Annual Practice Support Plan

Instructions and Narrative Report

RAE Name	Colorado Community Health Alliance (CCHA)
RAE Region #	6
Reporting Period	SFY21-22 07/01/2021 – 06/30/2022
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Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Network. As part of that responsibility, RAEs are required to provide practice support and transformation strategies to network providers. This report outlines each RAE's plan to accomplish this task.

Instructions: Please provide a narrative that outlines your strategic approach to supporting and transforming provider practices to increase value and to improve health outcomes and the experience of care of members. The narrative must include details regarding the following:

- the types of information and administrative support, provider trainings, and data and technology support offered and implemented with network providers;
- practice transformation strategies offered to network providers to help advance the Whole-Person Framework and to implement the Population Management Strategy; and
- the administrative payment strategies used to financially support and advance the capacity of network providers.

Where relevant, please provide supporting evidence for the respective approaches. Evidence can include but is not limited to: peer-reviewed research, operational excellence, and public feedback.

Please include how your strategy has or has not evolved since the previous year's submission. Please provide evidence to support these changes.

Please limit your plan to no more than five (5) total pages and use concise and concrete language.

Practice Support Plan

Instructions: Please provide a narrative that outlines your strategic approach to supporting and transforming provider practices to increase value and to improve health outcomes and the experience of care of members. This narrative must include the details outlined above.

Practice Support Plan

CCHA's provider support plan utilizes a multidisciplinary team dedicated to assisting primary care and behavioral health (BH) care providers in navigating Health First Colorado (Colorado's Medicaid Program) and achieving the goals of the Accountable Care Collaborative (ACC) program. CCHA works with providers to achieve these goals by educating providers about Health First Colorado benefits, providing data, sharing best practices, and aligning quality improvement activities and evidence-based programs. To align with the shifting efforts of the ACC, Practice Transformation Coaches (PTCs) work with practices on all aspects of the quadruple aim, with particular attention to helping practices recover from lower utilization due to the COVID-19 pandemic that occurred in state fiscal year 2020-2021 (SFY20-21). CCHA has a renewed focus on key

performance indicators (KPIs), particularly well visits and dental visits, which saw a significant decrease in SFY20-21. Additionally, CCHA is working to improve member health outcomes by developing and evaluating evidence-based interventions and programs to support condition management for complex members, diabetes, maternity, and other chronic conditions that impact members. CCHA is also working to finalize an updated definition of complex members and implement internally and among the provider network. These efforts will include the population management strategies outlined below based on research that practice transformation is a constant process and that a focus on preventive care at the practice level may reduce hospitalizations and total cost of care.

SFY21-22 Strategy

CCHA's practice support strategies have proven successful over the course of the RAE contract, as evidenced by upward trends in KPI performance (outside of COVID anomalies) and provider satisfaction (as evidenced by participation in quality improvement activities and regional meetings, and provider retention). CCHA believes that by applying these core approaches, effective change can occur within practices; thus, CCHA is not altering its practice support strategy and will continue to use the following approaches with practices:

- Individualize practice specific interventions based on unique performance and capabilities
- Support practice-directed goals through monthly quality improvement meetings and by using data to determine where gaps exist and information about their members
- Ensure consistent, quality improvement efforts with coaching accountability using standardized agendas and reports
- Encourage data-driven risk stratification to focus outreach and interventions
- Provide technical assistance to enhance programming for condition management as applicable
- Assist with maximizing earning potential by means of Alternative Payment Methodologies (APM), APM2, KPI incentive dollars, and other opportunities as appropriate, such as participation in the maternity bundled payment program.

Although the strategic approach remains unchanged due to its effectiveness, the areas of focus, tools and interventions have evolved this year, including:

Focus areas:

- **KPI Strategies -** As mentioned above, COVID-19 support was priority and reduced KPI efforts for most of the previous fiscal year. Starting in February 2021, PTCs evaluated capacity of Primary Care Medical Providers (PCMPs) and began to resume efforts on KPI strategies. Building upon work that was done prior to the pandemic, PTCs will help providers focus on members who missed appointments and help them develop strategies to outreach and address these members' needs.

Tools:

- **Provider Portal** - CCHA created a provider portal to share data more securely with providers and to allow them to pull their own data at their convenience.

