Colorado State Innovation Model (SIM) Proposed Alignment with the Comprehensive Primary Care Plus (CPC+) Initiative

JANUARY 5, 2017

Colorado SIM – Proposed Alignment with the Comprehensive Primary Care Plus (CPC+) Initiative

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Background

Colorado's proposal for the State Innovation Model (SIM) initiative was conceived and designed to serve as a catalyst for both new and existing efforts to transform the state's health care system. Colorado SIM's focus on the integration of physical and behavioral health as a cornerstone for improving patient outcomes and controlling costs adds a powerful new dimension to the state's efforts to achieve the Quadruple Aim. Yet Colorado SIM's overall impact and effectiveness in achieving systemic, sustainable health care reform will be realized not only though its innovative approaches, but also its capacity to build on, and align with, other state and federal initiatives.

Since its inception, Colorado SIM has sought to leverage existing federal, state, and private sector investments in primary care transformation and integrated care delivery, and to support high-performing primary care and integrated behavioral health. In developing the SIM proposal, Colorado specifically looked to the Comprehensive Primary Care initiative (CPCI) – an existing multi-payer, care delivery and payment reform initiative aimed at strengthening primary care in the state – and created programmatic alignment around clinical quality measures and practice transformation milestone activities. Colorado SIM also garnered the support and commitment of payers participating in CPC to extend and expand their efforts to strengthen primary care, and to include the integration of primary care and behavioral health services under the umbrella of Colorado SIM.

The Comprehensive Primary Care Plus (CPC+) initiative, which will serve as the next iteration of CPCI (which ended in Dec 2016), represents an enormous opportunity for Colorado. The scope and breath of CPC+ – in terms of the resources and the number of practices potentially involved – will support and advance current multi-payer, care delivery transformation efforts in the state. While payers, providers, and other stakeholders are justifiably excited about Colorado's selection as a CPC+ region, the introduction of another new, "like but not equivalent" initiative raises new challenges for alignment, particularly with Colorado SIM.

Potential Benefits of SIM – CPC+ Alignment

Lessons from Cohort 1 & the Comprehensive Primary Care Initiative (CPCI)

The practice transformation component of Colorado's SIM initiative includes three cohorts of primary care practices – which will include approximately 400 practice sites over the course of the Model Test award – that will receive practice transformation support and participate in alternative payment models. Although SIM's clinical quality metrics and practice transformation milestone activities and building blocks were based around CPCI requirements, all practices selected to participate in SIM receive the same practice transformation supports, and are subject to SIM-specific reporting requirements. To date, no adjustments have been made to SIM participation conditions based on a practice's participation in a separate initiative.

Practices participating in CPCI or other payer-specific alternative payment models were actively recruited for SIM Cohort 1, both by the SIM Office and through individual payer outreach. A total of 32 practices in CPCI were selected and enrolled in SIM Cohort 1. As SIM implementation efforts began and progressed over the spring and summer of 2016, the SIM Office received feedback from CPCI-SIM practices that the additional reporting requirements associated with SIM represented a significant burden for practices participating in both initiatives. In addition, participation in learning activities or sessions for both initiatives, which frequently covered similar topics, was seen as unnecessary and time-

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consuming. Such concerns led five practices participating in CPCI and SIM to withdraw from the first SIM cohort.

Based on this experience, the SIM Office is seeking ways to increase the programmatic and operational alignment between SIM and CPC+, which will run concurrently through the remainder of SIM, to help minimize provider burnout and frustration. To develop an alignment strategy, the SIM Office engaged in robust conversations with a wide range of stakeholders, including providers, payers, and practice transformation experts. Several key principles were identified during group discussions to ground and direct the decision-making process. Stakeholders were unified in seeking a strategy that would:

- Maintain the multi-payer focus of the SIM Initiative
- Ensure the diversity in the type of practices engaged in SIM
- Reduce the burden on practices that might want to participate in both initiatives
- Preserve Colorado SIM's unique focus on the integration of primary care and behavioral health

Overall, stakeholders arrived at a consensus that the interrelated goals and objectives of SIM and CPC+ create natural synergies that can accelerate and magnify one another – creating a true benefit for practices, providers, and payers electing to participate in both. This would mitigate the risk of practices making a choice between participating in SIM or CPC+, and accentuate the message that the initiatives are intended to be complementary and not competitive. The vision of alignment that emerged was one in which certain practice requirements – in areas such as practice transformation support, learning collaborative offerings, and quality measure reporting – would be coordinated to reduce provider burden in a manner that preserves SIM's focus on the integration of physical and behavioral health and coordination of primary care, and the coordination of primary care, public health and community health organizations.

Colorado Pathways to Transformation

The discussion surrounding SIM and CPC+ is part of a broader conversation about initiative alignment in the state. The continued introduction of federal initiatives – including SIM, CPC+, and the Transforming Clinical Practice initiative (TCPi) – along with the final MACRA regulations, have focused payer and provider attention on the central goals of improving population health outcomes, patient and provider experiences, and controlling costs while ensuring access to high-quality, evidence-based, coordinated care. Stakeholders recognize this level of transformation requires innovation, significant investment of resources, and intense coordination across all sectors of the healthcare system with an initial focus on primary care transformation and integration.

Recently, the Colorado Multi-Payer Collaborative (MPC, or Collaborative) developed a "Pathways to Transformation" concept to describe the inter-related nature of the multitude of healthcare reform activities and initiatives under way in Colorado (included as Attachment A). The MPC recognizes that each initiative brings value to the region, and encourages practices to engage in transformation efforts through one or more of the various paths available. While there is some variability across Colorado's initiatives (e.g., eligibility criteria, program requirements, practice benefits), there are commonalities along the path to the overarching goal of improving health and patient experience while reducing costs. Practices are able to actively work on transformation, and move towards whole-person care supported by value-based payments by choosing any of the options in the region – there is ***no wrong entry point*** on the transformation path. Some practices might not be eligible for all options; however, there are

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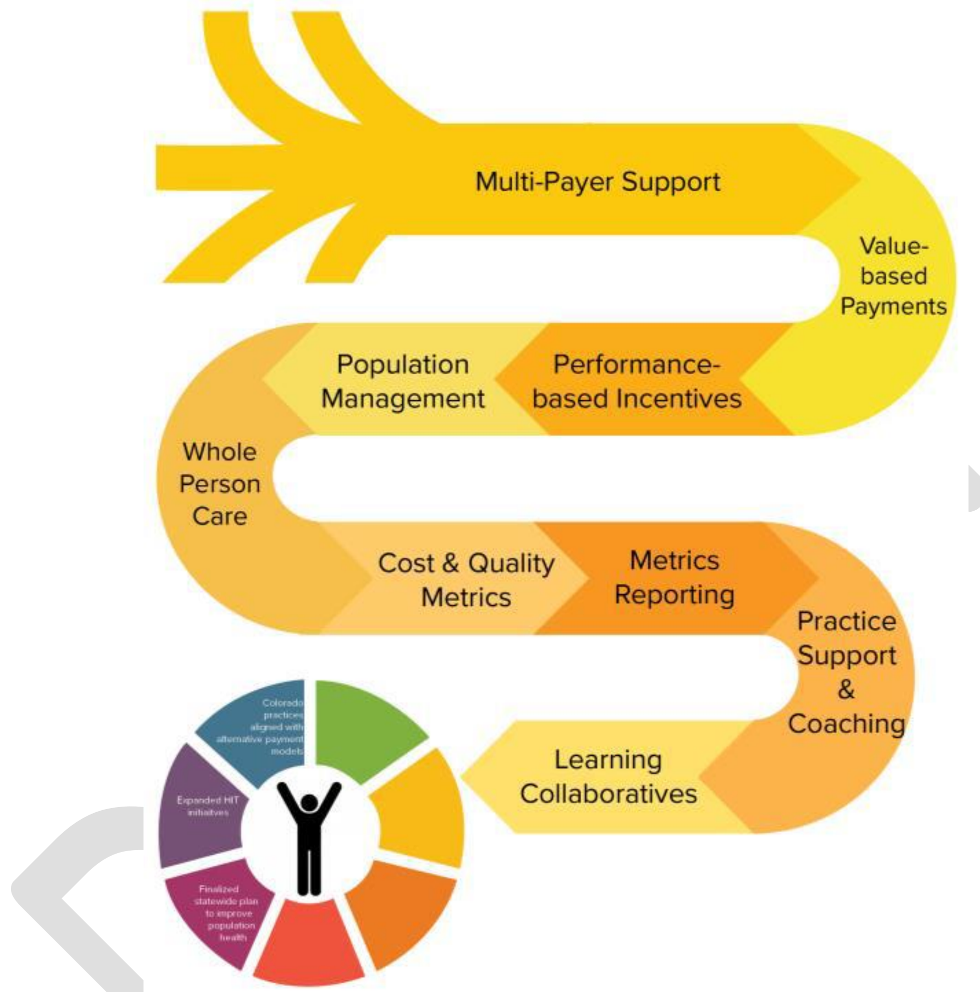
opportunities available for different types of practices at different levels of transformation. Some paths are best suited to specific types of practices, or might only be available to practices that meet certain requirements.

