COLORADO
Department of Health Care Policy & Financing

Annual Practice Support Plan
Instructions and Narrative Report

RAE Name	Colorado Community Health Alliance
RAE Region #	7
Reporting Period	SFY20-21Q1-4 07/01/2020 – 06/30/2021
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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 Narrative
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.

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Practice Support Plan Narrative

Colorado Community Health Alliance's (CCHA) Provider Support Plan utilizes a multidisciplinary team dedicated to providing assistance to primary care and behavioral health 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 our providers to achieve these goals through educating providers about Health First Colorado benefits, providing them with necessary data, sharing best practices, and alignment of quality improvement activities and evidence based programs. . To align with the shifting efforts of the ACC, Practice Transformation Coaches continue working with practices on all aspects of the quadruple aim, with particular attention to reduction in cost of care for FY20/21. Over the first years of the program, CCHA's focus on key performance indicators (KPIs) has resulted in a steady increase in well visits and dental visits. These efforts will be continued and expanded to include the population management strategies outlined below based on research that show practice transformation is a continuous process and that a focus on preventative care at the practice level may lead to reduction in hospitalizations and total cost of care.

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, etc. Advocate for providers and act as a liaison between the Department of Health Care Policy and Financing (HCPF) and the provider network.
- ***Practice Transformation Coaches (PTCs)*** – Support quality improvement activities, data sharing, quality improvement tools, and establishing quality improvement teams, supporting providers with ACC initiatives such understanding and meeting the key performance indicators (KPIs), the behavioral health (BH) incentive, and the Alternative Payment Methodology (APM) measures; as well as aligning quality improvement activities.
- **Clinical Quality** – Collaborates with providers to improve the health outcomes for members, 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, facilitate appointments with the Primary Care Medical Provider (PCMP) and other specialists or specialty BH network providers, co-located care coordinators, establish processes for PCMPs to refer members for care coordination services and provide 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 on a monthly, quarterly and yearly basis; topics will be identified through various channels (i.e. benefit changes, HCPF policy, provider requests, etc). Trainings 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 trainings (learning sessions, in-practice boot camps, Medicaid provider update meetings)
- Virtual trainings (live or recorded webinars)
- Provider open forums
- Provider orientations
- Provider portal, which is in progress and will be live by the end of the year

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 and behavioral health providers. They are available via the CCHA website and provider memos or bulletins will be sent by email, standard U.S. Mail or fax and may serve to amend or update the information in the provider manual between editions.

Provider Orientation – New physical health providers receive a formal orientation by a Network Manager. This orientation includes a review of the provider manual and CCHA policies and procedures. CCHA makes every effort to schedule initial training of newly contracted providers or provider groups within thirty (30) calendar days of their participating status date or 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 offered in either large group settings, virtually via webinars, or in-person. Provider orientations for behavioral health providers will include elements specific to capitated behavioral health such as utilization management and the claims submission process.

Website – The CCHA website, CCHAcares.com, has information for providers and members regarding CCHA, Health First Colorado, the ACC, and health resources. The website is available in English and Spanish and 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 that other languages can be translated by Google at the click of a button.
- ***Patient Education*** – All Health First Colorado and vendor information is listed and explained on the website to help members navigate the resources available to them. Information about staying healthy, emergency department (ED) utilization, choosing a doctor, etc., is also included on the website.

Materials – CCHA has developed a wide array of practice support and member materials to help explain the ACC and educate members about their health. Practice materials can be ordered for free from the website and include items such as a CCHA Quick Reference Guide, depression screening guides and tools, behavioral health referral guides, and KPI reference guides. Member materials include the Map to Medicaid brochures, care coordination brochures, prevention topics, behavioral health guides/referral information, general disease education materials, and more. Examples of these materials are available upon request.

