

2/26/25

Colorado Access Provider Forum

Phase III - Key Updates: Member Acuity & Care Coordination



Agenda

Phase III Changes

Member Acuity

Care Coordination

Questions & Next Steps

Current State of Primary Care Payments (Phase II)

PCMPs currently take part in numerous different funding streams and programs offered by multiple entities, all for rewarding the same performance.

Accountable Care Collaborative (ACC)

KPI/Performance Pool

RAE APM Programs

Medical Home Payments

HCPF

APM 1

APM 2

PACK

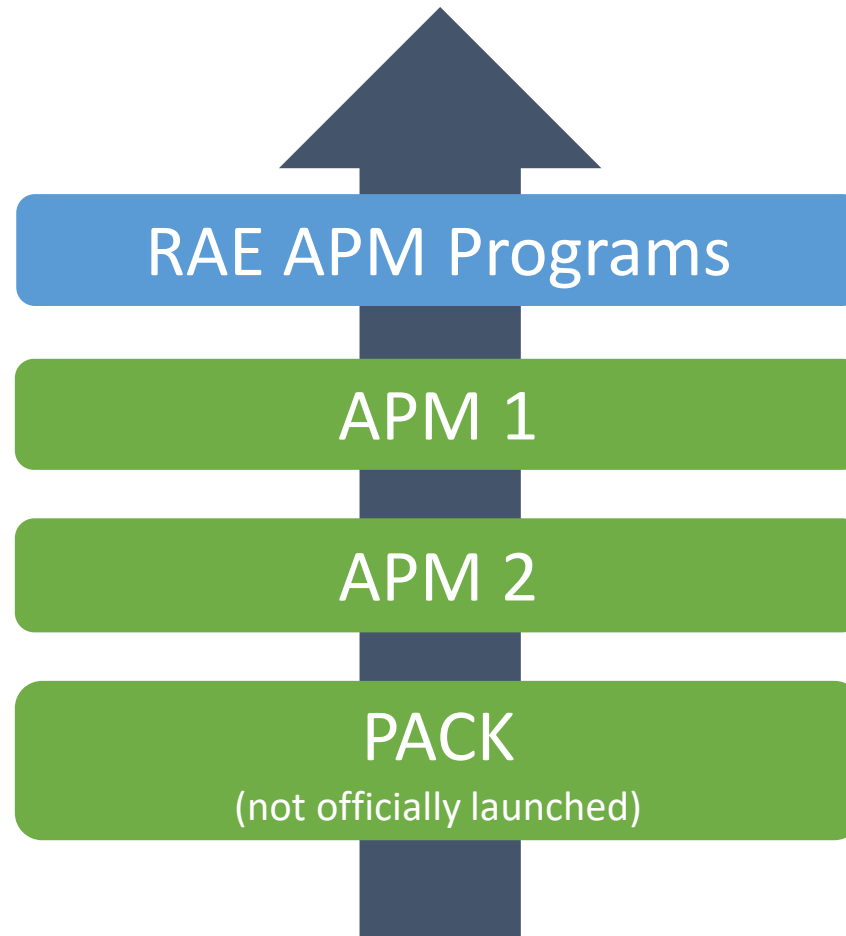
(Payment Alternatives for CO Kids)
(not officially launched)

