ROCKY MOUNTAIN HEALTH PLANS
REGIONAL ACCOUNTABLE ENTITY
2021 RESOURCE GUIDE

Region 1
A Resource Guide for Providers
# Table of Contents

- About This Guide .................................................................................................................. 3
- Know the Terminology ........................................................................................................... 4
- What is the RAE? ....................................................................................................................... 6
- Implications for Primary Care Practices ................................................................................ 9
- RMHP’s Vision for Value Based Payment .............................................................................. 11
- PCMP Payments and Attribution ....................................................................................... 13
- Department RAE KPIs .......................................................................................................... 16
- Department of Healthcare Policy and Financing Alternative Payment Model for Primary Care ................................................................................................................................. 27
- Get Involved .......................................................................................................................... 29
- Supplemental Resources for Patient Care ........................................................................... 31
- Primary Care Frequently Asked Questions (FAQs) ............................................................. 32

**RMHP RAE ATTESTATION PROCESS AND ONGOING TIER DEMONSTRATION** ................................................................................................................................. 33

- RAE Attestation Directions & Ongoing Tier Demonstration .................................................. 34
- New RAE PCMP Attestation & Ongoing Demonstration Materials ......................................... 36

**RMHP RAE PROVIDER NETWORK PARTICIPATION** ................................................................................................. 61

- RMHP RAE Provider Network Participation ........................................................................... 62

**RMHP PRIME: PAYMENT REFORM INITIATIVE FOR MEDICAID EXPANSION** ................................................................................................................................. 64

- RMHP Payment Reform Initiative for Medicaid Enrollee (RMHP Prime) ............................. 65

**RMHP RAE KEY CONTACT INFORMATION** ............................................................................. 71

- RMHP RAE Key Contact Information .................................................................................... 72

**EXHIBIT A: EASYCARE Colorado** ........................................................................................ 73

**EXHIBIT B: RURAL AUXILIARY SERVICES (RAS)** ...................................................................... 75
About This Guide

Rocky Mountain Health Plans (RMHP) is committed to ensuring providers have the tools and resources necessary to help best serve our Members.

We created this guide to help RMHP providers understand the Regional Accountable Entity (RAE) and ensure successful delivery of health care services to Members enrolled with RMHP, as the Health First Colorado RAE. Changes to RAE content and administration are subject to change upon notice.

Guide Components

- Know the Terminology
- What is the RAE?
- Implications for Primary Care Practices
- RMHP’s Vision for Value Based Payment
- Primary Care Medical Provider (PCMP) Payments and Attribution
- Primary Care Frequently Asked Questions
- RAE Key Performance Indicators (KPIs)
- RAE Tiering for New PCMPs and Ongoing Demonstration of Criteria
- RMHP Payment Reform Initiative for Medicaid Expansion (RMHP Prime)


- Page 8: Updated PCMP Payment Information
- Pages 9-10: Updated PCMP Steps for Contracting
- Pages 12-14:
  - 2021 PCMP Payment Methodology for monthly Medical Home Payments
  - Updated KPI Payment Information for Tier 4 to reflect January 1, 2021 contract changes
- Page 16: Updated auto-assignment processes
- Pages 17-24: Updated KPI one-pagers and baseline/target information
- Pages 25-26: Added RAE Performance Pool measure specifications
- Pages 29-31: Updated Resources to Support Practices
- Page 31: Updated Supplemental Resources for Patient Care information (EasyCareCO and Rural Auxiliary Services)
- Page 36: Updated timeline to meet tiering criteria
- Pages 46-47: Updated Tier 1 Assessment criteria
- Pages 50-58: Updated eCQM suite with 2021 benchmarks Primary Care Medical Provider (PCMP) Payments and Attribution
- Page 71: Additional RMHP Key Contacts included
- Page 73: Updated EasyCareCO flyer for patients
- Page 75: Updated Rural Auxiliary Services flyer for patients
Know the Terminology

We understand initiatives like the RAE can mean new acronyms. This definitions section is a reference for some of those terms you will find throughout this guide.

**Accountable Care Collaborative Program or ACC Program** – the Accountable Care Collaborative is a program of Health First Colorado (Colorado’s Medicaid Program) designed to help Health First Colorado enrollees connect with physical health providers, behavioral health providers, care coordinators, and local services and supports. The Accountable Care Collaborative Program works to build a medical home for each Member, and enhance Member and provider experience.