Whole Person Care and Population Management Strategies

CCHA relies on the quadruple aim as the overarching vision to drive successful population management and recognizes that our provider network plays an integral part in achieving these goals. As described in detail in our Population Management Strategic Plan, CCHA's Population Management Program is built upon understanding the population we serve and aligning our interventions to meet the unique needs and complexities of our members, supporting the providers that serve our members, and forming strong community partnerships. CCHA is focusing on using evidence-based models, aligning with provider interests and focus areas, and feedback from our performance improvement advisory committee as we continue to develop, evaluate, and modify interventions related to chronic conditions. Throughout the past year, CCHA has worked with providers to identify existing programs related to chronic conditions and supported providers as they transitioned into telehealth services for some appointments. Each month, CCHA stratifies and revises our outreach and interventions using RAE level data provided by HCPF, uses claims data to feed internal dashboards, and receives referrals from the PCMPs and community entities. Additionally, PTCs and clinical quality teams provide detailed data and high risk member lists to practices and behavioral health entities identifying their complex and high-cost members. These member lists help providers to recognize which members may benefit from care coordination and wrap around services with

within their own systems, in the case of the Accountable Care Network (ACN), or refer them to CCHA for care coordination.

CCHA is also committed to the objective and systematic monitoring and ongoing evaluation of the quality, safety, and effectiveness of our provider network. 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. In order to achieve these goals, new partnerships with top volume behavioral health providers will be created and cycles of continuous improvement will be facilitated through behavioral health focused scorecards and quality dashboards. Quality Improvement (QI) interventions will be implemented with the goal of increased member safety, improved functional outcomes, and increased satisfaction with services.

Beginning this year, practice transformation coaches will also provide practices, including ACNs, with practice profiles, which will give providers a more in depth look at their Medicaid population and costs related to them. These will include patients' spend 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 provides an in depth look at pharmacy claims, showing the top medications, pharmacies, and therapeutic drug classes by cost. Utilizing this information, CCHA will work with ACNs and other providers to ensure programming related to complex members best addresses member needs and leads to positive outcomes. Additionally, CCHA will be launching our provider portal and have at least 10 practices enrolled and engaged by the end of the year.

CCHA supports non-ACN providers with care coordination efforts including our recently created condition management program. Through this program, care coordinators will be able to identify members facing various conditions and help them connect with their PCMPs and specialists to obtain needed care in addition to collaborating with the member's entire care team to provide disease education and motivational interviewing techniques to engage the members in their own care. CCHA is also using research based risk stratification to identify members with chronic conditions who may benefit from more comprehensive care coordination services or community resources. Starting with diabetes, CCHA's PTCs will support implementation of evidence-based clinical guidelines related to chronic condition management at practices. The PTCs will help guide practices quality improvement activities related to condition management and providing supporting data to evaluate these initiatives.

In addition to condition management, PTCs aid practices in promoting wellness and establishing relationships between the members and their PCMP, which is shown to lead to 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 including unverified members who haven't been seen within the previous 24 months and may have unmet health care needs. PTCs review this data with practices at least monthly and also utilize this time to address key performance indicators that may indicate gaps in care for members, such as well visits, dental visits, and ED utilization.

Finally, PTCs will work with practices to implement sustainable telehealth practices, services, including sharing best practices, once the emergency rule expires, with the goal of increasing the number of telehealth PCMPs with telehealth office visits for members who don't have easy access to providers in the area. Education and information related to billing, coding, and best practices will be continually be shared with practice in additional to formal training, by way of webinar, to update providers on changes to telehealth benefits.

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Payment Strategies

Administrative payment strategies

Per Member Per Month Value-based Payment for PCMPs

CCHA has implemented a tiered per member per month (PMPM) payment strategy to encourage providers to outreach members. Under this arrangement, PCMPs receive a minimum PMPM for members attributed to the PCMP and an enhanced PMPM for attributed members that had a claim with the PCMP in the last 24 months (i.e. a verified relationship). While there weren't significant changes in the ratio of verified to unverified over the previous year, CCHA was successful in introducing providers to this type of arrangement identified ways in which the program shall involve. In this state fiscal year, CCHA plans to change this payment arrangement to incent quality care for complex members within innovative, sustainable infrastructure through the following: a higher PMPM for members with complex needs; incent providers to create evidenced-based programming for condition management; and pay less for members who are not utilizing any Medicaid services.

For the remainder of CY20, PCMPs that demonstrated behavioral health integration will continue receiving an additional PMPM payment through CCHA's Primary Care Integration Program. Practices had to meet eligibility requirements for this program as of January 2020 and the program runs for one year.

