matrix (Excel worksheet provided as a separate document).

Questions related to CHP+ (MCO contracts)

1. Are all services for CHP+ enrollees covered under the MCO capitation contracts? If not, what services are carved out and/or covered under separate contracts?

2. How are claims for services provided through Statewide Managed Care Network handled?

3. Describe process for determining eligibility status for capitation payments. How is historical enrollment data maintained within the system?

4. Do the contracted MCOs provide data/information to HCPF relative to CHP+ provided services? If yes, what data/information is currently being provided?

5. Describe any stand-alone systems used for data analysis and reporting, for example, data warehouse, maintained on site or through a vendor/affiliated organization. Probe: what is the role of the actuary? Could they produce the necessary reports to produce indicators? At what cost? How is data transmitted to the actuary? Probe – data source, mode of transmission, etc.

6. Does the Department currently produce any of the indicators (or variations of the indicators) for CHP+ enrollees or subgroup of enrollees? Are any of the indicators (or variations thereof) provided by the MCOs? If so, which ones? What is the process for computing the indicators? What is the level of analysis – state level, MCO level, by provider type, by individual provider, etc.?

General Questions – related to both Medicaid and CHP+

1. In computing the indicators, how do we ensure that the patient population used for measure calculation includes only Medicaid and CHP+ enrollees that meet defined criteria for continuous enrollment period?

    a. Are there methods that have been used successfully for other projects? If so, what are they?

b. What should enrollment period should be used to qualify patient for inclusion? Has this been used successfully for other projects?

2. What organization do you feel is or will be best suited for computing the measures? Department? MCO? CACHIE? Other? How will values be verified by other organizations? What are the resource considerations for computing measures through the identified organization? How might the required resources be paid for?

3. Are there any issues related to applying the measure (as defined) to the FQHC/RHC population that would reduce its validity and/or reliability?

    a. Any qualifiers or inclusion/exclusion of subpopulations?

    b. Issues related to attribution for services provided outside of the FQHC/RH

        i. When computing hospital readmission rates, emergency room utilization, and generic drug use rate?
        ii. When patients are seen by more than one FQHC or RHC during the measurement period?

    c. What patient attribute method has been used for similar projects? Did the method produce accurate and fair attribution?

4. What are the regulations related to filling prescriptions with generic versus brand within Colorado? Does the Department and/or MCOs have formularies for Medicaid/CHP+? How will regulations and formularies affect measure results? Note: work with HCPF Pharmacy Team (Jim Leonard, others); Casey will coordinate

APPENDIX D: PILOT TOOLS – DATA MATRIX

A data matrix, in Microsoft Excel format, was completed by pilot participants. The matrix itself is not feasible to reproduce in this appendix. Rather, this appendix details the items captured in the data matrix.

The following criteria were assessed for the variables listed below:

FQHC/RHC
Source from which variable is obtained
If source is "other" specify source
Paper Chart Captures
EMR Captures as Data Element
EMR Captures as Free Text
EMR Captures as Scanned document
PMS Captures
Able to extract
Able to report
Submitted to Outside Data Repository

MCO
Source from which variable is obtained
If source is "other" specify source
Captured in detail
Stored in detail
Able to extract
Able to report
Submitted to Outside Data Repository

HCPF MMIS
Source from which variable is obtained
If source is "other" specify source
Captured in detail
Stored in detail
Able to extract Able to report
Submitted to Outside Data Repository

Variables/Measure	General	ER Utilization	Ambulatory Care	All Cause Readmissions	Generic Drug Substitution	Hemoglobin A1c	Diabetes BP Management	Hypertension BP	Weight Screen & Follow Up	Tobacco
Patient name	x	x	x	x	x	x	x	x	x	x
Patient gender		x	x	x						
Patient date of birth	x	x	x	x	x	x	x	x	x	x
State ID Number	x									
Medicaid eligibility start date	x									
Medicaid eligibility through date	x									
CHP+ SMCN eligibility start date	x									
CHP+ SMCN eligibility through date	x									
CHP+ MCO eligibility start date	x									
CHP+ MCO eligibility through date	x									
Health Plan Assigned ID Number	x									
Assigned primary care provider	x									
Member months in measurement period for enrolled patients	x									
Date of service	x	x	x	x	x	x	x	x	x	x
Provider Tax ID Number	x		x	x	x	x	x	x	x	x
Facility name/code (include all acute facilities)		x		x						
Date of admission		x		x						
Place of Service Code			x	x	x		x	x	x	x
Date of discharge				x						
Discharge Code				x						
Claim status					x					
NDC Code for Pharmaceutical Prescribed					x	x	x			x
NDC Code for Pharmaceutical Dispensed					x					