Interventions:

- **Enhanced Risk Stratification** - In SFY21-22, CCHA made major changes to the complex member definition to better align with Department of Health Care Policy & Financing (HCPF) priorities, better identify members who may benefit from care coordination, align with performance measures, and to allow CCHA to better track and report on outcomes. This updated stratification will be shared with applicable network providers to support targeted and coordinated efforts.
- **Payment Strategies** - CCHA updated its provider payment strategies to focus more on condition management and caring for complex members in alignment with performance measures.
- **COVID-19 Support** - CCHA provided both financial support and quality improvement activities to providers throughout SFY20-21. PTCs helped providers become vaccination sites, set up telehealth workflows, and understand programmatic changes. These efforts diverted from the normal focus on performance measures, particularly the KPIs. Going forward, CCHA has plans to provide additional

financial support through the COVID-19 Vaccination Support Fund. PTCs will continue to meet regularly with practices, virtually if needed, to help with workflows as guidance continues to evolve, including encouraging vaccine sites to continue the efforts and provide boosters going forward.

- **Programming Support -** Through the revised payment methodology, CCHA will be incenting practices to develop their own evidence-based programming to support population health management for their attributed members. CCHA PTCs support practices by providing member-level data, developing workflows, guiding quality improvement efforts, using standardized tools to track progress, and support connection to community resources. This is supplemented by CCHA care coordination programs, including complex, diabetes, and maternity programs.

Additional information regarding each initiative is provided throughout the report. CCHA continues using lessons learned and assessing practice support strategies. We build upon progress year over year to support the medical home model as the focal point of care to increase preventative care, improve member outcomes, and reduce costs. PTCs are committed to sharing best practices so that successes can be scaled up across the region and reports are continuously improved to meet the changing needs of the RAE and providers.

Informational and Administrative Support

CCHA's practice support team includes the following:

- ***Network Managers*** - Contract with providers, help with billing and coding issues, communicate policy changes, system updates, provider portal signup and training, etc. Advocate for providers and act as a liaison between HCPF and the provider network.
- ***Practice Transformation Coaches (PTCs)*** - Support quality improvement activities, data sharing, quality improvement tools, establishing quality improvement teams, supporting providers with ACC initiatives such as understanding and meeting the KPIs, the BH incentive, and the Alternative Payment Methodology (APM) measures; as well as aligning quality improvement activities. PTCs are also working to support Accountable Care Network providers (ACNs) as CCHA works with HCPF to meet the updated extended care coordination (ECC) documentation standards.
- ***Population Health -*** Collaborate with providers to improve members' health outcomes, identify cost-saving strategies, and increase member satisfaction through targeted interventions, data sharing, and continuous improvement activities.
- ***Care Coordinators*** - Provide comprehensive and integrated care coordination support by:
  - Facilitating appointments with the Primary Care Medical Providers (PCMPs) and other specialists or specialty BH network providers;
  - Co-locating care coordinators in provider and hospital settings who have direct access to members in need of care coordination;
  - Establishing processes for PCMPs to refer members for care coordination services; and
  - Providing timely communication to PCMPs on care plans, community resource involvement, and patient/family goals.
- ***Community Liaisons*** - Establish relationships and collaborate with community partners to promote health, meet regularly with organizations that provide medical and non-medical community-based resources, and provide updates to the provider community on which resources are available.

Provider Training - Providers will receive ongoing education monthly, quarterly, and annually on topics identified through various channels (i.e., benefit changes, HCPF policy, provider requests, etc.). CCHA has found that by using a multi-modal approach to sharing information it is better able to reach and engage providers through their preferred methods. Training will be delivered through:

- Print communications (provider manuals, newsletters, clinical and non-clinical educational materials)
- Provider page and resources on the CCHA website
- In-person training (learning sessions, in-practice boot camps, Medicaid provider update meetings)

- Virtual training (live or recorded webinars)
- Provider open forums
- Provider orientations
- Provider Portal

Provider Manuals - Provider manuals outline the requirements with which network providers must comply. Updated at least annually, or as needed, CCHA publishes manuals specific to physical health (PH) and BH providers. They are available via the CCHA website, and by email, standard U.S. Mail, or fax upon request. CCHA will send provider memos or bulletins, which may serve to amend or update the information in the provider manual between editions.

Provider Orientation - New PH providers receive a formal orientation by a Network Manager, which includes a review of the provider manual and CCHA policies and procedures. CCHA attempts to schedule this training within thirty (30) calendar days of their contract effective date, dependent on practice schedules. CCHA will communicate sessions offered to all providers via mailings and/or provider website postings. Training may be provided in large group settings, virtually via webinars, or in person. Provider orientations for BH providers will include elements specific to capitated BH, such as utilization management and the claims submission process.