Colorado's Path to Transformation



Both SIM and CPC+, as stand-alone initiatives, represent two distinct "entry points" for practices to start down the care delivery transformation pathway. In the following proposal, Colorado seeks to create a new entry point and path for "SIM/CPC+" practices, which would maximize the benefits and reduce the burdens, when possible, of participating in both initiatives. The SIM team believes that offering a "dual pathway" for SIM/CPC+ practices will facilitate the achievement of SIM's objectives around practice transformation, payment reform, population health, and HIT, and maximize our ability to successfully achieve the overall goal of improving the health of Coloradans by providing 80% of state residents with access to integrated physical and behavioral health services in coordinated community systems, supported by value-based payment models by 2019.

The proposed modifications to the implementation plan presented in the Colorado SIM application and Year 1 Operational plan for SIM/CPC+ practices will provide the following benefits:

- Create an opportunity for practices and providers to participate in SIM and CPC+ in a manner that reduces, whenever possible, the burden of dual participation.
- Extend SIM's reach to include a diversity of practices in Colorado that are at various stages of integration and serve a diverse population. If SIM is perceived as an alternative to, rather than a complement of, CPC+, we run the risk of not recruiting more advanced practices and systems to SIM because practices might decide to only apply for CPC+, which might result in SIM's failure to meet recruitment goals for cohort 2.
- Enhance the progress of practices in achieving higher levels of behavioral health integration and collaboration with community and public health organizations by providing practices with additional practice transformation support that is not available through CPC+.
- Ensure that practices that are not eligible to participate in CPC+ have the opportunity to engage in SIM cohort 2 and receive practice transformation and multi-payer support to achieve higher levels of behavioral health integration and collaboration with community and public health organizations.

The SIM Office is committed to working with CMMI to ensure that implementation of the following proposal will not duplicate support activities available through SIM and CPC+ or supplant any funding. We also recognize that many of the of the operational details about the support activities and participation requirements for CPC+ practices have yet to be determined or announced. Our proposal is based on our understanding of information that is currently known, with the acknowledgement that further adjustments and refinement may be needed as additional details become available.

COLORADO PROPOSAL FOR SIM – CPC+ ALIGNMENT

The SIM Office proposes to align SIM and CPC+ by creating a specific track for primary care practices that are eligible for and selected to participate in both initiatives. These "SIM/CPC+" practices – which will consist of practices in SIM Cohort 1 and those applying to SIM Cohort 2 that also apply and are accepted to CPC+ – will receive a SIM package of transformation support tailored to wrap-around and build upon the support provided by CPC+.

In addition to the SIM/CPC+ track, the SIM Office will continue to offer a "SIM-Only" participation track for practices that are either ineligible for CPC+ (such as federally-qualified health centers, rural health centers, and pediatric practices), are not accepted to CPC+, or decide to only apply for SIM. Together, these two tracks will constitute the second SIM cohort. The SIM Office anticipates that SIM Cohort 2 will include at least 150 practices.

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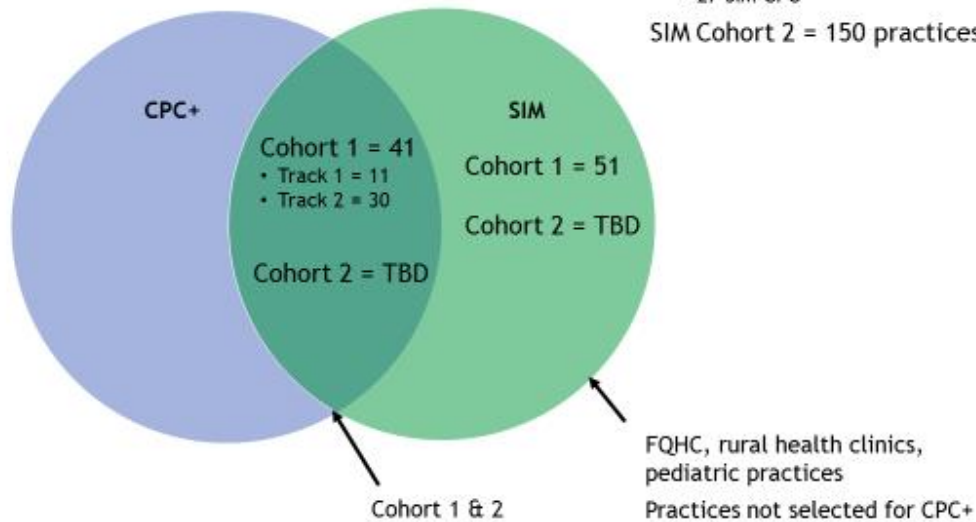

The SIM practice transformation support still will be granted to approximately 400 total practices, as follows:

- Cohort 1: 100 practices began participating in SIM in February 2016. Since that time, 8 practices have withdrawn, resulting in a cohort of 92 practices. Of these, 41 applied and were accepted to participate in CPC+. Practices in Cohort 1 will continue to receive SIM practice transformation support through March 2018.
- Cohort 2: Approximately 150 practices will be selected in total, including a “track” of SIM only practices, and a track of SIM/CPC+ practices. Practices participating in both tracks will receive two years of practice transformation support beginning in September 2017.
- Cohort 3: Practices are anticipated to be selected through a Request for Application (RFA to be released in winter/spring 2018 to begin transformation efforts in fall 2018. These practices will receive one year of transformation support. The size of this cohort will vary depending on the number of practices supported in cohort 2.

This proposal outlines the Colorado SIM model, describing the expectations and supports for SIM-only practices, followed by the outline of expectations and supports proposed for the SIM/CPC+ participating practices.

Colorado SIM Model for SIM-Only Practices

APPLICATION

The SIM Office anticipates that the application period for the second SIM Cohort will open in February 2017, and will run for 6 weeks, through approximately March 31, 2017.

Application for SIM-Only Practices:

Applicants for the SIM-Only track must complete and submit a full SIM application to the University of Colorado.

SELECTION CRITERIA

The University of Colorado will conduct a comprehensive, thorough, complete and impartial evaluation of each practice application – for both the SIM-Only and SIM/CPC+ tracks – submitted for SIM Cohort 2. Practices will be required to meet the same basic eligibility criteria, then will be ranked based on meeting the required and preferred characteristics as well as application responses.

Criteria for SIM-Only Practices:

Practices that apply to SIM only will be reviewed and selected for participation in SIM using the same process used in selecting practices for SIM Cohort 1. Practices must first meet minimum qualifications for participation that are listed in the SIM practice application. Practices meeting the minimum qualifications will then undergo a competitive selection process that involves a ranking of practices using criteria specified in the SIM practice application. In selecting the final list of cohort 2 practices, the SIM Office will also consider payer support as well as factors that affect the overall diversity of the cohort (such as practice geography, size, type, and system representation).

PRACTICE EXPECTATIONS

Expectations of SIM-Only Practices:

Practices selected for SIM cohort 2 will be held to a similar set of expectations as Cohort 1, including:

- Forming a cross-functional SIM implementation team with representation from various roles within the practice
- Allocating time for the SIM implementation team to regularly meet with the practice facilitator and Clinical Health Information Technology Advisor (CHITA)
- Completing activities that help the practice achieve the activities and building block competencies outlined in the revised SIM Practice Transformation Framework (described in following section)
- Reporting on the SIM Clinical Quality Measures
- Participating in two regional collaborative learning sessions annually
- Participating in the SIM evaluation process

Practice Transformation Framework

The SIM Office has worked to revise its set of practice transformation building blocks to better align with payer priorities and provide practices with greater focus regarding transformation activities. The new framework maintains the 10 practice transformation building blocks adapted from Thomas Bodenheimer's "10 Building Blocks of Comprehensive Primary Care" previously used by the SIM initiative. However, the revised framework includes a streamlined set of activities and metrics, identified by SIM-participating payers, that reflect the core competencies needed to integrate behavioral health services into the primary care setting while supporting this integration through a transition from fee-for-service to value-based payments.

The Colorado SIM initiative aims to improve health outcomes for all Coloradans by ensuring that high-quality whole-person care includes behavioral health. The initiative assumes that in order to effectively

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integrate behavioral health and primary care, practices and payers must fundamentally transform the way care is financed and delivered. Participating Colorado payers already have in place alternative payment models (APMs) that support primary care transformation. For SIM, participating payers have payment options for behavioral health integration based on the SIM building block framework (see Appendix A). Payers' existing APMs are already tied to outcomes measures at each plan, and payers are working through the Multi-Payer Collaborative to align their measures in support of behavioral health integration. For SIM, practices are expected to work through the building blocks, and maintain "good standing" with the behavioral health focus of the initiative through successful achievement of specific building block metrics, as outlined below. If practices are not in good standing with SIM, payers will individually determine the impact to their programs. The SIM Office will with work with Practice Transformation Organizations and the University of Colorado, Denver to support transformation and to determine practices' standing. Practice standing information will be shared with payers to inform eligibility for SIM payment structures. "Good standing" is defined as the following for each project year:

For practices participating in SIM only:

- **Project Year 1:** Practices must achieve building blocks 1 through 4 and 7 (as measured by Year 1 Metrics)
- **Project Year 2:** Practices must achieve building blocks 1 through 4 and 7, and two additional building block (as measured by Year 2 Metrics)

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Colorado SIM Practice Transformation Framework (Family and Internal Medicine)

