Controlled Chronic Conditions: ED Reduction Program (C3EDR)

A SUBSET OF THE COLORADO ACCESS ADMINISTRATIVE PAYMENT MODEL PROGRAM

FY 2021-22

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 utilization for low-income populations[2].

Colorado Access (COA) continues its work to evolve the Administrative Payment Model to reward providers for improved patient outcomes (See COA Administrative Payment Model Program Document). The Controlled Chronic Conditions: ED Reduction (C^3EDR) Program serves as a first step in our value-based programming to incentivize targeted work with high-risk members that often utilize high-cost emergency department (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. Eligible sites have been automatically opted into the program. Sites that want to opt out of the program must notify their Practice Facilitator by May 15, 2021.

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.

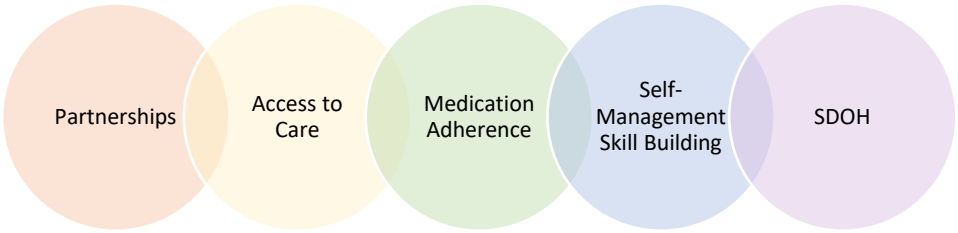
1. Jackson GL, Powers BJ, Chatterjee R, et al. The patient centered medical home. A systematic review. *Annals of Internal Medicine* 2013 Feb 5; 158(3):169-78.
2. Van den Berk-Clark C, Doucette E, Rottnek F, et al. Do patient-centered medical homes improve health behaviors, outcomes, and experiences of low-income patients? A systematic review and meta-analysis. *Health Services Research* 2018. Jun; 53(3):1777-1798

III. Program Requirements

At a high level, the C[3]EDR 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 program also requires that providers design and implement an intervention, to help members get their chronic conditions under control, that aligns 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 5 areas of 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.

B. 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.

1. Providers must meet with their assigned Practice Facilitator 6 out of the 12 months of the contract period. The agendas for these 6 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.

2. Providers must send representation to 2 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.

IV. Program Milestones

All providers are required to meet 3 program milestones by January 1, 2022.

Milestone 1 - due September 30, 2021. Providers are required to communicate their intervention strategy to their Practice Facilitator. Communication should include at minimum, a work plan outline and the required data elements for program implementation and evaluation.

Milestone 2 – due November 30, 2021. Providers are required to show draft data that demonstrates their ability to identify and prioritize targeted members for their intervention. Providers are welcome to use data provided by COA for this milestone, provided they can explain how they will use the data to drive their intervention.

Milestone 3 – due January 1, 2022. Providers confirm with their Practice Facilitator that their intervention is in place and working to improve member control of chronic conditions.

Providers that already have interventions in place that meet all previously described requirements and milestones need not develop another program. Providers may simply demonstrate to their Practice Facilitator that they have already met Milestones 1-3 and share their design, processes and any preliminary results they have collected from their intervention to date.

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. **PKPY 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 (per thousand per year).

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

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

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