Provider Portal - CCHA has created the Provider Portal to support contracted PCMP practices serving Health First Colorado members by providing a secure, consistent method for CCHA to share data and resources with providers and practice staff, as applicable. Expanding the portal to BH providers may be possible in the future. Using the portal creates a unique opportunity for improvement by reducing administrative burden of having to send individual (and sometimes encrypted) emails by automating the reporting process and providing a more efficient, centralized location for providers to report bi-directionally. In Region 6, 32 PCMP locations have signed up for the Provider Portal, can use the portal to access all financial reports, and will begin using the portal to report on condition management activities in the fall of 2021.

Website - The CCHA website, CCHAcares.com, has information for providers and members regarding CCHA, Health First Colorado, the ACC, and health resources. Available in English and Spanish, it includes a robust provider directory, community resources, educational materials, a health library with hundreds of health topics, and other health care information. The CCHA Program Improvement Advisory Committee minutes are also available on the website for providers to review and learn how to be involved.

- ***Language Options*** - The website is in English and Spanish and can be changed by selecting the language at the top of the homepage. The website is also built with Google translate so members can use their preferred language at the click of a button.
- ***Patient Education*** - All Health First Colorado and vendor information are listed and presented on the website to help members navigate the available resources. Information about staying healthy, emergency department (ED) utilization, choosing a doctor, COVID-19 updates, etc., is also included.

Materials - CCHA continues developing practice support and member materials to help explain Health First Colorado benefits and educate members about their health. Practice materials can be ordered for free from the website and include a CCHA Quick Reference Guide, depression screening guides and tools, BH referral guides, and KPI reference guides. Member materials include the Map to Medicaid brochures, care coordination brochures, prevention topics, BH guides/referral information, general disease education materials, and more. Examples of these materials are available upon request.

Population Health and Condition Management Strategies

CCHA relies on the quadruple aim as the overarching vision to drive successful population management and recognizes that its provider network plays an integral part in achieving these goals. As described in detail in the Population Management Strategic Plan, CCHA's Population Management Program is built upon understanding the populations served, aligning interventions to meet members' needs, supporting providers, and forming strong community partnerships. CCHA uses evidence-based models, for example, as it develops an updated definition for complex members to align with the best practices identified by the National Academy of Medicine: Effective Care for High-Need Patients. CCHA is aligning with provider focus areas, such as shifting back toward preventative medicine after the COVID-19 pandemic. CCHA applies feedback from the Program Improvement Advisory Committee to develop, evaluate, and modify interventions related to chronic conditions. Each month, CCHA stratifies and revises outreach and interventions using claims and RAE-level data provided by HCPF to feed internal dashboards, and then passes relevant information on to PCMPs. For example, PTCs and clinical quality teams offer detailed data and high-risk member lists to practices and BH entities identifying their complex and high-cost members who may benefit from care coordination and wrap-around services, in the case of the ACNs, or refer them to CCHA for care coordination.

In alignment with HCPF's priority areas, CCHA worked with providers to identify existing programs related to diabetes, maternity care, and complex members. For each program, CCHA is collaborating with providers in the following ways:

- ***Diabetes*** – CCHA works with providers to connect members to care coordination services, and the PTCs also share member-level data to help practices prioritize members, which includes:
    - Members with less than one A1c reading within the last 12 months
    - Last A1c reading, if available
    - Less than one visit a year with their PCMP

  Further, to prioritize medication adherence and assist with providers who may have challenges with pulling their own data, CCHA added this measure to the 2021 Provider Incentive Program and created a dashboard to share diabetes medication adherence data.
- ***Maternity*** - CCHA identified the OBGYNs with the most significant Medicaid utilization and births claims who CCHA has not contracted as PCMPs. CCHA is in the process of meeting with each of these providers to educate them on how CCHA can support them by providing care coordination, connecting members to community resources, and providing free educational information for members. Though it has sometimes been challenging to connect with these providers, CCHA has hired a physician consultant to help facilitate peer to peer connections with these OBGYNs. Additionally, CCHA has developed dashboards to share data with OBGYNs related to their member utilization patterns to decrease unnecessary ED utilization for pregnant women. CCHA encourages these providers to sign up for the CCHA specialist newsletter, which provides regular updates about CCHA programs and Health First Colorado benefits.
- ***Complex -*** CCHA will implement a refined, evidence-informed complex definition this year to align with HCPF's priorities and stratify members with the highest needs. Inspired by a literature review, CCHA has been working to identify critical characteristics of its most complex members in addition to the ten conditions identified by HCPF. This information will support use of predictive analytics to identify high-needs members and CCHA will share that information with PCMPs. In addition, as explained below, CCHA implemented a new payment arrangement with PCMPs on 7/1/21. This new payment methodology will allow more financial incentives and resources to manage the most complex members with the idea that a strong relationship between the PCMP and a member will lead to better condition management and decreased hospital and ED utilization.