Primary Care Service Payments

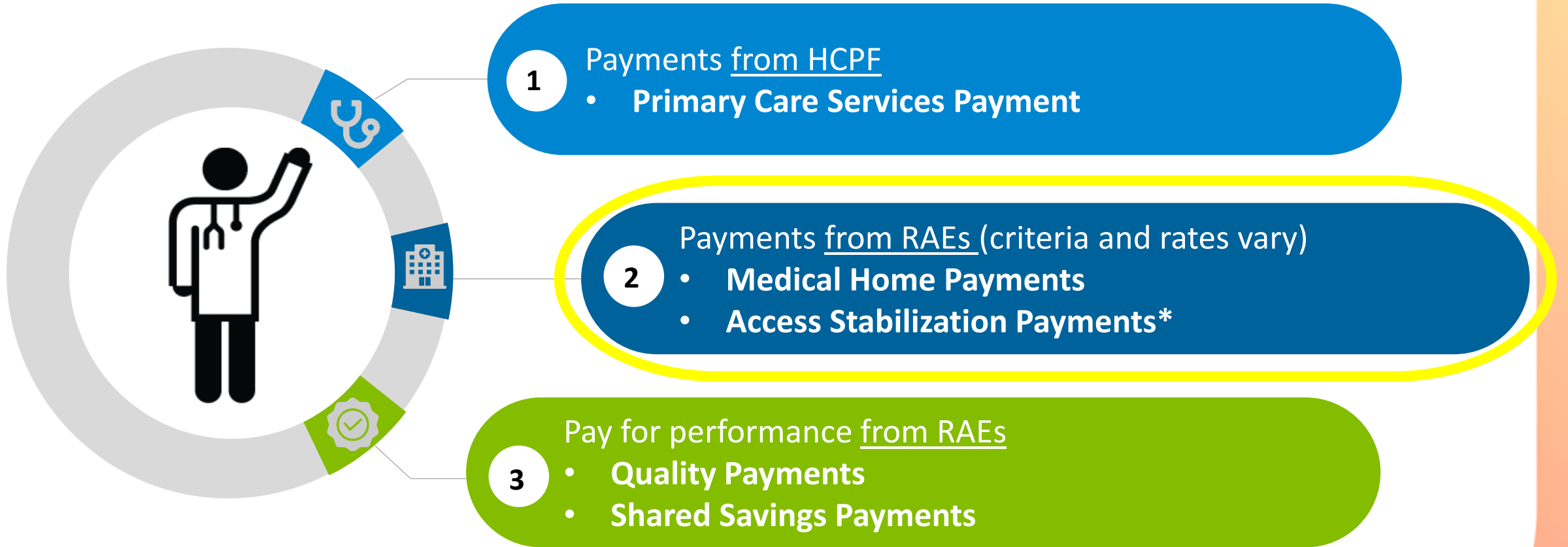


Note: Details subject to change as new information becomes available.