**Accountable Care Collaborative Member** – includes Health First Colorado Members enrolled with a RAE and Health First Colorado Members, also enrolled with RMHP, in the ACC program payment reform initiative known as, RMHP Prime.

**ACC Phase II** – the next iteration of the Accountable Care Collaborative seeks to leverage the proven successes of Colorado Medicaid’s Programs to enhance the Health First Colorado Member and provider experience. Regional RAEs are part of this next phase of the ACC, which launched on July 1, 2018.

**Accountable Health Communities Model (AHCM)** – As deployed by RMHP and its regional partners, the mission of the AHCM is to develop a more effective network to support the social, emotional, and physical health of Western Colorado. Participating primary care, behavioral health, and hospital partners will screen patients of all ages for social needs including transportation, utilities, housing, food, interpersonal violence, and social isolation. In connection with the Community Resource Network (CRN), a division of Quality Health Networks (QHN), that focuses on information exchange with social service organizations, patients will be connected to community organizations that target their unmet social needs. Patients with at least one unmet social need and two or more ER visits in the last year will also be invited to engage with an internal or external community navigation resource.

**Attribution** – the method used to link RAE Members to their medical home, or Primary Care Medical Provider (PCMP).

**Centers for Medicare and Medicaid Services (CMS)** – federal agency within the United States Department of Health and Human Services that works in partnership with state governments to administer Medicaid.

**Community Integration Agreement (CIA)** – a type of value-based payment that is available for RMHP RAE Tier 1 practices to receive. This agreement supports integrating primary care and behavioral health services, assessing and addressing social determinants of health, enhancing the delivery of team-based care, using advanced business practices that support value based payment, and other activities designed to improve Member health and experience of care.

**Department** – Colorado’s Department of Health Care Policy and Financing, which is the single state agency that administers Colorado’s Medicaid program. Also known as HCPF.

**eClinical Quality Measures (eCQMs)** – electronic clinical quality measures use data extracted from the electronic health records (EHR) or approved health information technology systems to measure the quality of health care provided. Tier 1 – 3 practices are expected to report eCQMs quarterly with annual evaluation.

**Health First Colorado** – the name of Colorado’s Medicaid Program.

**Health First Colorado Data Analytics Portal (DAP)** – a web portal designed to support Health First Colorado’s ACC by providing data to PCMPs and RAEs. The portal is hosted by IBM Watson Health (formerly Truven).

**Key Performance Indicators (KPIs)** – measures designed to assess the overall performance of the ACC Program and RAEs to reward RAEs for improvement of health outcomes, access to care, quality of services, cost savings, and regional delivery system as a whole.
Medical Home or Medical Home Model – the principles of a Medical Home Model include care provided in a manner that is: Member/family centered, whole-person oriented and comprehensive, coordinated and integrated, provided in partnership with the Member and promotes Member self-management, outcomes focused, consistently provided by the same provider as often as possible so a trusting relationship can develop, and provided in a culturally competent and linguistically sensitive manner.

Primary Care Medical Provider or PCMP – a primary care provider who serves as the medical home for attributed Health First Colorado Members and partners with their RAE to coordinate the health needs of their Members. To support the additional responsibilities for serving as a PCMP, the RAEs will distribute value-based administrative payments to contracted PCMPs. Providers must, at a minimum, meet the following criteria to qualify as a PCMP:

- Enroll as a Health First Colorado provider
- Hold an MD, DO, or NP provider license in one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics, and able to practice in Colorado. Physician Assistants (PAs) can provide care through a contracted PCMP practice.

PCMP Practice Site – a single brick and mortar physical location, where services are delivered to Members under a single Medicaid billing provider identification number.

Regional Accountable Entity or RAE – Colorado has seven Regional Accountable Entities that are part of ACC program. RMHP is the RAE for Region 1, which includes Western Colorado and Larimer County.

RAE Member – an individual who qualifies for Health First Colorado and is enrolled with a Regional Accountable Entity.

RAE Members without RMHP Prime – most RAE Members are not enrolled in RMHP Prime. This term is used in this document to clarify differences/similarities for RAE Members with and without RMHP Prime.

Regional Organization – In accordance with the style guidelines set forth by Health First Colorado, Member-facing communications to RAE Members use the term regional organization, rather than RAE. A Member’s understanding is that they belong to a regional organization.