Variables/Measure	General	ER Utilization	Ambulatory Care	All Cause Readmissions	Generic Drug Substitution	Hemoglobin A1c	Diabetes BP Management	Hypertension BP	Weight Screen & Follow Up	Tobacco
NDC classification					x					
Script inclusion of instruction "fill as written" or "no substitution"					x					
Date prescription written					x					
Date prescription filled					x					x
Acquisition cost of drug					x					
Dispensing facility code					x					x
Name of medication prescribed						x				
Date of BP reading								x		
Systolic reading(s)								x		
Diastolic reading (s)								x		
Maintain problem list								x		
Diabetes included on problem list when applicable										
Hypertension (HTN) included on problem list when applicable								x		
CPT code		x	x			x		x	x	x
CPT Category 2 "f" codes						x				
ICD9 code		x		x		x	x	x	x	x
ICD9 "V" codes								x	x	
UB Revenue Codes		x	x			x	x	x	x	
HBA1C Testing result codes ("f" codes)						x				
Documentation of nutrition counseling									x	
Weight management plan documented (adult only)									x	
BMI value documented (for adult)									x	
BMI percentile documented									x	
BMI percentile plotted on age-growth chart documented									x	

Variables/Measure	General	ER Utilization	Ambulatory Care	All Cause Readmissions	Generic Drug Substitution	Hemoglobin A1c	Diabetes BP Management	Hypertension BP	Weight Screen & Follow Up	Tobacco
HCPCS Codes									x	
HCPCS "S" codes									x	
HCPCS "D" Codes									x	
HCPCS "G" codes									x	
Tobacco use on social history										x
Tobacco use on problem list										x
Documented that patient queried about tobacco use										x
Date of query										x
Documentation of advice to quit										x
Referral for counseling										x
Pharmacologic therapy										x

APPENDIX E: SUMMARY OF PILOT MEETING DATES, FOCUS, AND ATTENDANCE

Date	Meeting Focus	Attendees
July 21, 2011 9:00 – 11:00AM MST	Pilot Check-In	HCPF, JSI, Colorado Access, Colorado Community Health Network, Colorado Community Managed Care Network, Colorado Rural Health Center, Denver Health, Metro Community Provider Network, Mountain Family Health Services, Salud Family Health Centers
August 4th, 2011 2:00 – 3:00PM MST	Subcommittee Meeting for Data Matrix Tool	JSI; Mountain Family Health Center - Chris Tonozzi; Denver Health Community Health Services - Ray Estacio
August 15, 2011 1:30 – 2:30PM MST	Pilot Check-In	HCPF, JSI, Clinica Family Health Services, Colorado Access, Colorado Community Health Network, Colorado Community Managed Care Network, Colorado Rural Health Center, Denver Health, Delta Dental, Mountain Family Health Services, Pediatric Associates of Montrose, Pueblo Community Health Center, Rocky Mountain Health Plans, Salud Family Health Centers
September 7, 2011 9:00 – 10:00AM MST	Conference Call: HEDIS Contractors	HCPF, JSI; Health Services Advisory Group (HSAG) - Terry Wilkens, Marilea Rose, Maricris Kueny; QMark, Inc - Michelle Piccininni, Lorene Brill
September 12, 2011 1:30 – 2:30PM MST	Pilot Check-In	HCPF, JSI, Colorado Access, Colorado Community Health Network, Colorado Community Managed Care Network, Colorado Rural Health Center, Metro Community Provider Network, Mountain Family Health Services, Rocky Ford Family Health Center, Rocky Mountain Health Plans
September 20, 2011 2:00– 2:30PM MST	Conference Call: 340B and Generic Drugs	HCPF, JSI; Clinica Family Health Services - Luis Rivera-Ileras
September 29, 2011 2:00– 3:00PM MST	HCPF Data Section Meeting	HCPF, JSI; HCPF Data Section - Beth Martin, Rene Horton
October 17, 2011, 2:00 – 3:00PM MST	Pilot Check-In	HCPF, JSI, Colorado Choice, Colorado Community Health Network, Colorado Community Managed Care Network, Colorado Rural Health Center, Denver Health, Metro Community Provider Network, Mountain Family Health Services, Rocky Mountain Health Plans
November 28, 2011 1:00 – 2:00 PM MST	Pilot Check-In	HCPF, JSI, Colorado Access, Colorado Community Health Network, Colorado Community Managed Care Network, Colorado Rural Health Center, Delta Dental, Metro Community Provider Network, Rocky Ford Rural Health Center
December 19, 2011 12:00 – 1:00 PM MST	HCPF Data Section Meeting	HCPF, JSI; HCPF Data Section – James Bloom