BUILDING BLOCK	MEASURE	YEAR 1 METRICS	YEAR 2 METRICS	DOCUMENTATION
ONE Practice has engaged leadership, supportive of integration and change	Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation under SIM.	Practice establishes agreement(s) with payer(s) covering at least 150 patients Practice has completed an annual budget that includes SIM revenue and planned expenses Practice develops Quality Improvement team and meets monthly Leadership present at meetings & clinical champion attends learning collaboratives Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation signed by leadership	Leadership allocates appropriate resources to complete QI work Practice designs plan to evaluate impact of value-based payment agreements	Attestation using milestones inventory Report selected behavioral health pathway (collaborative care management, on-site behavioral health provider)
TWO Practice uses data to drive change	Practice uses EHR clinical quality measures to provide quarterly panel reports on all SIM measures not extracted through claims data, as well as uses claims data provided through Stratus™ to inform quality improvement processes	Practice successfully submits eCQMs quarterly Practice reviews data with PF/CHITA quarterly Practice begins utilizing model for improvement & has identified opportunities for improvement using CQM data Practice begins utilizing Stratus™ to review cost and utilization data	Practice reviews eCQM & Stratus™ data to inform rapid cycle improvement processes Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data Practice conducts regular PDSA/QI activities on identified CQMs	Attestation of: quarterly reporting of CQMs, PDSA cycles being developed, use of Stratus™

THREE Practice population is empaneled	Practice has, and maintains, at least 75% of its patient population empaneled	Practice has assessed patient panel & assigned PCPs/care teams to 75% of patient population Practice reviews payer attribution lists monthly Practice designs & implements process for validating PCP/care team assignment with patients	Practice maintains 75% empanelment of patient population to provider or care teams Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, & ensuring continuous coverage	Attestation Practice reports empanelment as numerator/ denominator (# of empaneled patients/# of total patients)
FOUR Practice provides team-based care	The care team uses shared operations, workflows, and protocols to facilitate collaboration and consistently implements specific shared workflows rather than informal processes for at least three measures, including at least one behavioral health measure.	Practice uses established tool to assess baseline team relationship Practice has written job descriptions Practice identifies & implements a team-based care strategy (e.g., team huddle, collaborative care planning)	Practice re-evaluates team relationship using tool from Year 1 Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure) Practice performs task distribution activity to inform development of team-based care P&Ps	Attestation
FIVE Practice has built partnership with patients	Practice has established use of evidence-based shared decision-making aids or self-management support tools for at least three, preference-sensitive conditions, including at least one behavioral health condition, and tracks the use of these tools	Practice evaluates patient population to identify three preference-sensitive conditions (with at least one behavioral health condition) that would be appropriate for decision-aids or self-management support tools Practice identifies & selects evidence-based decision-aids or self-management support tools for identified conditions	Practice identifies patients eligible for selected decision aids or self-management support tools Practice implements decision aids or self-management support tools & establishes protocol & workflow for use Practice develops process for tracking & evaluating use of	Attestation

			decision-aids or self-management support tools	
	Practice has established a Patient & Family Advisory Committee (PFAC) to provide input and feedback on practice transformation activities and progress.	Practice has established a Patient & Family Advisory Committee, and meets at least quarterly	Practice uses PFAC to evaluate care experience	Attestation
SIX **Practice is actively managing patient population using data**	Practice uses population-level data to manage care gaps, develop care management care plans and institute those plans for high-risk patients	Practice identifies & has documented a risk stratification methodology Practice identifies strategy to identify care gaps (e.g. patient registry, Stratus™)	75% of empaneled patients are risk-stratified 75% of high-risk patients have documented care plan Practice implements proactive care gap management & tracks outcomes Practice embeds care plan template in EMR	Attestation
SEVEN **Practice has linked primary care to behavioral health & social services**	Practice screens at least 90% of patients for substance use disorder and/or other behavioral health needs, and includes behavioral health and community services as part of care management strategies	Practice has identified behavioral health resources for patients, including health plan support from SIM participating plans Practice has identified a screening tool for reporting on at least two of the five behavioral health screening measures for SIM (depression, maternal depression, anxiety, substance use disorder and developmental screening) and screens 25% of patients	50% of patients are screened for behavioral health condition(s) **Practice performs an assessment of community resources to assist patients with social needs (such as food, housing, transportation)** 50% of patients identified with behavioral health need are connected to resource	Attestation

		Practice has documented process for connecting patients with behavioral health resources (from screening), including standing orders and or/protocols and follow-up		
EIGHT **Practice provides prompt access to care, including behavioral health care**	Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements	Practice has representative with EMR access available 24 hours, 7 days per week **Practice performs an assessment of referral pathways and available after-hours support for behavioral health**	Practice has established a collaborative agreement with at least one behavioral health provider	Attestation
	Clinical data based on collaborative care management agreements with behavioral health providers is able to be shared bi-directionally within 7 days	Practice identifies data sources & technology necessary for bi-directional data sharing	Practice develops plan for bi-directional data sharing with behavioral health provider	Attestation
NINE **Practice provides comprehen-sive care coordination for primary and behavioral health care**	Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with anxiety, depression, and substance use disorder, as compared to non-SIM practices	Practice can identify total cost of care for patient panel, & subset of patients with behavioral health condition Practice identifies & implements policy and procedures that included timely follow-up for ED & hospital admissions	Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation Practice identifies cost drivers for patients with behavioral health condition & incorporates in QI processes Practice creates and reports a measurement to assess impact and	Attestation

			guide improvement on at least one of the following: 1) Notification of ED visit in timely fashion, 2) Medication reconciliation process completed within 72 hrs, 3) Notification of admission and clinical information exchange at the time of admission, or 4) Information exchange between primary care and specialty care related to referrals	
TEN Practice has fully integrated behavioral health care to provide whole-person care	Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment	Practice has identified & documented referral pathway for behavioral health needs (**including assessment of referral pathways and available after-hours support for behavioral health and a representative with EMR access available 24 hours, 7 days per week**) Practice develops a plan to systematically measure & track patient behavioral health outcomes Practice develops care plans that include patient actions to manage behavioral health conditions	Practice systematically measures & tracks patient behavioral health outcomes Practice documents & implements protocols to manage care provided to identify high-risk behavioral health populations Practice identifies & implements at least two opportunities to adjust its protocols to improve behavioral health status of patients	Attestation

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Quality Measure Reporting

The set of 15 SIM clinical quality measures for cohort 1 practices largely aligned with measures used by CPCI, but included three additional measures related to behavioral health – anxiety screening, developmental screening, substance use screening – and diabetes: blood pressure management. Over the last year, the SIM Office engaged Mathematica to develop specifications for these four measures.

For cohort 1, Colorado SIM established a phased approach for practices to report on quality measures. During the first three months of participation, practices were asked to report on three measures (starting with core metrics) as part of an initial "test" period. Practices have been required to report on additional metrics on a quarterly basis, and by year 2 of participation are expected to report on all metrics appropriate for their practice type (adult versus pediatric) in the SIM minimum dataset. Metrics are reported at the practice level through a portal on the University of Colorado practice transformation website.

The SIM Office anticipates using the same set of clinical quality measures and a similar phased reporting approach for Cohort 2 practices. Proposed modifications to the measure set include:

- Updating the measures to align with CPC+ and MACRA
- Working with Mathematica, practices and EHR vendors to determine the feasibility of adding measures developed for anxiety screening, developmental screening, substance use screening, and diabetes: blood pressure management to the practice's EHRs reporting schedules. In situations where such upgrades would be cost-prohibitive, practices would not be required to report on these measures.
- The SIM Office is working with the payers and practice transformation partners at the University of Colorado to determine "priority" measures, which are either the basis for payment, or can be most effectively improved through practice transformation support. At this time, we anticipate that the measure set will remain the same, but practices may be asked to focus efforts on specific metrics.

Clinical Quality Measures for SIM Cohort 2

SIM		
CMS ID	**NQF#**	**Measure Title**
N/A	N/A	Anxiety Screening
CMS 126v4	NQF 0036	Use of Appropriate Medications for Asthma
CMS 125v5	NQF 2372	Breast Cancer Screening
CMS 130v5	NQF 0034	Colorectal Cancer Screening
CMS 2v5	NQF 0418	Screening for Clinical Depression & Follow-up Plan
N/A	NQF 1448	Developmental Screening in the First Three Years of Life
CMS 122v5	NQF 0059	Diabetes: Hemoglobin A1c Poor Control
N/A	NQF 0061	Diabetes: Blood Pressure Management

CMS 139v5	NQF 0101	Falls: Screening for Future Fall Risk
CMS 147v5	NQF 0041	Influenza Immunization
CMS 165v4	NQF 0018	Controlling High Blood Pressure
CMS 82v3	NQF 1401	Maternal Depression Screening
CMS 155v4	NQF 0024	Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents
CMS 69v4	NQF 0421	Body Mass Index (BMI) Screening and Follow-up Plan
Testing phase	NQF 2597	Substance Use Screening Composite

PRACTICE TRANSFORMATION SUPPORT

Support for SIM-Only Practices:

Practices in cohort 2 will be provided with the following package of SIM practice transformation support:

- Technical assistance via:
    - A practice facilitator
    - A CHITA
    - Access to business support services
    - Participation in bi-annual learning collaboratives
    - Access to additional training opportunities
    - Access to a regional health connector