A Singular Comprehensive Payment Structure



Primary Care Payment Structure

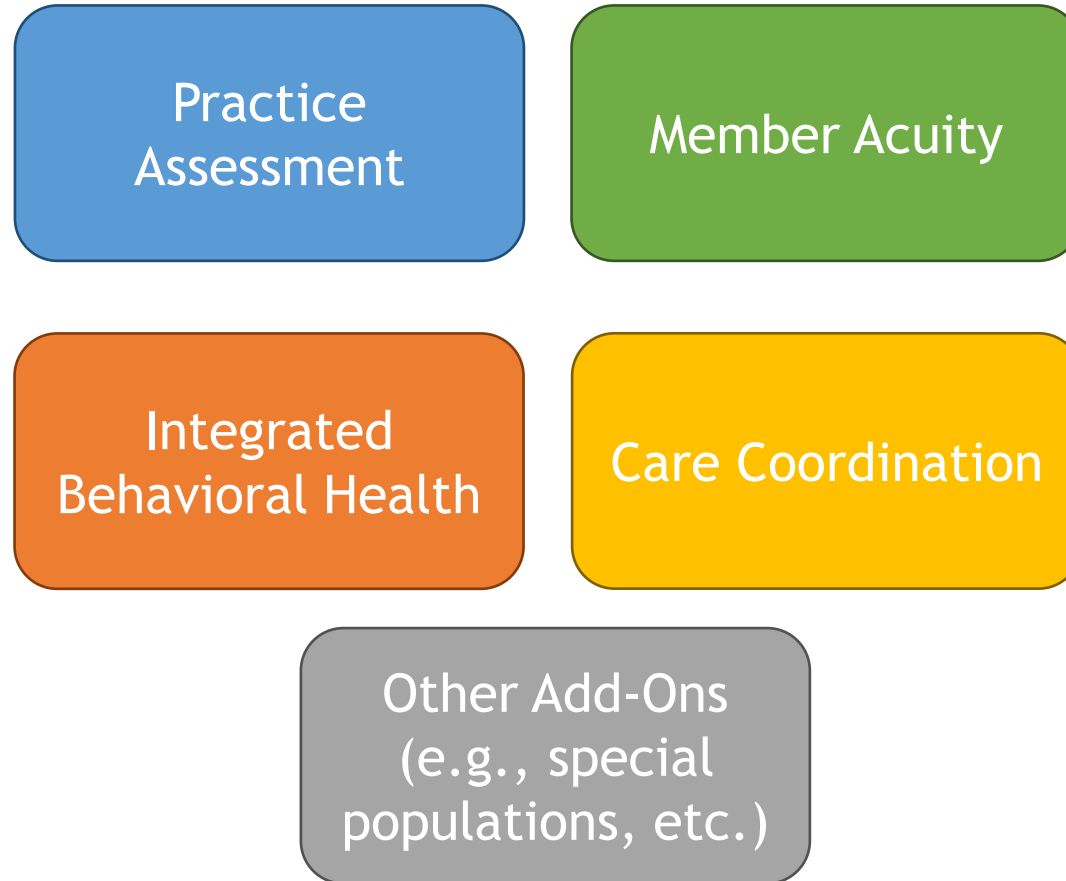


The background of the slide features a blurred image of a person in a white lab coat, likely a healthcare professional, with their hands visible. One hand is holding a coin, poised to drop it into a slot. In the foreground, there is a stylized graphic of a bar chart with several vertical bars of varying heights. Each bar is topped with a large, colorful arrow pointing upwards. The arrows are in shades of red, white, green, blue, and orange. The chart itself is semi-transparent and overlaid on the background image. The overall theme suggests financial growth, investment, or the economic impact of healthcare services.

Medical Home Payment

Medical Home Payment

Funds PCMP expectations to provide advanced primary care with increased accountability



(formerly value based model and/or administrative PMPM)



***Note:** Details subject to change as new information becomes available.*

Medical Home Payment

Funds PCMP expectations to provide advanced primary care with increased accountability

Practice Assessment

State-wide standardized tool that inventories, evaluates, and captures information about a PCMP's unique competencies within CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models and tiers providers into 1 of 3 tiers with tier 3 receiving the highest PMPM

Integrated Behavioral Health

State-wide standardized eligibility criteria defining highly integrated care that provides additional PMPM to site meeting criteria

Other Add-Ons (e.g., special populations, etc.)

RAE specific criteria that allow flexibility to meet needs unique to regions

(formerly value based model and/or administrative PMPM)

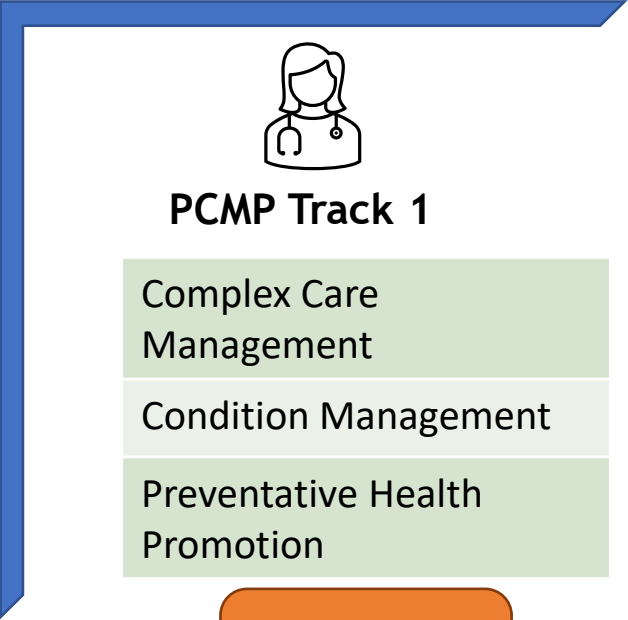


Note: Details subject to change as new information becomes available.