APPENDIX F: SAMPLE DATA REPORTS – COLORADO ACCESS

Table 1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

		BMI Percentile			Counseling for Nutrition			Counseling for Physical Activity		
Data Elements	**Total**	**(3-11)**	**(12-17)**	**Total**	**(3-11)**	**(12-17)**	**Total**	**(3-11)**	**(12-17)**	**Total**
Eligible population										
Number of numerator events by administrative data in eligible population (before exclusions)										
Current year's administrative rate (before exclusions)										
Minimum required sample size (MRSS) or other sample size										
Oversampling rate										
Final sample size (FSS)										
Number of numerator events by administrative data in FSS										
Administrative rate on FSS										
Number of sample records excluded because of valid data errors										
Number of records excluded because of contraindications identified through administrative data										
Number of records excluded because of contraindications identified through medical record review										
Number of employee/dependent medical records excluded										
Records added from the oversample list										
Denominator										
Numerator events by administrative data										
Numerator events by medical records										
Reported rate										
Lower 95% confidence interval										
Upper 95% confidence interval										

Table 2: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Member Level Detail

Member Number	Last Name	First Name	Date of Birth	Primary Key	Gender	Age End Report Year	Age Group	Age Gender	Continuous Enrollment	Anchor Date	Benefit	BMI Percentile	Counseling for Nutrition	Counseling for Physical Activity	Exclusion	Event Diagnosis

Product Line	Employer Number	PCP Number	Outpatient Visit	BMI Percentile Date	Counseling for Nutrition Date	Counseling for Phys. Act. Date	Pregnancy Date	Sample	Numerator 1 Compliance flag	Numerator 2 Compliance flag	Numerator 3 Compliance flag	Sample ID	PROV_ LNAME	PROV_ FNAME	PROV_ MNAME

Table 3: Outpatient Visits

Year Month	Lob_ Rollup	Membno	PS_Mbr_Nm	Bthdat	Pcpcod	Prov Alias Pcp.provname_ concat	Claimno _fmt	Diagn1	Dbo Diagcode. Desctn	Svccod	Dbo Servcode. Desctn	Svcdat	Postdt	Clm Count	To Pay	Provno	Dbo Provdir.provname_c oncat

Lob_Rollup	Pcpcod	Prov Alias Pcp.provname_concat	Clm Count	Member Months	Outpt Clms per 1000

Table 4: ER Admissions

Lob_ Rollup	Dbo Placserv. Descrp	Poscod	Membno	PS_ Mbr_ Nm	Sexcod	Bthdat	Prvorg	Pcpcod	Prov Alias Pcp . provname _concat	Claimno_ fmt	Year Month	Svcdat	Day of Week

ER Visit Time Grouping	Time of ER Visit	Admtim	Distim	Provno	Dbo Provider .provname _concat	Diagn1	Desctn	Prvorg	Claamt	To Pay	Er Visit

Lob_Rollup	Pcpcod	Prov Alias Pcp.provname_concat	Er Visit	Member Months	ER Visits per 1000

Table 5 Readmissions

Lob_ Rollup	Memb no	PS_Mb r_Nm	Pcpcod	Prov Alias Pcp.provna me_ concat	Admdat	Disdat	Week Day	Admits	Day Count	Days Between Admits	Poscod	Provno	Dbo Provider. provname _ concat	Hospital Transfer	Re Admission within 7 days	Re Admission within 30 days	Re Admission within 90 days