- Financial support via:
    - A $5,000 practice participation payment
    - The opportunity to apply for small grants (up to $40,000 per practice) to support transformation efforts
    - Value-based payment support from at least one SIM-participating payer

Business Support Services

Practices will have access to a set of benefits provided by the Medical Group Management Association (MGMA) that will help them prepare for and receive value-based payments. MGMA will provide practices with instruction and guidance on how business and financial processes – including budgeting, staffing, and billing – function differently in a value-based reimbursement structures, and offer the following tools and learning opportunities:

1) Licenses to *MGMA DataDive™*, a comprehensive, web-based cost and compensation benchmarking data tool; SIM practices will be able to access the Physician Compensation and Production, Management and Compensation, and Cost and Revenue data sets

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2) Monthly webinars and open office hours on *MGMA DataDive™*: how to participate in, understand, and effectively use the information and benchmarking available through MGMA's proprietary software
3) Monthly webinars on elements of improving business processes needed to succeed in value-based compensation

In addition, starting in March 2017 MGMA will offer a four-month skills development program for practice physicians and administrators aimed at developing essential skills for success in value-based payments arrangements. Training will consist of one face-to-face session and three remote sessions (one being post program follow-up), and cover topics including:

- Care management care coordination staffing models and budgeting for such services
- Care coordination codes, SBIRT codes and behavioral health codes and other ancillary codes for reimbursement documenting and billing
- Staffing models, billing and budgeting for various forms of telehealth, such as behavioral health, tele-psychiatry, physician to physician etc.
- Assisting SIM practices with SIM payer contract requirements for practice efficiency and outcomes
- Practice budgeting for Medicare practices with MACRA/MIPS in mind
- Understanding and using the state total cost of care data at the practice level

Practice Achievement payments

The SIM Office is proposing to repurpose approximately $2.4 million formerly allocated to the SIM Funding Stream of the Practice Transformation Fund to provide non-competitive payments of up to $8,000 that would be directly tied to achievement of activities within the SIM practice transformation building blocks. A copy of this proposal is included as Attachment B.

Behavioral Health Integration

Behavioral health integration (BHI) refers to members of a primary care team and behavioral health practitioners working together with patients and families and using a systematic, cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization. Colorado Sim is built on the foundation of comprehensive primary care inclusive of behavioral health integration. With the introduction of strategies to support behavioral health integration into CPC+, Colorado has chosen to align our models to assure synergy and success for our practices.

Practices in SIM will be able to choose one of two pathway for behavioral health integration based on their practice capacity, patient population needs, and supportive payment models available:

- Care Management for mental illness or
- Primary Care Behaviorist Model

These strategies provide the framework for building integrated behavioral health into primary care settings, facilitated by payment reform, and will help guide practices as they achieve the building block

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metrics. When considering which strategy to use as the basis for behavioral health integration, practices may consider:

- Prevalence, severity, and range of mental health conditions in the population served by the practice.
- Effect of behavioral health conditions on physical health in the population served by the practice.
- Current or planned practice-based screening for behavioral health conditions and psychosocial stressors.
- Existing resources including: care manager background/interest/training; space; teleconferencing equipment; community resources including behavioral health specialists.
- New resources needed to achieve the integrated care goals including capital investments, personnel, and technology costs.

Option 1: Care Management for Mental Illness
Individuals with the identified mental health condition should be offered proactive, relationship-based care management (CM), with specific attention to care management of the mental health condition (e.g., Major Depressive Disorder/Dysthymia, Generalized Anxiety Disorder, and Panic Disorder). Practices that develop their capabilities to deliver care management for mental illness will work through the SIM building blocks to successfully:

- Select mental health condition(s) to prioritize and method to identify patients to target for care management.
- Identify or develop stepped care, evidence-based, treatment algorithms for mental health condition(s) identified for care management, incorporating principles of shared decision making and self-management support.
- Develop a workflow for screening, enrollment in integrated care services, process for referral when necessary, tracking follow up and response to treatment, and communicating with patients.
- Identify a practitioner or team member (e.g., RN or behavioral health specialist) who will provide care management and ensure training to support stepped care approach.

Option 2: Primary Care Behaviorist Model (PC Behaviorist)
The PC Behaviorist model integrates behavioral health into the primary care workflow through warm handoffs or coordinated referrals to a co-located behavioral health professional to address mental illness in the primary care setting and behavioral strategies for health behavior change, management of chronic general medical illnesses, and facilitate specialty care engagement for serious mental illness. Practices that choose the primary care behaviorist model will work through the SIM building blocks to successfully:

- Select mental health condition(s) to prioritize and method to identify patients to target for referral to the primary care behaviorist.
- Identify a credentialed behavioral health provider (e.g., psychologist, social worker) trained in the primary behaviorist model of co-located care. (If the behavioral health professional does not have training, they may engage in training during the participation in SIM.)
- Develop a workflow for screening, enrollment in integrated care services, tracking follow up and response to treatment, and communicating with patients.
- Develop a workflow to integrate referrals (warm hand-offs) to the behavioral health specialist.

PAYMENT MODELS

Payer Support of SIM-Only Practices:

Practices that participate in SIM-Only will receive payer support through payment models that each payers establishes for SIM. Participating payers have agreed to apply organization-specific payment model(s) and establish their own agreements with practices selected for SIM. Payers are utilizing models in Categories 2 and 3 of the Health Care Payment and Learning Action Network's Alternative Payment Model framework, with an aim to evolve toward Category 4 methodologies during the 4 year timeline of SIM.

Although the payers have committed to making a good faith effort to align payment models for SIM around a common set of metrics and accountability targets, the SIM Office did not strictly define parameters for alignment. The SIM Office is currently working with payers to establish a clearer and more transparent understanding of payment model alignment under SIM, through a collaborative and voluntary process. While each payer is utilizing their own payment model to support SIM's transformation goals, SIM payment models for Cohorts 1 and 2 include the following elements:

- Fee-for-service payments;
- Payments that including behavioral health integration through one of the following mechanisms:
    - Up-front payments;
    - Population-based payments (e.g., PMPM)
    - Care coordination payments;
    - Payments for additional codes; and
- Shared savings opportunities OR incentive payments based on performance and/or outcomes linked to quality.

Payment support for practices participating in CPC+ and SIM or in SIM-Only will be clearly communicated to all practices prior to their decision to participate in either or both initiatives, to avoid mismatched expectations between practices and payers.

Colorado SIM Model for SIM/CPC+ Participating Practices

APPLICATION

The SIM Office anticipates that the application period for the second SIM Cohort will open in February 2017, and will run for 6 weeks, through approximately March 31, 2017.

Application for SIM/CPC+ Practices:

Applicants for the SIM/CPC+ track must also complete and submit a full SIM application to the University of Colorado.

SELECTION CRITERIA

The University of Colorado will conduct a comprehensive, thorough, complete and impartial evaluation of each practice application submitted for SIM Cohort 2. SIM/CPC+ practices will be required to meet

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the same basic eligibility criteria and SIM-only practices, then will be ranked based on meeting the required and preferred characteristics as well as application responses.

Criteria for SIM/CPC+ Practices:

Practices that apply to CPC+ and SIM will be evaluated and ranked using the same criteria as the SIM-only applicants and included in a combined rank ordering of SIM only and CPC+/SIM applicants. The SIM Office will actively recruit practices that were not selected for CPC+ for SIM-Only participation.

PRACTICE EXPECTATIONS

Expectations of SIM/CPC+ Practices:

Practices that participate in CPC+ and SIM will be expected to adhere to all expectations outlined for CPC+ participation, including:

- Undertaking care delivery transformation activities outlined in the Care Delivery Requirements established by CMS, focused around five Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health
- Participating in the CPC Learning system
- Reporting on the practice-level measures established annually by CMS
- Participating in the CMS evaluation process

Recognizing the burdens associated with participating in multiple concurrent initiatives, the SIM Office proposes that practices selected for CPC+ and SIM would be expected to meet a modified set of SIM requirements, as outlined below.

Practice Transformation Framework

The SIM building block framework closely aligns with the Five Primary Care Functions that form the basis for the CPC+ care delivery design. Both models recognize the central importance of primary care in improving health outcomes and reducing costs, and include activities designed to improve a practice's capacity to deliver comprehensive, coordinated, whole-person care. The revised SIM Practice Transformation framework includes many elements of the Care Delivery Requirements for CPC+, but includes a specific focus on behavioral health. A cross-walk of the CPC+ Primary Care Functions and the ten building blocks of the SIM Practice Transformation Framework is included as Attachment C.

Practices participating in SIM and CPC+ would be expected to demonstrate achievement of all activities associated with building blocks 1,2,3,4, and 7 of the revised SIM Practice Transformation framework, for the appropriate participation year, to remain in "good standing" with SIM. The activities in these building blocks focus on achieving or improving core competencies around comprehensive primary care delivery, which are fundamental to both initiatives. Practices that are enrolled in SIM and CPC+ will be given the opportunity to focus their efforts on activities related to building blocks 8, 9, and 10, which are more specific to behavioral health and compliment the foundational work that practices will do within each factor for CPC+. SIM and CPC+ practices will receive practice transformation and CHITA support in achieving these advanced activities (see model below).