RMHP Prime or Prime – “Payment Reform Initiative for Medicaid Enrollees” – a payment reform initiative under the ACC Program in which RMHP functions as a payer for Medicaid physical health services. Within RMHP Prime, the Department pays a fixed global payment to RMHP for medical services provided to RMHP Prime Members. RMHP Prime operates within RMHP’s RAE contract with the Department. As such, all RMHP Prime Members are also enrolled with RMHP, as a RAE Member, for behavioral health services and other applicable services provided by the RAE. This aligned administration of behavioral and medical services, along with community social determinant of health activities, supports a whole person, community-connected approach to care.

RMHP Prime Counties – Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties.

RMHP Prime Member – an individual who qualifies for Health First Colorado and is enrolled by the Department with RMHP, under an ACC program payment reform initiative known as RMHP Prime. Eligible individuals must reside in an RMHP Prime county. This includes adults who receive full Health First Colorado bene and children with disability status. All RMHP Prime Members are also enrolled with RMHP as the RAE for behavioral health services. Also, RMHP Prime Members may be referenced as RAE Prime Members.
What is the RAE?

In October 2017, the Colorado Department of Health Care Policy and Financing (the Department) awarded RMHP the contract to serve as the RAE for Region 1 of the Health First Colorado ACC. This contract became effective July 1, 2018.

As the RAE, RMHP is responsible for connecting Health First Colorado Members with both primary care and behavioral health services for Region 1, which includes Western Colorado and Larimer County. Members know their RAE as their regional organization. This builds upon our foundation of our previous services as a Regional Care Collaborative Organization (RCCO) and growing our community-oriented approach for Health First Colorado Members as RMHP Community.

The RAE (pronounced “RAY”) for Region 1 includes:

- Services previously performed by RMHP as the Regional Care Collaborative Organization (RCCO), including the primary care medical provider network and care coordination services
- Services previously performed by the regional Behavioral Health Organization (BHO), including managing covered services under the Medicaid Capitated Behavioral Health Benefit
- Western Colorado payment reform initiative known as RMHP Prime
- Additional services to support whole person care, including activities to address social determinants of health
Role of the RAE: Community Health

Support and Promote Whole Person Care
- Develop a cohesive health neighborhood where care across disparate providers is coordinated and collaborative
- Establish and improve referral processes, including use of care compacts
- Encourage collaborations and strategies with a wide range of community partners to address social determinants of health

Promote Population Health
- Develop a population health management plan to prevent the onset of health conditions and lessen the impact of health conditions on Member’s lives
- Utilize evidence-based practices and promising local initiatives, including those addressing social determinants of health

Role of the RAE: Responsibility to Providers

Contract and Engage with Primary Care Medical Providers
- Develop and maintain a network of participating Primary Care Medical Providers (PCMPs)
- Provide training and support to primary care practices
- Reimburse PCMPs through a value-based payment model

Contract and Engage with Behavioral Health Providers
- Develop and maintain a credentialed and contracted statewide network of behavioral health providers to provide covered behavioral health services in primary care offices, community mental health centers, and independent practice sites
- Provide utilization management of covered behavioral health services
- Reimburse behavioral health providers for services covered under the Capitated Behavioral Health Benefit
- Provide training and support to behavioral health providers, such as learning events, peer-to-peer networking, resources, and other practice transformation support

RMHP’s RAE Behavioral Health Provider Manual can be accessed at rmhp.org. Select I am a Provider, then choose Provider Resources > Commonly Used Forms. We strongly encourage primary care, independent, and community mental health center behavioral health providers and administrators to read this for more details on expectations related to providing behavioral health services for Health First Colorado Members.

What should PCMPs expect from RMHP?
- RMHP will serve as a central point of contact regarding Health First Colorado services and programs, regional resources, clinical tools, and general administrative information.
- RMHP will support providers that are interested in integrating primary care and behavioral health services; addressing social determinants of health; enhancing the delivery of team-based care by leveraging all staff and incorporating patient navigators, peers, promotoras, and other lay health workers; advancing business practices and use of health technologies; participating in APM; and other activities designed to improve Member health and experience of care.
- RMHP will offer general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support.
- RMHP will provide care coordination services for providers Health First Colorado Members, with support from integrated community care teams, where available.
**Understanding RAE Processes**  
Please contact RMHP with any questions about the below information.