Practice
Assessment

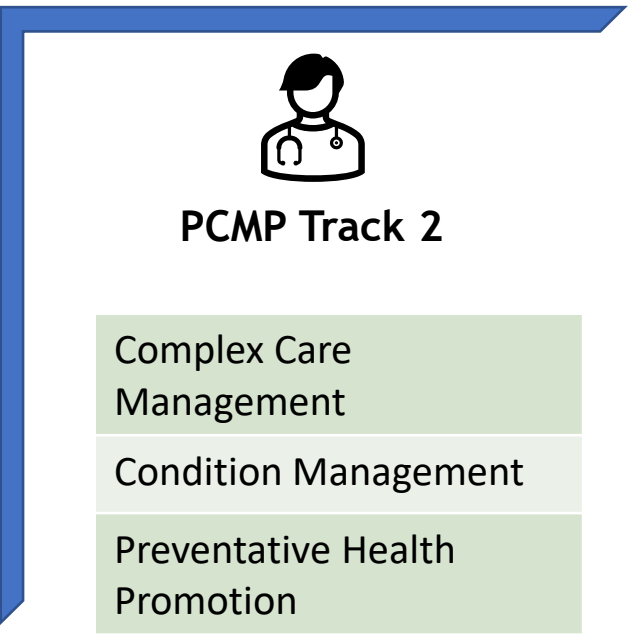
Member
Acuity



PCMP Track 1

- Complex Care Management
- Condition Management
- Preventative Health Promotion

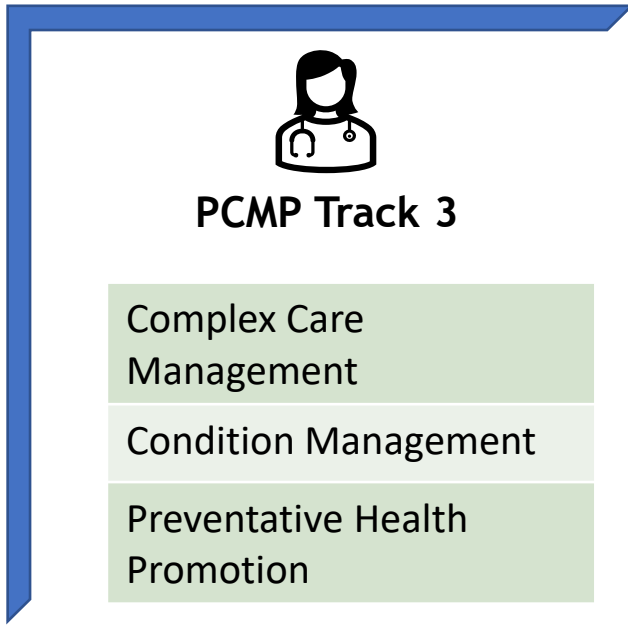
Integrated Behavioral Health



PCMP Track 2

- Complex Care Management
- Condition Management
- Preventative Health Promotion

Integrated Behavioral Health



PCMP Track 3

- Complex Care Management
- Condition Management
- Preventative Health Promotion

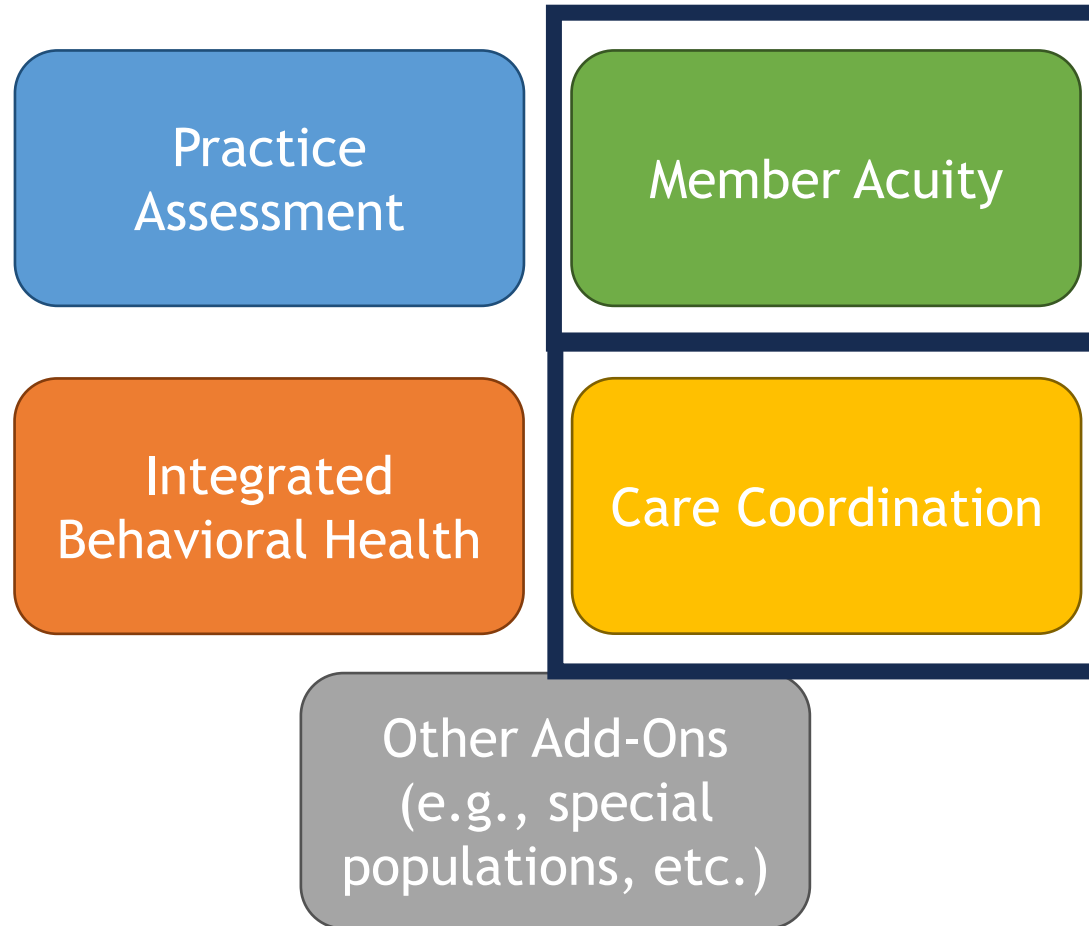
Integrated Behavioral Health

Care Coordination

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Member Acuity

Current State

Each RAE has their own definition of “complex members”.

COA has complex member definition unique to peds and adults that applies to 3-4% of the population

Definition includes both physical and behavioral health conditions

Providers doing and reporting care coordination activities receive higher PMPM for this population

Future State

Entire member population will be tiered into 1 of 3 tiers with tier 3 representing highest acuity

*RAEs will largely develop their own tiering methodology

COA will be using Chronic Illness and Disability Payment System (CDPS) to stratify population

Tier 3 (highest acuity) members will range between 10-15% of total population

Providers doing and reporting care coordination activities receive higher PMPM for this population



*RAEs and HCPF are actively in conversations to finalize this plan.

Chronic Illness and Disability Payment System (CDPS) Overview

What is CDPS?

A widely used risk adjustment model for Medicaid health plans.

Specifically designed for Medicaid populations.

Accounts for higher prevalence of chronic conditions and disabilities in Medicaid membership

How do risk scores work?

Diagnosis-driven: CDPS assigns risk scores based on diagnoses coded in claims (not procedures or costs).

Hierarchical structure: Within each major category (e.g., cardiovascular, diabetes), only the most severe diagnosis counts, but conditions add up across categories (e.g., a patient with both heart disease and diabetes will have a higher score).

Why CDPS?

Supports budgeting and resource allocation and helps predict costs and invest in high-risk populations effectively.

Encourages comprehensive care management by identifying members with complex needs for targeted programs and interventions.

Improves population health insights and analysis of risk trends to advocate for policy changes based on data.

Member Acuity

What we know

In year 1, a higher PMPM will be paid to providers for members in tier 3 doing and reporting care coordination activities

Evolving member acuity and getting deeper insights into tiering will be a key priority for year 1 of Phase III

Provider feedback will be encouraged and requested as we learn more about CDPS and our populations

Tier 3 population will be much larger than our current complex member population

What we don't know

What additional factors will be added to the CDPS framework to best represent our populations