CCHA regularly informs network providers and community partners how to refer members to CCHA for care coordination services. CCHA disseminates this information through various avenues, including monthly provider

newsletters, monthly quality meetings with CCHA PTCs, a routine collaboration between care coordinators and PCMP practices, and CCHA community liaison meetings with community organizations.

CCHA is also committed to the objective and systematic monitoring and ongoing evaluation of the provider network's quality, safety, and effectiveness. This multidimensional approach enables the team to focus on opportunities for improving clinical care, service quality, member safety, and member experience. Over the next year, CCHA will continue to monitor the quality of services provided and implement new quality improvement strategies to improve these services. For example, CCHA will create new partnerships with top-volume BH providers and facilitate continuous improvement cycles through BH-focused scorecards and quality dashboards. In addition, quality improvement interventions will be implemented to increase member safety, improved functional outcomes, and increased satisfaction with services.

Recently, CCHA developed practice profiles detailing the risk-adjusted total cost of care at the practice site level to help providers better understand their membership and opportunities for improvement. CCHA designed the practice profile reports to compare spending and utilization across an entity's practices and the RAE as a whole. These will include member costs and utilization related to professional and outpatient services, long-term care services, hospital services, and home and community-based services. These profiles also show the top providers and services by cost related to home health and home and community-based services and provide an in-depth look at pharmacy claims, offering the top medications, pharmacies, and therapeutic drug classes by cost. CCHA shared the first iteration of the practice profile reports with Clinica Family Health and STRIDE CHC in Region 6. Pending feedback, the information will be finalized and shared with the broader network.

In addition, PTCs aid practices in promoting wellness and establishing relationships between the members and their PCMP, which can positively influence patient outcomes. PTCs provide practices with their Medicaid rosters, which indicate if the member is verified, meaning that the member has received services from the practice in the previous 24 months. This data allows the practice to identify all of their Health First Colorado members and unverified members who haven't been seen within the last 24 months and may have unmet health care needs. PTCs review this data with practices at least monthly and utilize this time to address KPIs that may indicate gaps in care for members, such as well visits, dental visits, and ED utilization.

Payment Strategies

Administrative payment strategies

- ***Tiered Payment Model (PCMPs) -*** Beginning July 1, 2021, CCHA implemented a new tiered payment model for the PCMP network that aligns with the HCPF's Population Management Framework. This Framework is designed to help achieve HCPF and state goals aimed at improving health outcomes and reducing unnecessary costs through targeted condition management programs that address conditions most prevalent among Health First Colorado members, as identified by the state. CCHA's new tiered payment model is designed around condition management programming available within the network. The new tiered payment model will increase resources for programs and services provided to members engaged in care, particularly those who require a higher degree of support to manage or prevent the progression of complex health conditions identified as priority by the state.
- ***COVID-19 Support -*** In SFY20-21, CCHA provided PCMPs with both operational and financial support during the COVID-19 pandemic. The immediate and unexpected reduction of in-person services created significant financial barriers for providers; however, many reported the additional funding from HCPF, passed down through the RAEs, helped prevent unnecessary closures and access issues. In Region 6, using a combination of earned KPI funds and performance pool financial support, CCHA paid out $3,295,067.52 to PCMPs. PTCs also educated PCMPs on changes to telehealth benefits, helped set up telehealth workflows, and shared best practices as PCMPs learned to navigate a new normal throughout the pandemic. Additionally, CCHA PTCs and Network Managers helped practices navigate barriers

around establishing telehealth services and workflows to better serve members both now and in the future when in-person care may not be practicable.

CCHA supports providers by sharing the most current information about COVID-19 and updates providers through the provider newsletter and email blasts as important information becomes available. CCHA works with providers to leverage state and local initiatives (such as the interim payment program), encourage providers to become vaccination sites and understand cultural differences that may fuel vaccine hesitancy among their members. In addition to resource sharing, PTCs have helped identify vaccine sites for vulnerable members, for example, Colorado Community Clinic is working with CCHA Care Coordinators to set up COVID-19 vaccine appointments for members who are releasing from the Department of Corrections.