As noted above, the SIM Office recognizes that practices in CPCI that were selected to participate in CPC+, as well as practices accepted to Track 2, will be required to develop their capacities to integrate behavioral health into care delivery through at least 1 of two pathways laid out by CMMI: care

management for mental illness, or a primary care behaviorist model. SIM has adopted a similar approach, with the same pathways, for both SIM and CPC+ practices and SIM-only practices to ensure alignment and coordination (determining and developing a plan for either path is one of the activities in building block 1).

In addition, CMS expects CPC+ practices that have already integrated foundational strategies into their workflows to implement targeted tactics to support more robust behavioral health integration, which potentially include:

- Screening and brief intervention for alcohol misuse
- Cognitive behavioral therapy (CBT)
- Problem-solving therapy (PST), or mindfulness-based therapies for chronic pain conditions
- Supporting behavior change for high-risk conditions (e.g., tobacco cessation, obesity, and medication adherence).

All SIM practices will be working on similar tactics or activities; however, SIM contains additional complimentary activities in building blocks 8-10 that are not included in current CPC+ guidance that will strengthen the practices ability to be successful in integrating behavioral health into their practice and working within alternative payment models:

- Bi-directional data sharing between primary care and behavioral health providers;
- Identifying total costs of care and cost drivers for patients with behavioral health conditions and incorporating this data into quality improvement processes; and
- Measuring and tracking behavioral health outcomes.

The value for practices participating in both SIM and CPC+ is the additional support available to complete building blocks 8 through 10, ensuring the practice is well posed to be successful in CPC+ and prepared for MACRA. Practices would be expected to achieve the activities outlined in building blocks 8 through 10 and would receive additional SIM-specific support to accelerate their advancement.

For practices participating in SIM and CPC+:

- **Project Years 1 & 2:**
    - Practices must achieve the Project year 1 and Year 2 metrics (these overlap with CPC+ factors--see appendix for crosswalk)
    - Practices will focus on be achieving the metrics in building blocks 8 through 10 after successful completion of foundational building blocks

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Colorado SIM Practice Transformation Framework (Family and Internal Medicine)

BUILDING BLOCK	MEASURE	YEAR 1 METRICS	YEAR 2 METRICS	DOCUMENTATION
ONE Practice has engaged leadership, supportive of integration and change	Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation under SIM.	Practice establishes agreement(s) with payer(s) covering at least 150 patients Practice has completed an annual budget that includes SIM revenue and planned expenses Practice develops Quality Improvement team and meets monthly Leadership present at meetings & clinical champion attends learning collaboratives Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation signed by leadership	Leadership allocates appropriate resources to complete QI work Practice designs plan to evaluate impact of value-based payment agreements	Attestation using milestones inventory Report selected behavioral health pathway (collaborative care management, on-site behavioral health provider)
TWO Practice uses data to drive change	Practice uses EHR clinical quality measures to provide quarterly panel reports on all SIM measures not extracted through claims data, as well as uses claims data provided through Stratus™ to inform quality improvement processes	Practice successfully submits eCQMs quarterly Practice reviews data with PF/CHITA quarterly Practice begins utilizing model for improvement & has identified opportunities for improvement using CQM data Practice begins utilizing Stratus™ to review cost and utilization data	Practice reviews eCQM & Stratus™ data to inform rapid cycle improvement processes Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data Practice conducts regular PDSA/QI activities on identified CQMs	Attestation of: quarterly reporting of CQMs, PDSA cycles being developed, use of Stratus™

THREE Practice population is empaneled	Practice has, and maintains, at least 75% of its patient population empaneled	Practice has assessed patient panel & assigned PCPs/care teams to 75% of patient population Practice reviews payer attribution lists monthly Practice designs & implements process for validating PCP/care team assignment with patients	Practice maintains 75% empanelment of patient population to provider or care teams Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, & ensuring continuous coverage	Attestation Practice reports empanelment as numerator/ denominator (# of empaneled patients/# of total patients)
FOUR Practice provides team-based care	The care team uses shared operations, workflows, and protocols to facilitate collaboration and consistently implements specific shared workflows rather than informal processes for at least three measures, including at least one behavioral health measure.	Practice uses established tool to assess baseline team relationship Practice has written job descriptions Practice identifies & implements a team-based care strategy (e.g., team huddle, collaborative care planning)	Practice re-evaluates team relationship using tool from Year 1 Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure) Practice performs task distribution activity to inform development of team-based care P&Ps	Attestation
FIVE Practice has built partnership with patients	Practice has established use of evidence-based shared decision-making aids or self-management support tools for at least three, preference-sensitive conditions, including at least one behavioral health condition, and tracks the use of these tools	Practice evaluates patient population to identify three preference-sensitive conditions (with at least one behavioral health condition) that would be appropriate for decision-aids or self-management support tools Practice identifies & selects evidence-based decision-aids or self-management support tools for identified conditions	Practice identifies patients eligible for selected decision aids or self-management support tools Practice implements decision aids or self-management support tools & establishes protocol & workflow for use Practice develops process for tracking & evaluating use of	Attestation

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			decision-aids or self-management support tools	
	Practice has established a Patient & Family Advisory Committee (PFAC) to provide input and feedback on practice transformation activities and progress.	Practice has established a Patient & Family Advisory Committee, and meets at least quarterly	Practice uses PFAC to evaluate care experience	Attestation
SIX Practice is actively managing patient population using data	Practice uses population-level data to manage care gaps, develop care management care plans and institute those plans for high-risk patients	Practice identifies & has documented a risk stratification methodology Practice identifies strategy to identify care gaps (e.g. patient registry, Stratus™)	75% of empaneled patients are risk-stratified 75% of high-risk patients have documented care plan Practice implements proactive care gap management & tracks outcomes Practice embeds care plan template in EMR	Attestation
SEVEN Practice has linked primary care to behavioral health & social services	Practice screens at least 90% of patients for substance use disorder and/or other behavioral health needs, and includes behavioral health and community services as part of care management strategies	Practice has identified behavioral health resources for patients, including health plan support from SIM participating plans Practice has identified a screening tool for reporting on at least two of the five behavioral health screening measures for SIM (depression, maternal depression, anxiety, substance use disorder and developmental screening) and screens 25% of patients	50% of patients are screened for behavioral health condition(s) **Practice performs an assessment of community resources to assist patients with social needs (such as food, housing, transportation)** 50% of patients identified with behavioral health need are connected to resource	Attestation

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		Practice has documented process for connecting patients with behavioral health resources (from screening), including standing orders and or/protocols and follow-up		
EIGHT **Practice provides prompt access to care, including behavioral health care**	Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements	Practice has representative with EMR access available 24 hours, 7 days per week **Practice performs an assessment of referral pathways and available after-hours support for behavioral health**	Practice has established a collaborative agreement with at least one behavioral health provider	Attestation
	Clinical data based on collaborative care management agreements with behavioral health providers is able to be shared bi-directionally within 7 days	Practice identifies data sources & technology necessary for bi-directional data sharing	Practice develops plan for bi-directional data sharing with behavioral health provider	Attestation
NINE **Practice provides comprehen-sive care coordination for primary and behavioral health care**	Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with anxiety, depression, and substance use disorder, as compared to non-SIM practices	Practice can identify total cost of care for patient panel, & subset of patients with behavioral health condition Practice identifies & implements policy and procedures that included timely follow-up for ED & hospital admissions	Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation Practice identifies cost drivers for patients with behavioral health condition & incorporates in QI processes Practice creates and reports a measurement to assess impact and	Attestation

			guide improvement on at least one of the following: 5) Notification of ED visit in timely fashion, 6) Medication reconciliation process completed within 72 hrs, 7) Notification of admission and clinical information exchange at the time of admission, or 8) Information exchange between primary care and specialty care related to referrals	
TEN Practice has fully integrated behavioral health care to provide whole-person care	Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment	Practice has identified & documented referral pathway for behavioral health needs (**including assessment of referral pathways and available after-hours support for behavioral health and a representative with EMR access available 24 hours, 7 days per week**) Practice develops a plan to systematically measure & track patient behavioral health outcomes Practice develops care plans that include patient actions to manage behavioral health conditions	Practice systematically measures & tracks patient behavioral health outcomes Practice documents & implements protocols to manage care provided to identify high-risk behavioral health populations Practice identifies & implements at least two opportunities to adjust its protocols to improve behavioral health status of patients	Attestation

Quality Measure Reporting

CPC+ practices will be required to report on nine of 14 metrics annually at the practice level. Of the 14 identified measures, five overlap with SIM quality metrics. The SIM Office proposes to accept the CPC+ measures where they align with existing SIM measures – depression and substance abuse – provided that practices select those aligned measures within the reporting groups.