<table>
<thead>
<tr>
<th>Process</th>
<th>RAE Fast Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members</strong></td>
<td></td>
</tr>
<tr>
<td>Mandatory Enrollment</td>
<td>Enrollment is mandatory.</td>
</tr>
<tr>
<td></td>
<td>No opt-out. All Health First Colorado Members must enroll.</td>
</tr>
<tr>
<td>Enrollment Effective Date</td>
<td>Enrollment begins upon Member’s Health First Colorado eligibility determination.</td>
</tr>
<tr>
<td>Member Enrollment Region</td>
<td>Member enrollment in the RAE is based on the physical location of the Member’s attributed PCMP site, not the Member’s residence.</td>
</tr>
<tr>
<td>Member Attribution</td>
<td>RAE Members are immediately attributed to a PCMP upon being determined eligible for Health First Colorado benefits.</td>
</tr>
<tr>
<td></td>
<td>RAE Members are attributed to a PCMP, even when there is no prior claim or patient choice history.</td>
</tr>
<tr>
<td></td>
<td>For RAE Members enrolled in RMHP Prime, attribution follows current RMHP attribution methodology and process.</td>
</tr>
<tr>
<td>Member Re-Attribution</td>
<td>Every 6 months the Department will run a re-attribution process to attribute RAE Members/PCMPs based on claims during the most recent 18 months.</td>
</tr>
<tr>
<td></td>
<td>If the Member’s new attributed PCMP is in a different region, the Member’s RAE enrollment will change to the PCMP’s region.</td>
</tr>
<tr>
<td></td>
<td>For RAE Members in RMHP Prime, re-attribution follows RMHP’s current process.</td>
</tr>
</tbody>
</table>

**PCMPs**

<table>
<thead>
<tr>
<th>PCMP Agreement</th>
<th>Each PCMP site has an agreement with the RAE in that site’s region. The Department will no longer have a unique PCMP contract with providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMP Payments</td>
<td>RAE pays a monthly PMPM to PCMPs for RAE Members based upon: 1) the practice’s tier 2) the Member’s acuity level 3) the Member’s age 4) the Member’s language/ethnicity/race</td>
</tr>
<tr>
<td>Physical Health Reimbursement</td>
<td>Physical health claims for RAE Members are paid by Health First Colorado fee-for-service rates by the Department. Physical health claims for RAE Members enrolled in RMHP Prime are paid by RMHP.</td>
</tr>
<tr>
<td>RMHP Prime</td>
<td>RMHP Prime continues. Additionally, as the RAE, current Prime services and RAE behavioral health services are covered by RMHP.</td>
</tr>
</tbody>
</table>
Implications for Primary Care Practices

RMHP RAE Provider Contracting

- If you are already validated with Health First Colorado, are participating with RMHP as a PCMP, and have signed an agreement and attested to a specific tier with RMHP, nothing further will be required contractually and your network status and tier placement will remain as it is. Providers always have the option to participate at a higher tier as is described, later in this guide.

- PCMPs that have a practice site in Region 1 and are not yet participating with RMHP should sign a participating agreement with RMHP. Practices and/or practice sites must complete the Health First Colorado validation process prior to signing an RMHP RAE participating agreement. If you are currently validated with Health First Colorado and would like to participate as a PCMP in the RMHP RAE, please contact your RMHP Provider Relations and contracting team at 970-244-7798 or 888-286-7372.

- Behavioral health providers that wish to participate with RMHP must complete RMHP's standard credentialing process and agree to accept RMHP's RAE fee schedule agreement to be a participating RMHP RAE provider. Current RMHP credentialed providers are not required to complete additional credentialing by RMHP; however, they must agree to accept RMHP’s RAE fee schedule agreement and be enrolled as a Health First Colorado provider to be a participating RMHP RAE provider. If you are currently validated with Health First Colorado and would like to participate in the RMHP RAE, please contact your RMHP Provider Relations and Contracting Team at 970-244-7798 or 888-286-7372.

We are here to help. Please contact RAE Support for any questions about these activities.

In the RAE, a PCMP practice site is defined as a single brick and mortar physical location where services are delivered to Members under a single Medicaid billing provider identification number.

With this, each PCMP site must:

Step 1: Enroll or Re-validate as a Health First Colorado Provider
PCMPs must be enrolled and validated as a Health First Colorado provider. Information about this requirement can be found on Department’s website. Providers that have already successfully enrolled and re-validated with Health First Colorado will not need to re-validate again until their next re-validation cycle.