CCHA Incentive Programs and Key Performance Indicator Strategies

CCHA is committed to investing all KPI incentive dollars earned back into the community. 75% of funds go back to PCMPs through the Provider Incentive Program; the remaining 25% of funds are directed to community partners or providers through the Community Incentive Program to fund innovative projects that address high-priority community and member needs.

- ***Primary Care Medical Provider Incentive Program*** - For CCHA to payout incentive dollars to PCMPs, CCHA as a region must first accomplish the KPI Tier 1 or Tier 2 goals. PCMPs with attribution of 300 or greater and rural providers are eligible for CCHA's incentive program. CCHA's incentive criteria include the following elements:
    - Clinical Quality Indicators
    - ACC performance measures
    - Member outcomes
    - Focus on prevention and primary care
    - Efficient and appropriate utilization of services and benefits

  The SFY20-21 PCMP Incentive Program also included an asthma clinical outcome metric, which requires at least 50% of members with asthma have at least one visit with the provider annually. PTCs continue working with PCMP practices to initiate quality improvement activities to meet and improve on asthma incentive metrics, including identifying members who have not been seen by the practice in more than a year and implementing an outreach campaign to get members seen. Additionally, CCHA developed an asthma medication adherence dashboard that coaches share with practices to identify members who are not adherent to their medications.

  In SFY20-21, CCHA paid $3,753,934.93 in incentives to PCMPs in Region 6. CCHA will reevaluate the criteria included in this program for next year, such as new medication adherence measures, to better align with HCPF initiatives related to decreasing costs and managing chronic conditions. Nevertheless, pay for performance has shown to be an effective strategy to address gaps in care related to chronic conditions, hopefully reducing complications and costs.
- ***Community Incentive Program -*** CCHA's Community Incentive Program invests money for services that are not billable Health First Colorado benefits or to support organizations with starting a new resource or service not requiring ongoing funding. Activities or services must align with at least one of the priorities of the ACC program, KPIs, and/or other incentive measures. The CCHA Community Incentive Program application and selection process is managed by the voting members of CCHA's regional Performance Improvement Advisory Committee (PIAC). In 2021, CCHA will pay $700,000 to the selected projects in Region 6. Examples include:
    - Clinica Family Health to support a task force and implement programs that will address service gaps for underserved people in Clear Creek, Gilpin, and Western Boulder counties

- University of Colorado Medicine to mobilize remote patient monitoring resources to Health First Colorado members who are high-risk for COVID-19 complications or avoidable emergency department use in Jefferson County.

As mentioned above, CCHA is committed to improving dental and well-visit KPI rates that fell during the height of the pandemic. With an ever-increasing denominator due to the public health emergency orders, PTCs are helping PCMPs stratify members overdue for these visits by creating goal-driven plan-do-study-act cycles. For instance, CCHA learned that some practices are overwhelmed by trying to get everyone in for well visits at once, so one Region 6 practice outreached members with birthdays in the coming month, to make a more manageable outreach plan. These efforts have increased their well-visit rate by 6% since January. PTCs will share this lesson learned and other best practices with PCMPs to help meet KPIs and quality improvement goals.

Behavioral Health Quality Improvement Program (BHQIP)

CCHA recognizes the unique challenges providers experience while caring for members with complex BH needs and appreciates the quality of care BH network providers consistently offer to members. Moving forward in recognition of those efforts, CCHA will implement the BH Quality Incentive Program (BHQIP), which will provide incentives to eligible BH network providers for supporting quality care and service to its Medicaid members with BH needs. Centered around improving clinical quality indicators, health outcomes, and a focus on prevention and appropriate follow-up, the BHQIP will create efficiencies, reduce inappropriate utilization, address social determinants of health (SDOH), and increase the value of services. Providers participating in the program who meet pre-determined quality, service, and utilization goals will be eligible to receive incentive payments annually.

CCHA has also designed the Social Determinants of Health Provider Incentive Program (SDOHPIP) to encourage BH providers to identify and assist members with SDOH needs. SDOHPIP will offer incentives to BH providers to screen for SDOH needs, submit appropriate SDOH-related diagnosis codes on their claims, refer members to relevant community-based organizations (CBOs), and for updating the status of those referrals to indicate that a member attended that appointment. CCHA anticipates improved health outcomes for these members due to this enhanced collaboration with BH providers.