CPC +		
CMS ID	**NQF#**	**Measure Title**
Report 2 of Group 1 outcome measures		
CMS 159v5	0710	Depression Remission at Twelve Months
CMS 165v5	0018	Controlling High Blood Pressure
CMS 122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)*
Report 2 of Group 2 complex care measures:		
CMS 156v5	0022	Use of High-Risk Medications in the Elderly
CMS 149v5	N/A	Dementia: Cognitive Assessment
CMS 139v5	0101	Falls: Screening for Future Fall Risk*
CMS 137v5	0004	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment
Report 5 of 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):		
CMS 50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report
CMS 124v5	0032	Cervical Cancer Screening
CMS 130v5	0034	Colorectal Cancer Screening
CMS 131v5	0055	Diabetes: Eye Exam
CMS 138v5	0028	Tobacco Use: Screening & Cessation Intervention
CMS 166v6	0052	Use of Imaging Studies for Low Back Pain
CMS125v5	2372	Breast Cancer Screening

SIM		
CMS ID	**NQF #**	**Measure Title**
N/A	N/A	Anxiety Screening
CMS 126v4	NQF 0036	Use of Appropriate Medications for Asthma
CMS 125v5	NQF 2372	Breast Cancer Screening
CMS 130v5	NQF 0034	Colorectal Cancer Screening
CMS 2v5	NQF 0418	Screening for Clinical Depression & Follow-up Plan
Under dev	NQF 1448	Developmental Screening in the First Three Years of Life
CMS 122v5	NQF 0059	Diabetes: Hemoglobin A1c Poor Control
N/A	NQF 0061	Diabetes: Blood Pressure Management
CMS 139v5	NQF 0101	Falls: Screening for Future Fall Risk
CMS 147v5	NQF 0041	Influenza Immunization
CMS 165v4	NQF 0018	Controlling High Blood Pressure
CMS 82v3	NQF 1401	Maternal Depression Screening
CMS 155v4	NQF 0024	Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents
CMS 69v4	NQF 0421	Body Mass Index (BMI) Screening and Follow-up Plan
Testing phase	NQF 2597	Substance Use Screening Composite

The SIM Office is still working to refine and update CQM reporting requirements for all practices, including SIM-only and SIM/CPC+, hopes to work with CMS to explore potential mechanisms for reducing the burdens associated with metric reporting for both initiatives. As presently structured, practices participating in both initiatives will be required to report metric information in the form of practice-level numerators and denominators, through different systems. The benefits of having aligned

(overlapping) measures is therefore negated to a degree, as practices will still be required to enter the same data in different locations. However, we could lift part of the reporting burden if CMS would share measure data reported by SIM and CPC+ practices with the Colorado SIM Office.

Learning Collaborative Participation

Practices participating in CPC+ and SIM will be required to participate in all elements of the CPC+ Learning System and activities. In addition, practices will be given access to all SIM collaborative learning sessions and online modules, which provide the opportunity for continuing medical education and/or maintenance of certification credits. SIM may also create or tailor in-person collaborative learning sessions and/or online resources to complement CPC+ resources that will be available to practices participating in both initiatives.

As additional information about the National and Regional Learning Communities is available, the SIM Office would like to work with CMS to coordinate learning activities between the initiatives to avoid duplication and maximize the breadth and scope of resources available to participating practices.

Evaluation

The SIM Office has been in regular communication with the federal evaluators of the SIM initiative in an effort to coordinate state and federal evaluation efforts wherever possible. While understanding the limitations and/or restrictions around data sharing, SIM would like the opportunity to engage with the selected federal evaluator for CPC+ in an effort to minimize the evaluation activities that practices will be expected to engage in for both initiatives.

PRACTICE TRANSFORMATION SUPPORT

Support for SIM/CPC+ Practices:

Practices that participate in both CPC+ and SIM will receive a limited package of practice transformation support that adds to the resources available to CPC+ practices rather than duplicates them. This support will differ from that accessed by SIM-only practices in the following ways:

- Financial support will include a practice participation payment, but SIM/CPC+ practices will not be eligible to apply for small grants through the Practice Transformation fund
- The package of technical assistance offered to practices will complement, rather than duplicates, what is offered by CMS via the CPC+ initiative.
- Three areas of proposed, enhanced technical assistance and support for SIM/CPC+ practices include:
    - Additional practice transformation support focused on behavioral health integration
    - Business consultation and support
    - Health information technology assistance

Practice Achievement payments

The SIM Office is proposing to repurpose approximately $2.4 million formerly allocated to the SIM Funding Stream of the Practice Transformation Fund to provide non-competitive payments of up to $8,000 that would be directly tied to achievement of activities within the SIM practice transformation building blocks. A copy of this proposal is included as Attachment B.

Behavioral Health Integration

As previously noted, practices in CPC+ and SIM will be expected to focus their efforts on achieving the activities outlined in building blocks 8-10 of the revised SIM Practice Transformation framework, which relate specifically to behavioral health integration. SIM practice facilitators and CHITAs for these practices would tailor their hands-on, on-site support towards these activities and objectives, including:

- Identifying data sources and technology needed for bi-directional data sharing, and developing a plan for bi-directional data sharing with behavioral health providers
- Identifying total costs of care and cost drivers for patients with behavioral health conditions, and incorporating this data in quality improvement processes
- Developing and implementing processes to systematically measure and track patient behavioral health outcomes

The SIM Office recognizes that CPCI practices accepted to CPC+ and practices accepted to CPC+ Track 2 will be required to develop their capacities around integrated care delivery. The degree to which the behavioral health foundational strategies and target tactics will be supported through CMS technical assistance is unclear at this time. The SIM Office is committed to working with CMMI to ensure that the SIM practice transformation support available to SIM and CPC+ practices does not overlap or duplicate services provided through CPC+ and is a true value-add to practices participating in both initiatives.

Business Support Services

Practices participating in CPC+ and SIM will have access to the same set of business supports that are available to SIM-only practices.

Health Information Technology Assistance

As indicated in the CPC+ Request for Application (V3.1), practices in both CPC+ tracks will be required to use certified Health IT and ensure that care team (or covering care team) members have real time, remote 24/7 access to the medical record. Practices in both tracks will also need to report on electronic clinical quality measures (eCQMs) and generate quality reports at the practice and panel/care team level. In addition, Track 2 practices will be required to implement enhanced tools that support more comprehensive and coordinated care of patients with complex needs. To achieve optimized EHR/HIT use, Track 2 practices will work with their EHR vendors as a condition of participation.

The CPC+ RFA also notes data sharing will be an important component of CPC+, and practices in both tracks will receive regular feedback data to inform their efforts to impact patient experience, clinical quality measures, and utilization measures that drive total cost of care. However, CMS also acknowledges: "We expect that participating primary care practices will have widely varying resources and technical capabilities to interpret and use data from disparate sources and payers, as we saw in the Original CPC model. While some Original CPC practices have internal technical and analytic resources to manipulate and understand their cost and utilization data, many practices have just begun to use these kinds of data in their work. Building on lessons learned in the Original CPC model, we recognize the need to pursue multiple approaches to data sharing to accommodate the broad range of practices' needs and capabilities, existing regional resources, and regional payer priorities."

Colorado SIM, which shares core goals with CPC+ around the use of technology and data to drive care delivery and payment reform, provides practices with several sources of support to improve and enhance the use of EHRs and cost and utilization data, and how these tools can be incorporated into

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practice workflows to improve the quality and efficiency of patient care. Colorado SIM proposes to provide SIM-CPC+ practices with the following additional resources to assist with HIT adoption and utilization.

CHITA support

- Assist with practice data reporting and review of data quality plan
- Build/support practice data capacity
- Analyze and identify ways to improve practice data systems
- Optimize workflows for data collection, reporting, and analysis
- Use data to guide improvement priorities

Health Information Exchange support

- Support connecting to a Health Information Exchange (HIE) to share data and coordinate care
- Subsidies for non-profit practices to install or upgrade broadband, a key step toward developing the infrastructure necessary to provide telehealth services

PAYMENT MODELS

Payer Support of SIM/CPC+ Practices:

Practices that participate in both CPC+ and SIM will receive payer support through payment models that each payer participating in CPC+ has established for that initiative. CMS requires participating payers to align their CPC+ payment models with Medicare's overall approach to key payment, quality and data-sharing elements for Track 1 and Track 2. Medicare is a participating payer in CPC+.

The SIM Office is **not** proposing to require that payers participating in CPC+ and SIM offer separate or additional payments to practices participating in both initiatives. The SIM Office anticipates that payers participating in CPC+ will support SIM/CPC+ practices through the payment model established for CPC+ (which may or may not match the model they elect to use under SIM). Payers may elect to provide additional support to practices participating in both initiatives, but will not be required to do so.

In addition, not all payers participating in SIM are also participating in CPC+. Payers that are not participating in CPC+, but have signed the memorandum of understanding (MOU) with the SIM Office, have pledged to make good faith efforts to provide value-based payments to SIM-participating practices within their networks. However, practices selected to participate in CPC+ and SIM may or may not receive payment support for SIM participation from payers that are not participating in CPC+.

Finally, the SIM Office is **not** proposing to require payers that are participating in CPC+ and SIM to offer the same payment model to practices participating in SIM only. Payers may elect to use the same payment model for both initiatives, and provide the same level of support, but will not be required to do so.

Conclusion

Colorado SIM remains committed to its vision of creating a coordinated, accountable system of care that will provide Coloradans access to integrated primary care and behavioral health in the setting of a patient's medical home. We believe alignment with CPC+ will allow us to broaden and strengthen the foundation for healthcare transformation in Colorado, which will benefit current and future initiatives in the state. This proposal offers an initial outline of how we see these two programs working together,

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and we are open to exploring different options. We appreciate your time and consideration, and look forward to hearing your feedback.