Initial enrollment/re-validation
To be reimbursed for services to Health First Colorado Members, providers must be approved through initial enrollment/re-validation, which puts them into the new Colorado interChange System. Enrollment and re-validation are combined in your initial enrollment.

You can view instructions for completing the application on the Department’s website.

Ongoing requirement for re-validation
Once your initial enrollment/re-validation is complete, you will be required to re-validate every 3–5 years depending on your risk-level. The Department and its fiscal agent, DXC, will notify you when you need to re-validate. You can find your risk-level on the Department’s website. Federal regulations established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and re-validation for all participating providers. These regulations are designed to increase compliance, quality of care, and reduce fraud.

Step 2: Ensure Compliance with the Colorado NPI Law
RAE Members are attributed to the PCMP's brick and mortar service location, by the service location’s unique Medicaid Site ID. When submitting claims to Health First Colorado, PCMPs must include the appropriate National Provider ID (NPI). A unique NPI is required in accordance with the Colorado NPI law. The Medicaid Site ID is not required on the claim, but is derived from the combination of the NPI, taxonomy, and 9-digit zip code of the service location. Claims should not use one billing address for all locations.
Step 3: Sign a RAE PCMP Agreement with RMHP
If you currently participate as a PCMP and have signed an agreement and attested to a specific tier with RMHP, nothing further will be required contractually and your network status and tier placement will remain as it is. PCMPs that have a practice site in Region 1 and are not yet participating with RMHP should sign a participating agreement with RMHP. If you are currently validated with Health First Colorado and would like to participate as a PCMP in the RAE initiative, please contact your RMHP Provider Relations and Contracting Team at 970-244-7798 or 888-286-7372.

Step 4: Complete Attestation Process
If you currently participate as a PCMP in the RAE initiative, you have already completed your attestation and are participating according to the tier in which you have been verified. If you are just beginning your participation, you will need to attest to your appropriate tier according to the information to follow in the RAE Primary Care Attestation Directions section of this guide.
RMHP’s Vision for Value Based Payment

RMHP is dedicated to strengthening primary care. We strive to help our providers serve our Members in a manner that enhances the total health care experience, including quality of care, access to care, and reliability of care. We advocate for whole person, coordinated care, aiming for better health outcomes, more efficient spending, and healthier communities.

Together, RMHP and providers work towards these goals with access to evidence-based resources and tools and we reward high-quality, high-value care by reimbursing through a payment structure that supports these goals.

Provider Payments for RAE Region 1 Members

RMHP has implemented a value-based payment model for all participating RAE Region 1 PCMPs. This payment model outlines a clear delineation of provider responsibilities, as well as resources available for different levels of accountability. The levels of participation and accountability, identified as Tiers 1 – 4, reflect this effort to align payment with activities that lead to better patient outcomes and mitigate against growing costs and limited resources.

Provider payments for RAE Region 1 Members are as follows:

- RMHP maintains the PCMP network and an advanced payment model.
- Physical health care claims for RAE Members continue to be paid by the Department at Health First Colorado fee-for-service rates.
- Behavioral health care services covered under the behavioral health capitation benefit for RAE Region 1 Members are paid by RMHP.
- For RAE Members enrolled in the Health First Colorado Payment Reform Initiative, known as RMHP Prime, primary care practices continue under the RMHP Prime Advanced Payment Model. Physical health care services and behavioral health care services are paid by RMHP.