COVID Support

As described in our COVID part 1 deliverable, CCHA conducted a provider survey to determine what impact COVID was having on member care and their knowledge on available financial assistance. CCHA utilized the results of this survey to assess the best ways to support providers operationally and financially moving forward, such as supporting all behavioral and physical health providers in implementing telemedicine policies and procedures so that access wouldn't be impacted. Billing, coding resources, and training materials were made available to providers related to support this change in telehealth requirements.

In the survey mentioned above, 50% of providers who responded have already applied for financial assistance. To further support providers financially through these difficult times, CCHA created a COVID Support Fund for providers with the performance pool dollars earned by CCHA from the previous fiscal year. Providers that were eligible for this fund are safety net clinics, federally qualified health centers, and practices with less than 500 employees that are not part of a health system or national company; providers must also have at least 300 CCHA members attributed to their practice. The expectation of providers who received support through this fund is that they will use it to ensure practices return to pre-COVID operations and offer the quality, comprehensive care that members need. Once a practice recovers operationally, CCHA expects that remaining unused funds be specifically directed towards the care of members with chronic conditions, including those who are receiving long term service and supports and/or are high utilizers of the health care system, specifically identified as complex by the Department. Since funds have been distributed, CCHA has been checking with providers about their intention for and/or use of these funds in hopes that practices share stories related to how the COVID Support Fund enabled their practice to better serve CCHA members. CCHA is anticipating utilizing a similar methodology for performance pool dollars earned in this fiscal year.

Key Performance Indicator Incentive Payment Strategies

CCHA is committed to investing all KPI incentive dollars back into the community. 75% of funds go back PCMPs through the Provider Incentive Program, while the remaining 25% of funds are directed to community partners through the Community Incentive Program to fund innovative projects that address high priority community and member needs. Community Incentive Program awards are determined by the regional Program Improvement Advisory Committee (PIAC), annually.

Annual Practice Support Plan

CCHA Primary Care Medical Provider Incentive Program

This program is funded using incentive payments CCHA has earned for achieving KPI goals set by HCPF. In order for CCHA to pay out incentives dollars to the PCMP, CCHA as a region must first achieve the KPI Tier 1 or Tier 2 goals. CCHA's incentive criteria include the following elements:

- Clinical quality Indicators
- ACC performance measures
- Member outcomes
- Focus on prevention and primary care
- Integration of behavioral and physical health
- Efficient and appropriate utilization of services and benefits

As a result of the provider incentive program, CCHA saw consistently improved KPI performance over the last year, increased provider engagement in practice transformation efforts, and a better overall understanding of member needs and provider resources needed to meet them. In SFY 19/20, CCHA paid $6,738,252 in incentives to PCMPs and an additional $2,246,084 to the community partners who assisted in earning these incentives. CCHA will be reevaluating the criteria included in this program for FY 20/21 to better align with HCPF initiatives related to decreasing costs and managing chronic conditions. Pay for performance has shown to be an effective strategy to address gaps in care related to chronic conditions, hopefully leading to a reduction in complications and, therefore, costs.

Furthermore, CCHA has invested performance pool incentive dollars in programs designed to help reduce costs by providing services to high-cost members that will hopefully decrease ED utilization, and inpatient admissions and readmissions. For example, CCHA is partnering with AspenPointe, the community mental health center in Region 7, in a pilot program which AspenPointe will outreach members on the Rapid Readmissions list to engage them in behavioral health services and use intensive case management in order to reduce readmissions, decrease ED utilization, and lower total cost of care. Telehealth for behavioral health services is a promising strategy to improve access to care, though it has lagged behind use in primary care settings on a national level.

Behavioral Health Quality Improvement Program (BHQIP)

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

Behavioral Health Facility Improvement Program (BHFIP)

The BHFIP is designed to reward eligible Institutions for Mental Disease (IMD) providers for delivering timely, cost-effective, high-quality care to our members. Using both absolute targets and year-over-year improvements, the program uses efficiency measurements and pay-for-performance principles to incentivize facilities to utilize evidence-based methods designed to maximize treatment benefits while maintaining sound stewardship of resources. The BHFIP is incorporated into the IMD's contract and they are eligible to receive performance payments in recognition of their efforts to improve clinical quality indicators, health outcomes, and use of preventative and follow-up services. Providers must meet performance outcomes related to appropriate utilization of services to receive additional funds.