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ATTACHMENT A – Pathways to Transformation

Colorado Multi-Payer Collaborative
Pathway to Transformation

Colorado is home to more than 5 million people, whose health needs are met by over 6,000 primary care providers throughout the state. Colorado seeks to improve population health outcomes, patient and provider experiences, and to control costs while ensuring access to high-quality, evidence-based, and coordinated care. This level of transformation requires innovation, significant investment of resources, and intense coordination across all sectors of the health care system.

The Colorado Multi-Payer Collaborative's (Collaborative) mission is to *"increase quality, improve efficiency, higher value, continuous improvement and diffusion of innovative and successful strategies through increased system accountability, improved health outcomes and experiences for patients and providers, and decreased total cost of care."* The Collaborative contributes to Colorado's health transformation goals by transforming the way care is financed and delivered. To do this, the Collaborative has initially focused on primary care transformation by supporting coordinated payment methodologies, the use of actionable data, and practice learning.

While practices, payers, and other stakeholders in Colorado are on an overall path to transformation, there are multiple initiatives (or "entry points") in the state designed to transform the way in which primary care is delivered and financed. The Collaborative recognizes that each of these initiatives is important in achieving the goals outlined above, and there are design elements that are common across many of the initiatives along the transformation path (See figure 1 Colorado's Path to Transformation). In Colorado, practices are able to choose the entry point that makes the most sense for them, to actively work on transformation, move towards whole-person care supported by value-based payments, and receive common elements of support—regardless of entry point or initiative. There is no wrong way to enter the transformation path.

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Figure 1. ***Colorado's Path to Transformation***

While many initiatives have common transformation elements, each also has its own requirements and area of focus. As a result, some practices may not be eligible for all "entry points" along the transformation path, and certain initiatives may be better suited to practices' specific goals and objectives than other. However, there is at least one point of entry appropriate for every primary care practice in Colorado that chooses to participate (See Figure 2 Transformation Initiatives Overview).

Figure 2. ***Transformation Initiatives Overview***

	CPC+	Payer-Specific	SIM	TCPI
Multi-Payer Support	6 payers & CMS	1 payer*	8 payers	? payers
Value-based Payments	X	X	X	
Performace-based Incentives	X	X	X	
Population Management	X	X	X	
Whole Person Care	Behavioral Health Integration		Behavioral Health Integration	
Cost & Quality Metrics	X	X	X	
Metrics Reporting	EHR & Stratus		EHR & Stratus	
Practice Support & Coaching	National & Regional Supports	Payer Supports	Regional PTOs	

* *While multiple payers have their own initiatives, practices would engage with only one payer on payer-specific initiatives*

The Collaborative is comprised of public and private payers working together to align measures, resources, and payment methodologies to reduce practice burden, and to support the transformation path, regardless of the entry point a practice uses.

ATTACHMENT B – Payment Proposal

Proposal for Achievement-Based Payments to Support Practice Transformation

January 2, 2017

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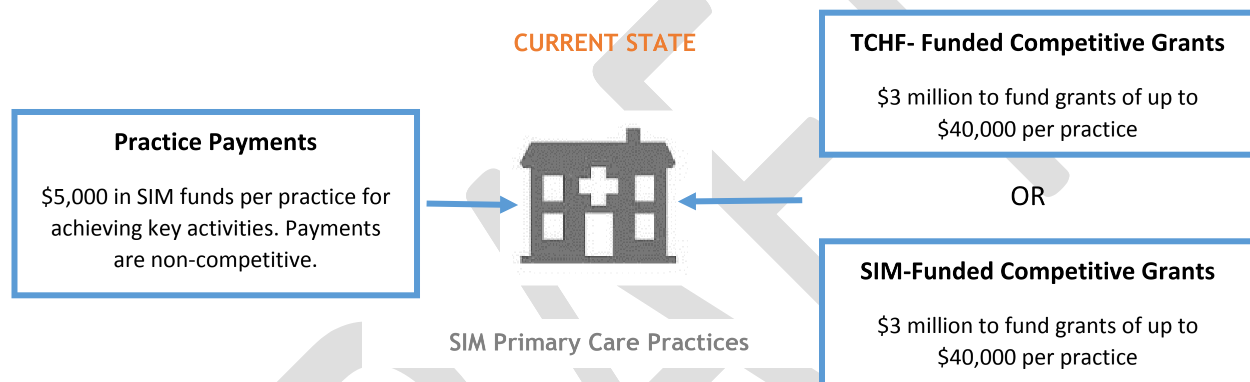
Background:

Practice Transformation in SIM: Colorado SIM currently supports 93 primary care practices in advancing comprehensive primary care, preparing to accept value based payments, and integrating behavioral healthcare. The SIM Office anticipates recruiting a second cohort of approximately 150 practices in 2017 and a third cohort of 150 practices in 2018.

Financial Support for Practices: Currently, SIM practices qualify for payments of up to $5,000 for completing key activities, such as reporting on clinical quality measures and attending twice-yearly Collaborative Learning Sessions. In addition to these non-competitive payments, a Practice Transformation Fund, consisting of approximately $3 million in federal SIM funds from CMMI and approximately $3 million in funds from The Colorado Health Foundation (TCHF), was established to fund competitive grants of up to $40,000. These grants are intended to help SIM practices advance toward greater integration of behavioral healthcare and to implement their practice improvement plans.



A request for applications (RFA), was issued in April of 2016. Practices could apply for a small grant from either a SIM funding stream or a TCHF funding stream (but not both). A total of 66 practices submitted applications, 42 to the TCHF funding stream and 24 to the SIM funding stream. A total of 27 practices were selected to receive funds through the TCHF funding stream, and 20 were selected to receive funds through the SIM funding stream. Currently, the SIM Office anticipates disbursing $879,274.00 in grants from TCHF funding stream and $598,036.00 from the SIM funding stream to the practices currently participating in the first cohort of SIM, leaving approximately $4.5 million in the Practice Transformation Fund to support practices in cohorts 2 and 3.

Proposed Strategy:

For cohorts 2 and 3, the SIM Office is proposing to repurpose the approximately $2.4 million of funds in the SIM funding stream of the Practice Transformation Fund and using them to provide non-competitive payments of up to $8,000 that would be directly tied to achievement of activities within the SIM practice transformation building blocks. The $5,000 payments already in existence and the competitive grants from The Colorado Health Foundation would continue to remain in place. However, competitive grants would only be available to practices that are not also participating in CPC+.

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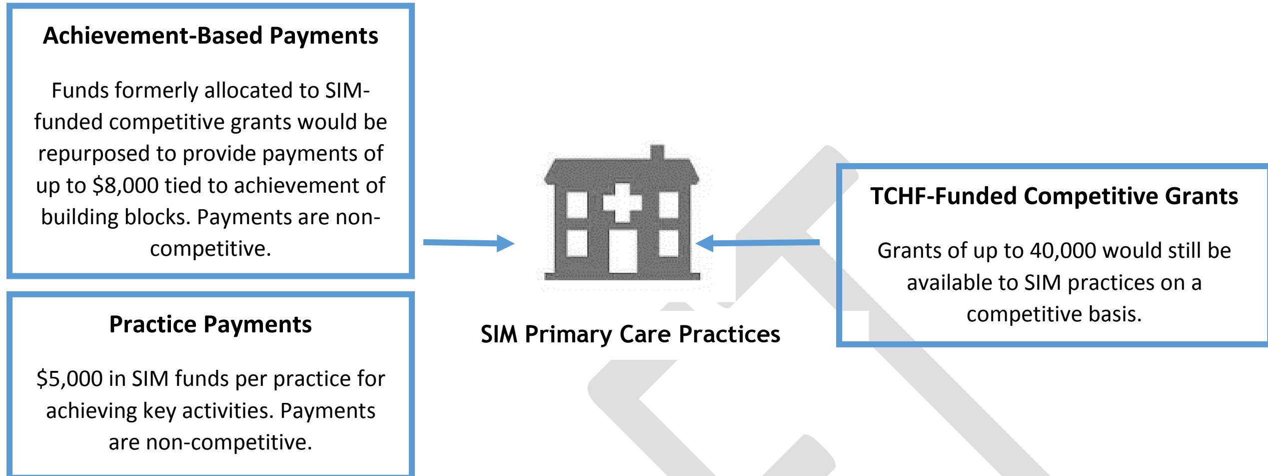

Proposed Eligibility for Funding by Practice Type
(Cohorts 2 and 3)

	Practice Payments (Up to $5,000)	Achievement Based Payments (Up to $8,000)	Colorado Health Foundation Grants (Up to $40,000)
SIM-Only Practice	x	x	x
CPC+/SIM Practice	x	x	

Rationale for Proposed Strategy:

Repurposing the SIM small grants as a means of increasing participation payments would offer several advantages:

Encouraging Practices to Achieve Key Competencies: Achievement-based payments directly tied to SIM building blocks that build practice capacity will help to ensure practice progress toward SIM goals (more information on the SIM building blocks follows below). By repurposing grant funds, the SIM Office can better support meaningful achievement of the 10 building blocks across all SIM practices, rather than concentrating resources on a smaller number of participants.