APPENDIX G: SAMPLE DATA REPORTS – THE DEPARTMENT

PARTICIPATING PROVIDERS **PROPOSED MEASURES**

Provider ID	Provider Name		Emergency Room Utilization	Hospital Readmissions	Outpatient Visits	Generic Drug Substitution	Diabetes: Hemoglobin A1c Testing	Diabetes: Blood Pressure Management	Hypertension	Body Mass Index 2-18 years	Body Mass Index Adult	Tobacco Use Assessment	Tobacco Cessation Intervention
		Numerator	TBD	TBD	TBD	TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Denominator										N/A	N/A
		Numerator	TBD	TBD	TBD	TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Denominator										N/A	N/A
		Numerator	TBD	TBD	TBD	TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Denominator										N/A	N/A

NOTES:
All Denominators numbers are member months
Zeroes indicate that there were no clients/member months associated with this provider for this measure
N/A indicates that we cannot calculate this with our claims data
TBD indicates it is either unclear if we can calculate this measure and/or it will take much more analysis and time to get this data

APPENDIX H: DATA REPORT VALIDATION TOOL

PPS+ Data Collection Pilot for Value-Based Purchasing in CHP+ and Medicaid

Feedback on Measure Reports

Background

The data collection pilot for the Value-Based Purchasing in CHP+ and Medicaid project is intended to help the Department identify gaps and challenges related to the generation of clinic-specific measures (or similar measures) that might be used in a future value-based purchasing methodology for FQHCs and RHCs. The pilot is gathering information on the availability of data at the clinic, MCO and Department levels, as well as the potential for aggregating and analyzing data through statewide bodies such as CACHIE (Colorado Associated Community Health Information Enterprise) or CORHIO (Colorado Regional Health Information Organization).

Ideally, any measure used for value-based purchasing would be generated by the Department or state-wide entity, based on information already submitted by the participating clinics as part of the existing care delivery/claim submission process. In such a case, a report would be provided to the clinic for validation.

Colorado Access is the MCO participating in the data collection pilot. Colorado Access has generated a report with clinic-specific information on the following pilot measures:

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Ambulatory Care Utilization visits
- Childhood Body Mass Index (BMI) Screening and Follow-Up

Please note that data for the first four indicators was generated using claims for 2010 Calendar year. Data for the BMI indicator was generated through a retroactive analysis of data pulled for HEDIS measures for CY 2010, so that chart audit data is included only for those records on which chart audits were required at that time.

The Department is asking for your feedback, as a clinic participating in the pilot, on the report generated by Colorado Access. Your feedback will provide valuable information for the design of reports used in any future value-based purchasing methodology. You may want to generate reports within your system to validate the information provided by Colorado Access. However, it is not required that the reports be reconciled fully with your information – we ask you to do whatever validation is practical (including reviewing measures for reasonableness) within your system in order to provide feedback within the designated time frame.

Please consider the following questions prior to the scheduled conference call with JS, and submit completed response to Christine Barron (cbarron@jsi.com) by November 29 2011. Feel free to use

additional space for your responses if needed. If you have any questions please contact Elena Thomas Faulkner at ethomas@jsi.com; 303-262-4320 or Christine Barron at the email above or 303-262-4343.

1. Name of your organization: _____
2. Names and titles of persons providing feedback (please list)

3. Please describe the method you used to validate the information in the Colorado Access Report. (For example, did you use data from a standing report already in your system, did you run an ad-hoc report for the same time frame and patient population, etc.) If you were not able to validate the report against any internal data, please describe why not. If you were not able to validate, do you find the information reported by Colorado Access to be reasonable based upon your patient population?
   - Emergency Room Utilization
   - Hospital Readmissions (any cause)
   - Ambulatory Care Utilization Visits
   - Childhood Body Mass Index (BMI) Screening and Follow-Up

4. Does the number of member months included for the measures appear to be correct ?

If not, please note what you would expect this number to be, and any ideas you have about why it is different in the report:

5. Does the Universe (Denominator) for each measure appear to be correct given the time frame and the parameters used for the indicator?

If not, please note what you would expect this number to be, and any ideas you have about why it is different in the report:

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Ambulatory Care Utilization Visits
- Childhood Body Mass Index (BMI) Screening and Follow-Up

6. Does the number of patients meeting the measure parameters (numerator) for each measure appear to be correct given the time frame and parameters used for the indicator?

If not, please note what you would expect this number to be, and any ideas you have about why it is different in the report:

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Ambulatory Care Utilization Visits
- Childhood Body Mass Index (BMI) Screening and Follow-Up

7. Colorado Access generated the reports based on enrollees assigned to your FQHC/RHC for primary care. For each member please respond?

a. Do the reports include any patients that you did not consider to be your patients and/or eligible for CHP+ during 2010?

b. Are there additional patients with CHP+ you feel should be included who do not appear on the report?