How we will incorporate SDOH needs into risk stratification algorithm



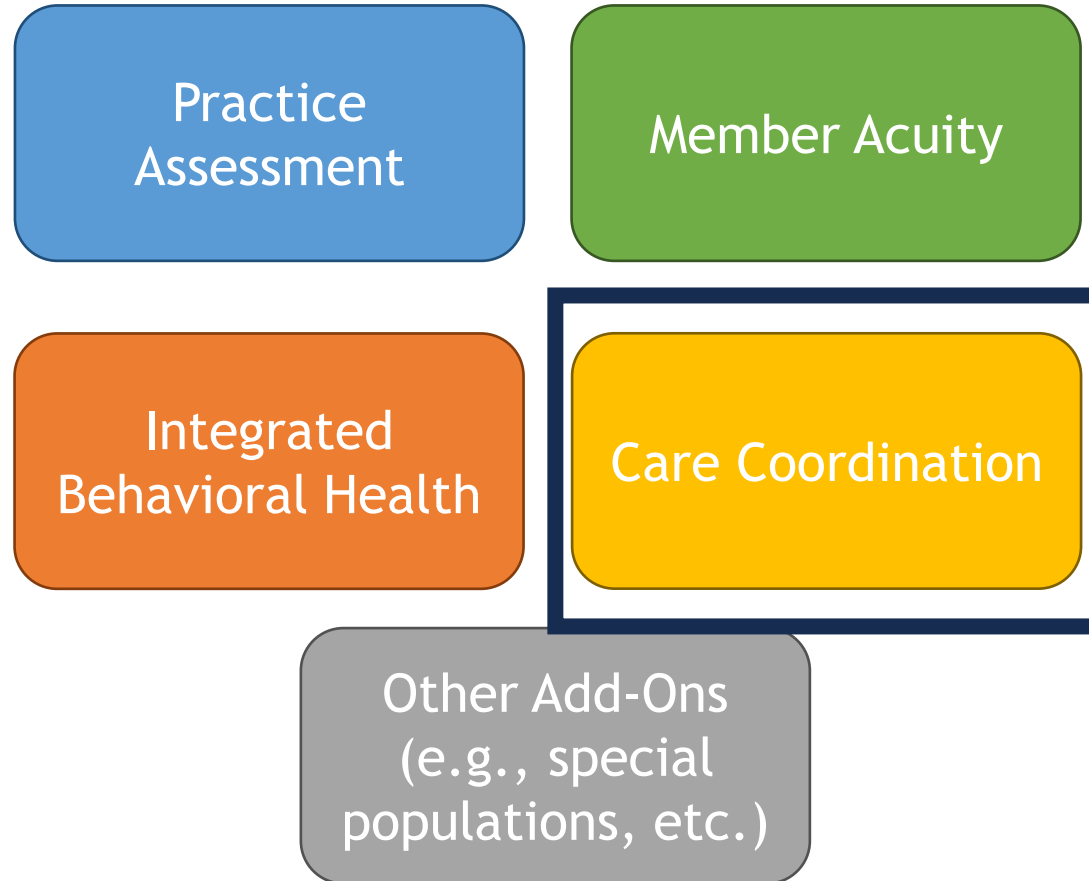


Questions?



Medical Home Payment

Funds PCMP expectations to provide advanced primary care with increased accountability



(formerly value based model and/or administrative PMPM)



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Care Coordination



Care Coordination

Current State

Providers providing and reporting care coordination activities are paid an enhanced PMPM

~50% of COA's population is attributed to a provider providing care coordination

To receive care coordination PMPM, providers must also demonstrate competencies in quality improvement, population health and clinical practice

Providers doing care coordination are responsible for additional performance metrics tied to care coordination activities and population health outcomes

Audits occur 2x a year and performance impacts payment



Future State

Providers providing and reporting care coordination activities are paid an enhanced PMPM

New performance standards will be required, and performance will impact provider payment over time

Care coordination audits will align with NCQA standards which require additional elements

Tier 3 (highest acuity) members will represent 10-15% of total population

Increased transition of care requirements and associated multi-department case conferences

Ongoing eligibility for care management PMPM will be based on performance, populations served, and the outcomes achieved

