COLORADO ACCESS

CONTROLLED CHRONIC CONDITIONS: ED REDUCTION PROGRAM (C^3EDR)

A SUBSET OF THE COLORADO ACCESS ADMINISTRATIVE PAYMENT MODEL PROGRAM FY 2022-23

I. Background:

The patient-centered medical home (PCMH) model is, to date, considered the vehicle that delivers the highest quality of primary care services for patients with one or more chronic conditions[1]. Preliminary evidence also shows that the PCMH model produces better clinical outcomes, higher adherence and lower emergency department (ED) utilization for low-income populations[2].

Colorado Access (COA) continues its work to evolve the Administrative Payment Model (APM) to reward providers for improved patient outcomes (See COA Administrative Payment Model Program Documents). The Controlled Chronic Conditions: ED Reduction (C^3EDR) Program serves as a first step in the value-based programming of COA to incentivize targeted work with high-risk members that often utilize high-cost ED services as a means of managing their chronic conditions. The C^3EDR program incentivizes providers to deliver an intervention that aids the delivery of high-value primary care services aimed at improving control of members' chronic conditions with the ultimate goal of helping members avoid the acute exacerbations that lead to emergency department visits.

II. Program Overview

Goal: To reduce ED visits and costs by implementing interventions that aim to improve control of diabetes, asthma and/or COPD.

Eligibility Criteria: A provider must have previously participated in HCPF's APM Program or currently have at least 200 attributed members to be eligible for the C^3EDR Program.

Participation: The C^3EDR program is a pay for participation program. The program is optional for PCMP and PCMP+ sites. The program is required for all ECP sites. As of May 1, 2022, all eligible sites have been automatically opted into the program. For a list of participating sites, please email practice_support@coaccess.com. The C^3EDR Program is effective through June 30, 2023.

Payment: Providers that participate in the C^3EDR program will receive an additional $0.50 PMPM for all of their utilizer members. The payment will be added onto their earned utilizer PMPM.

III. Program Requirements

The C^3EDR Program requires the use of data to identify members with diabetes, asthma, and/or COPD and prioritize which members are in most need of help with managing their chronic conditions. The intervention should align with one of five areas set forth by Colorado Access.

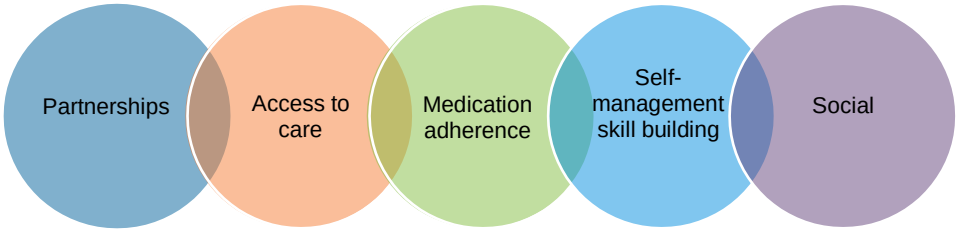
A. The Five Areas of Intervention

Colorado Access collaborated with providers' clinical experts to identify five areas of

[1] Jackson GL, Powers BJ, Chatterjee R, et al. The patient centered medical home. A systematic review. *Annals of Internal Medicine* 2013 Feb 5; 158(3):169-78.

[2] Van den Berk-Clark C, Doucette E, Rottnek F, et al. Do patient-centered medical homes improve health behaviors, outcomes, and experiences of low-income patients? A systematic review and meta-analysis. *Health Services Research* 2018. Jun; 53(3):1777-1798

intervention that offer the most promise in increasing member control of chronic conditions. The areas are broad, and the descriptions below offer only a few examples of how a provider might employ an intervention to address the particular area. Providers are free to design their own unique interventions as long as they are able to describe how it addresses one or more of the areas depicted in the figure below.



1. **Partnerships Across Sites of Care** – Providers may implement a partnership with another provider type (behavioral health, specialists, emergency departments, etc.) to improve member handoffs in care.
2. **Access to Care** – Providers may improve member access to care by providing care at alternative sites (non-office-based visits), such as home visits or community venues (churches, libraries, etc.). Providers may also expand on their offering of telehealth services that target members with diabetes, asthma, and/or COPD. Or providers may choose to implement extended hours or increased availability of walk-in appointments.
3. **Medication Adherence** – Providers may work on methods of better educating members about the purpose and proper administration of their prescription medications. Or providers may work to improve member access to medications by assisting them with setting up prescription deliveries. Providers may also choose to employ medication reminders or regular check-ins with members to ensure they are adhering to their medication regimen.
4. **Self-Management Skill Building** – Providers may employ or partner with coaching, classes, or support groups that help members build their condition self-management skills.
5. **Social Determinants of Health** – Providers may work with members to improve health literacy. Or they may employ an intervention aimed at addressing cultural barriers or health equity issues unique to their patient population.

IV. PCMP and PCMP+ Program Engagement Requirements

Providers that are identified as PCMP or PCMP+ are required to adhere to some basic program engagement requirements in order to remain eligible for the C^3EDR program payment in future years.

A. Providers must meet with their assigned practice facilitator six out of the 12 months of the contract period. The agendas for these six meetings may include any and all business between the provider and COA. This requirement is meant to enhance the partnership between COA and network providers to allow COA to offer coaching, actionable data, and/or general support to providers that want it.

B. Providers must send representation to two educational opportunities during the 12 months of the contract period. This requirement is meant to build provider alliances, increase knowledge about Colorado's Medicaid population, and develop skills to address areas of greatest need.

V. Colorado Access Provider Performance Tracking

While all providers are expected to evaluate their own programs in order to learn what works and what doesn't for their practice and their patients, Colorado Access plans to track all providers' performance on the following metrics: Emergency Department Visits Associated with Uncontrolled Diabetes, Asthma, and COPD

A. Per thousand per year ED visits –Members with diabetes, asthma, and COPD at each practice site will be divided into diagnosis specific cohorts and each cohort will be tracked to measure number of ED visits over time.

B. Per member per month ED visit costs – The same diagnosis specific cohorts will be tracked to measure per member per month ED costs over time.

C. Per thousand per year inpatient visits – Since many ED visits result in admission, COA plans to track each diagnosis specific cohort's number of inpatient visits over time.

D. Per member per month Inpatient costs – The same diagnosis specific cohorts will be tracked to measure per member per month inpatient costs over time.