- Emergency Room Utilization
- Hospital Readmissions (any cause)
- Ambulatory Care Utilization Visits
- Childhood Body Mass Index (BMI) Screening and Follow-Up

8. Did the report contain sufficient information about how the numbers were generated to allow you to validate the information within your system? If not, what additional information would have been helpful?

9. Is the layout of the report effective? If not, please describe why not and any recommendations for changes you would have.

10. Please share any other comments or recommendations you have regarding data reports and/or the validation process for any future value-based purchasing methodologies.

APPENDIX I: PAYMENT METHODOLOGIES

Fee for Service

Fee for service (FFS) is depicted as the lowest step in the continuum of payment methodologies. Providers are paid established rates for rendering, for the most part, face-to-face, health consultations and procedures for patients. The financial incentive under this system is for providers to see more patient volume There is no incentive to use high-value approaches or deliver on desired outcomes. While PPS is actually a bundled payment for a host of clinical and enabling services, because health centers are paid on per-face-to-face visit with a provider, we place PPS in this step of the continuum.

Fee for Service Plus

"Fee-for-service plus" or "PPS plus" encapsulates the first generation of incentive programs that are layered on top of the traditional FFS or PPS payment methodology. Under these payment methodologies, payers reward providers for performing on one or more identified metrics from one or more measurement domains, including quality, patient experience, access, cost efficiency, and delivery system transformation, medical home recognition being the most common example.

Pooled Incentives

Pooled incentive-based reimbursement represents a step up in the continuum because these methodologies are more comprehensive than performance bonuses for just a few measures. They often involve composite scores based on performance on multiple metrics within a number of measurement domains. A health plan might also pool at-risk dollars across providers.

Primary Care Capitation

Primary care capitation is where a provider agrees to a set payment per beneficiary per month. It is the first step in the continuum where a provider can assume both upside and downside risk. The downside risk is limited by the fact that a provider would only be responsible for extra primary care services that a beneficiary seeks. In exchange for this risk, a provider also gains flexibility on how to spend the dollars. The financial incentive is to provide the most cost-effective modes of care. The fear with capitated payment methodologies is that providers will limit access or compromise on quality. A critical aspect of capitation arrangements is ensuring a patient is "bound" to a provider assuming responsibility and payment for that patient's care.

Professional Services Capitation

Professional services capitation is where an organization or group of providers assumes risk for all professional costs associated with primary care, ancillary services and specialty care. In addition to the incentives and benefits of primary care capitation, professional services capitation adds an incentive to establish pre-negotiated rates for ancillary services and specialty networks. The use of high-value

specialty networks has been identified as a key component of medical homes that show high levels of cost savings.[12]

Global Payment

Global Payment is where an organization or group of providers accepts a single payment per capita for the total health care of a population. It is a jump above other capitation arrangements because the organization must assume payment responsibility for inpatient facility costs, which form a much larger proportion of total cost of care than professional costs. Under global payments, an organization assumes both clinical risk for the management of conditions and a certain degree of insurance risk for the occurrence of conditions within a population. To mitigate the substantial downside risk under a global payment arrangement, providers must negotiate some protection from total insurance risk through mechanisms such as risk adjustment of payments, reinsurance, or limits or caps on high-cost cases. In addition to the attribution challenges with all capitated arrangements, an additional challenge within global capitation is that once an umbrella organization, such as an Accountable Care Organization (ACO) or a managed care organization (MCO), accepts a global payment, there still must be a method to distribute dollars to all providers providing services to assigned beneficiaries.

Episodic or Bundled Payment

It should be noted that episode-based and bundled payments are also payment models that are being implemented as an alternative to the FFS payment methodology. Episode-based payments and bundled payments have theoretical appeal because they move away from payment for volume of services. However, episode-based payments are being tested mostly for acute conditions in the hospital setting (ex. total hip or knee replacement). Central challenges with episode-based payments include attribution of the episode to a dominant provider and how each individual provider will be paid for his/her portion of the episode of care. For the most part, primary care based systems and health centers are not considering episode-based payment methodologies because of the acknowledged complexity of administrating them in primary care.

[12] Milstein, A., & Gilbertson, E. (2009). American medical home runs. *Health Affairs*, 28(5):1317–26.