Care Coordination Reporting

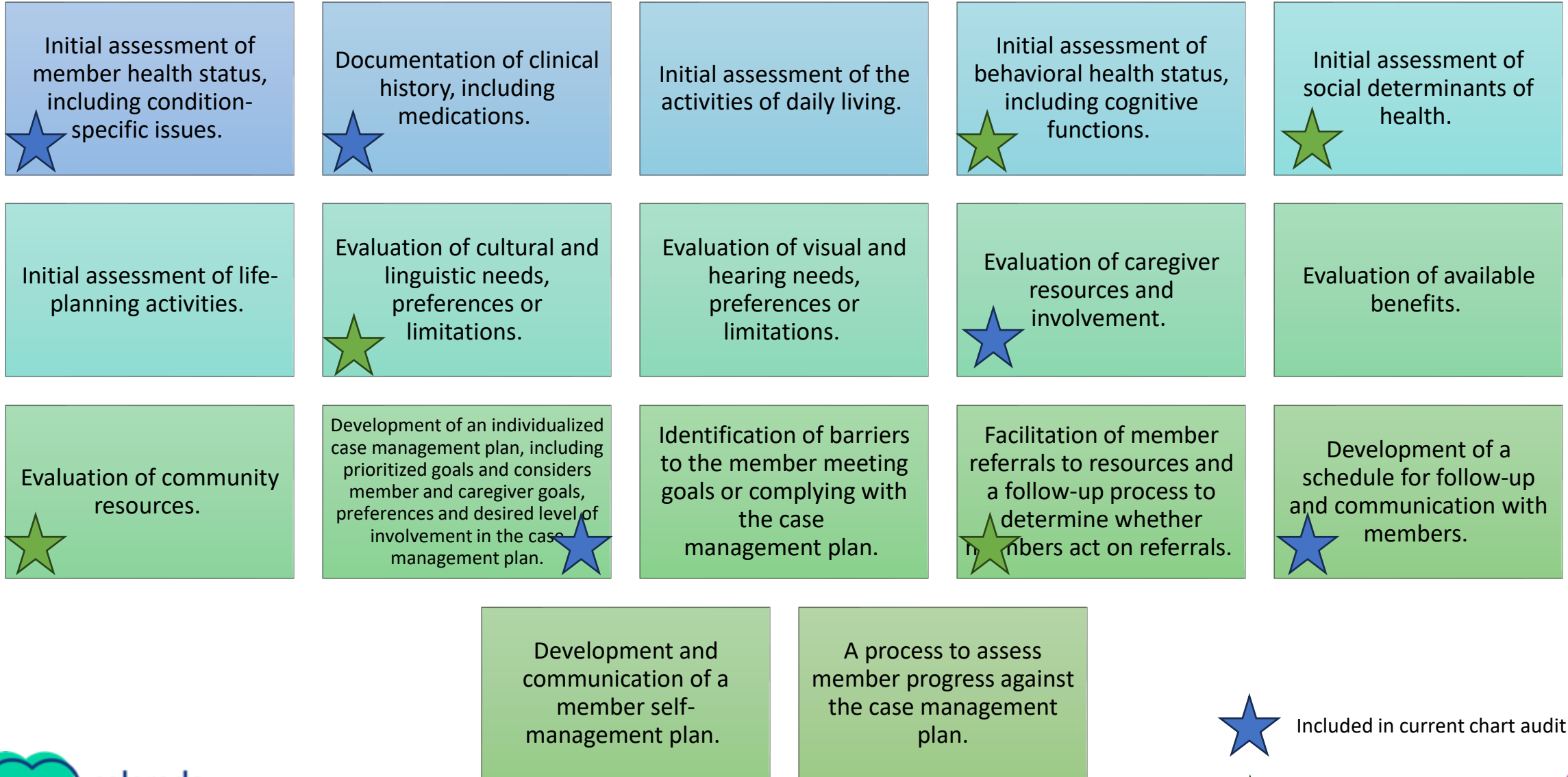
Excel file and narrative due quarterly
(second Monday after quarter closes)

Template & definitions remains the
same for year 1

Bi-Annual Audits aligned with NCQA
requirements

More rigorous reporting expectations
to ensure data quality

Care Coordination Audits – Complex Case Management



Included in current chart audit



Included in current annual assessment

Performance Standards

Ensure that at least 25 care plans per 1,000 assigned members per year are created for members eligible for Tier 3 Care Management.

Maintain the Hospital All-Cause Readmission rate for Tier 3 Care Management members at or below the previous three-year average.

Improve emergency department (ED) visit performance for members eligible for Tier 2 Care Coordination and Tier 3 Care Management, following an agreed-upon annual improvement methodology.

Maintain the dental visit engagement rate at or above the previous three-year average.



Questions?





Next Steps



Next Steps

- Practice assessment need to be completed by 2/28 – **end of this week!**
- Reach out with any questions or implementation concerns

Upcoming Provider Forums : 12 – 1pm

You're invited to three sessions on Wednesdays from 12:00 p.m. to 1:00 p.m. to help prepare you for these upcoming changes. At each session, you will receive key updates and have an opportunity to ask questions. Topics may change as more information from the Department of Health Care Policy and Financing (HCPF) is available.

- **Wednesday, March 12:** Learn more about Quality Payments and Quality measures in Phase III.

SAVE THE DATE:

Thursday, April 17th: Phase III Medical Home Payment Model Rollout

Join us for an informative session following the release of new provider contracts and rates. This forum will cover key details, answer questions, and provide clarity on what these changes mean for you. Don't miss this opportunity to connect, get the latest updates, and ensure a smooth transition. Invitation will be sent soon!



Please note sessions will be recorded.

A close-up photograph of a person's hand holding a fork, lifting a portion of food from a white bowl. The food consists of a salad with green leafy vegetables, red tomatoes, and a generous topping of golden-brown tortilla chips. In the background, a glass of water with a lemon slice is visible. The overall scene is set on a dark, textured table.

Thank you!



Before you go, we'd love 30 seconds of your thoughts to make future sessions even better. Just scan this QR code!

Provider Forum Feedback