Reducing Burden on Practices: While the SIM Office attempted to streamline the application process for grant applicants, SIM practices still provided feedback that filling out an additional grant application presented a significant challenge, as most practices had little to no prior experience applying for grants and very few resources to commit to the process. By tying payment to achievement of building blocks, the SIM Office could ensure that even those practices that were unable to apply for a grant (or were

unsuccessful in the competitive process), could still benefit from resources that would support achievement of building blocks.

Increasing Capacity of the SIM Office: The SIM Office has limited staff capacity to administer a very complex initiative. Administration of the small grants has presented a substantial burden for the SIM Office. Writing and releasing an RFA that reflects two funding streams, reviewing applications, coordinating with two funders, drafting purchase orders, reviewing deliverables, managing payment, and supporting 47 awardees during the first cohort has created a significant drain on resources that will only be exacerbated as more practices come on board. By limiting the amount of grants to the TCHF funding stream, the SIM Office can dedicate staff to other impactful activities that ensure practice progress.

Greater Likelihood of Practice Recruitment for Future Cohorts: Increasing the amount that all practices are eligible to earn will likely attract more practices to the SIM initiative. As the SIM Office looks to recruit practices for cohorts 2 and 3, providing as much clarity regarding the package of support offered to practices is critical. The ability to concretely state what financial supports practices will receive, as opposed to the ambiguity presented by a competitive grant process, may make participating in SIM more appealing to potential applicants. This shift can ultimately help Colorado SIM achieve its goal of supporting 400 practices across the state.

Overview of SIM Practice Transformation Building Blocks:

In order to receive grant funds, SIM practices had to clearly describe how proposed activities would help them achieve goals in their practice improvement plans that are tied to the Cohort 1 practice transformation building blocks. Each of the ten building blocks, adapted from Thomas Bodenheimer's "Ten Building Blocks of Comprehensive Primary Care," includes specific activities designed to build practice competencies to provide more comprehensive primary care, transition to value based payments, and integrate behavioral health.

For Cohorts 2 and 3, the SIM Office has worked to revise its set of practice transformation building blocks to better align with payer priorities and provide practices with greater focus regarding transformation activities. The new framework maintains the ten practice transformation building blocks previously used by the SIM initiative, but now includes a streamlined set of activities and metrics, approved by SIM-participating payers, that better reflect the core competencies needed to integrate behavioral health services into the primary care setting while supporting this integration through a transition from fee-for-service to value-based payments.

Practices will be expected to work toward achieving each activity associated with the appropriate year of their participation in the SIM initiative. However, in order to remain in "good standing" with payers, practices must demonstrate achievement of all activities associated with building blocks 1,2,3,4, and 7, for the appropriate participation year, which have been identified as high priorities by payers. Practices that fail to meet activities affiliated with each milestone at the end of each SIM year (or to demonstrate progress toward activities during the year) will be reviewed by the Quality Assurance Committee; if practices are not in good standing with SIM, payers will individually determine the impact to their programs. Furthermore, practices that are also enrolled in CPC+ are expected to focus their efforts on activities related to building blocks 8, 9, and 10 after achieving the activities outlined in building blocks 1,2,3,4, and 7.

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The attached document reflects the building blocks and activities expected of practices that serve adults. A modified milestone table is being developed for pediatric practices.

The new revision of the building blocks framework offers new focus and direction. The proposed achievement-based payment structure outlined below can help ensure that practices can be successful in progressing through this framework.

Proposed Activities and Payment Structure:

Achievement-Based Payment Activities: The SIM Office proposes tying payments to completion of activities associated with practice transformation building blocks 4 and 7. These building blocks were selected because they represent the subset of the building blocks identified as priorities by payers (1,2,3,4, and 7) that are most likely to build critical capacity in new areas for practices. Furthermore, these activities can be concretely measured to track practice progress. In order to qualify for a payment, a practice must complete ALL activities within a given building block.

Due to the fact that CPC+/SIM dual-participating practice will have an added focus on achieving activities in building blocks 8, 9, and 10, CPC+ practices also must choose one of these three building blocks to complete for payment.

Building Block	Year 1 Activities	Year 2 Activities
FOUR: Team-based care	Practice uses established tool to assess baseline team relationships Practice has written job descriptions Practice identifies & implements a team-based care strategy (e.g., team huddle, collaborative care planning)	Practice re-evaluates team relationships using tool from Year 1 Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure) Practice performs task distribution activity to inform development of team-based care policies and procedures
SEVEN: Continuity of care linked to behavioral health and social support	Practice has identified behavioral health resources for patients, including health plan support from SIM participating plans Practice has identified a screening tool for reporting on at least two of the five behavioral health screening measures for SIM (depression, maternal depression, anxiety, substance use disorder and developmental screening) and screens 25% of patients Practice has documented process for connecting patients with behavioral health resources (from screening), including	50% of patients are screened for behavioral health condition(s) & linked with community resources to address needs (food, housing, etc.) 50% of patients identified with behavioral health need are connected to resource

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	standing orders and or/protocols and follow-up	

CPC+ Practice Choose ONE of the Following in Addition to Building Blocks Above		
Building Block	Year 1 Activities	Year 2 Activities
EIGHT: Prompt access to care, including behavioral health	Practice has representative with EMR access available 24 hours, 7 days per week, including assessment of referral pathways and available after-hours support for behavioral health	Practice has established a collaborative agreement with at least one behavioral health provider
	Practice identifies data sources & technology necessary for bi-directional data sharing	Practice develops plan for bi-directional data sharing with behavioral health provider
NINE: Comprehensive and coordinated care across primary and behavioral healthcare	Practice can identify total cost of care for patient panel, & subset of patients with a behavioral health condition Practice identifies & implements policy and procedures that included timely follow-up for ED & hospital admissions	Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation Practice identifies cost drivers for patients with behavioral health condition & incorporates in QI processes Practice creates and reports a measurement to assess impact and guide improvement on at least one of the following: 1) Notification of ED visit in timely fashion, 2) Medication Reconciliation process completed within 72 hours, 3) Notification of admission and clinical information exchange at the time of admission, or 4) Information exchange between primary care and specialty care related to referrals
TEN Practice has fully integrated behavioral healthcare to provide whole-person care	Practice has identified & documented referral pathway for behavioral health needs (including assessment of referral pathways and available after-hours support for behavioral health 24/7 access) Practice develops a plan to systematically measure & track patient behavioral health outcomes Practice develops care plans that include patient actions to manage behavioral health conditions	Practice systematically measures & tracks patient behavioral health outcomes Practice documents & implements protocols to manage care provided to identify high-risk behavioral health populations Practice identifies & implements at least two opportunities to adjust its protocols to improve behavioral health status of patients

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NOTE: The SIM Office is working to create a set of activities tailored to pediatric practices. While the SIM Office anticipates that payments to pediatric practices will be tied to building blocks 4 and 7, the activities associated with each of the two building blocks may differ from the above.

Achievement Based Payment Amounts: The SIM office anticipates granting out $598,036 of the $3 million originally slated for competitive grants through the SIM funding stream, leaving $2.4 million remaining for practices in Cohorts 2 and 3. The SIM Office proposes dividing these remaining funds equally among the 300 practices anticipated to join each future cohort (150 in Cohort 2 and 150 in Cohort 3), meaning that each practice would be eligible to receive up to $8,000 in additional achievement based payments.

Non-CPC+ Practices: Each SIM practice will be eligible to receive $2,000 per building block achieved each year, totaling $8,000.

CPC+/SIM Practices: Due to the fact that CPC+/SIM dual-participating practices will have an added focus on achieving activities in building blocks 8, 9, and 10, CPC+ practices also must choose one of these three building blocks to complete for payment. The proposed table of payments, divided by practice type, follows below.

	Building Block 4		**Building Block 7**		**Building Blocks 8,9, or 10 (choose one)**	
Practice Type	**Year 1**	**Year 2**	**Year 1**	**Year 2**	**Year 1**	**Year 2**
SIM Practice	$2,000	$2,000	$2,000	$2,000	-	-
CPC+/SIM Practice	$1,000	$1,000	$1,000	$1,000	$2,000	$2,000

Disbursement of Payment: Practices will be required to submit proof of completing each activity associated with the building block to their practice facilitator at the end of each year. The practice facilitator will then attest that the practice has met all activities in a given building block. The SIM Office will have final discretion as to whether payments will be issued for completion of activities within a building block. Payments will be issued through the University of Colorado.

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ATTACHMENT C - Cross-walk of CPC+ Primary Care Functions and SIM Building Blocks

CPC+ Primary Care Functions	SIM Building Blocks	Proposed Priorities for CPC+-SIM Practices
Access and Continuity	Engaged Leadership Empanelment Prompt Access to Care, including Behavioral Health Care	
Care Management	Population Management Comprehensive and Coordinated Care Across Primary Care & Behavioral Health Care	
Comprehensiveness and Coordination	Continuity of Care Linked to Behavioral Health and Social Support Comprehensive and Coordinated Care Across Primary Care & Behavioral Health Care Prompt Access to Care, including Behavioral Health Care	• Bi-directional data sharing with behavioral health providers
Patient and Caregiver Engagement	Patient-team Partnership	
Planned Care and Population Health	Data-driven Improvement Full Integration	• Identify and incorporate data regarding total cost of care & utilization for patients with behavioral health condition(s) into care delivery & QI Processes • Systematically measure and track patient behavioral health outcomes

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