Who Pays?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>RMHP RAE Members without RMHP Prime</th>
<th>RMHP RAE Members with RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Services</td>
<td>Bills sent to and paid by Department following Department claims and authorization methodology.</td>
<td>Bills sent to and paid by RMHP following Provider-RMHP agreement.</td>
</tr>
<tr>
<td>Behavioral Health Services Outside of PCMP Practice</td>
<td>Bills sent to and paid by the RAE behavioral health benefit including SUD benefits.</td>
<td>Bills sent to and paid by the RAE behavioral health benefit including SUD benefits.</td>
</tr>
<tr>
<td>Six Behavioral Health Sessions at PCMP Practice</td>
<td>Up to six Behavioral Health sessions per RAE Member provided by a Behavioral Health Provider and billed by the PCMP to the Department following the Department’s methodology on procedure codes and licensure requirements. After six sessions, the Behavioral Health Provider bills RMHP. The Behavioral Health Provider must be contracted with and credentialed by RMHP. Paid by RMHP under the RAE behavioral health benefit following RMHP-provider agreement.</td>
<td>Up to six Behavioral Health sessions per RMHP Prime Member provided by a Behavioral Health Provider and billed by the PCMP to RMHP following RMHP’s billing procedures. Paid by RMHP under the physical health benefit. The Behavioral Health Provider must be contracted with and credentialed by RMHP. After six sessions, the Behavioral Health Provider bills RMHP. Paid by RMHP under the RAE behavioral health benefit following the RMHP Provider agreement. The Behavioral Health Provider must be contracted with RMHP as an independent provider.</td>
</tr>
<tr>
<td>PCMP Medical Home Payments</td>
<td>Paid by RMHP for RMHP RAE Members attributed by the Department to Region 1 PCMP.</td>
<td>Paid by RMHP following RMHP attribution methodology and Provider RMHP Prime agreement.</td>
</tr>
</tbody>
</table>
### RAE Payment Umbrella: A Quick Reference for Primary Care Medical Practices (PCMPs)

#### RAE non-PRIME

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Medicaid FFS</th>
<th>RAE Medical Home Payments</th>
<th>KPI Quarterly Performance Payments</th>
<th>APM FFS% Reduction</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Pays?</td>
<td>State</td>
<td>RMHP</td>
<td>RMHP</td>
<td>State</td>
<td>State/RMHP</td>
</tr>
<tr>
<td>How much?</td>
<td>HCPF Fee Schedule</td>
<td>See information in table above “Payment Structure by Tier”</td>
<td>Up to: Tier 1 - $4.25 Tier 2 - $2.50 Tier 3 - $1.00</td>
<td>Up to 4% FFS Reduction on APM Code Set (Eligible practices must participate to avoid FFS Reduction)</td>
<td>HCPF Fee Schedule/RMHP Contracted Rates</td>
</tr>
<tr>
<td>How often?</td>
<td>Practice Billing</td>
<td>Monthly</td>
<td>Quarterly (Exact payment timing is contingent upon RMHP’s receipt of final performance data/payment files from HCPF)</td>
<td>Practice Billing</td>
<td>Practice Billing</td>
</tr>
<tr>
<td>Notes</td>
<td></td>
<td>This is for RMHP RAE Region 1</td>
<td>These dollars are passed from the State to RMHP to the practices based upon RAE Region 1 performance</td>
<td>This is a State Program, but RAE assists practices with measure support, success, etc.</td>
<td>First 6 BH visits are paid by the State from physical health benefit; RMHP pays claims after the 6 from BH benefit</td>
</tr>
</tbody>
</table>

#### RAE PRIME

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Global Payment</th>
<th>Shared Savings</th>
<th>FFS for non-E&amp;M codes</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Pays?</td>
<td>RMHP</td>
<td>RMHP</td>
<td>RMHP</td>
<td>RMHP</td>
</tr>
<tr>
<td>How much?</td>
<td>Varies due to Risk adjusted PMPM</td>
<td>Based upon program/practice financial &amp; quality performance</td>
<td>RMHP Contracted Rates</td>
<td>RMHP Contracted Rates</td>
</tr>
<tr>
<td>How often?</td>
<td>Monthly</td>
<td>Annually</td>
<td>Practice Billing</td>
<td>Practice Billing</td>
</tr>
<tr>
<td>Notes</td>
<td>Practice must meet shared savings criteria -eCQMs: CMS137 -Reduction in ED Visits (RMHP must meet MLR targets to pass through the dollars)</td>
<td></td>
<td></td>
<td>First 6 visits are from the physical health benefit; after the 6, it comes from the BH benefit. All paid by RMHP</td>
</tr>
</tbody>
</table>
PCMP Payments and Attribution

**RMHP Medical Home Payment**

RMHP is committed to supporting primary care practices in developing the competencies to show value through delivery of advanced primary care. The RAE tiers have varying expectations for the following elements:

- Levels of transformation activities completed by the practice (as an indicator of the practice’s capacity and capability around providing advanced primary care);
- Ability to report and achieve electronic clinical quality measures (eCQMs);
- Commitment to accepting Health First Colorado Members;
- Health First Colorado Alternative Payment Model (APM) performance;
- Collaborating with high-volume / critical specialists; and
- Willingness to engage with RMHP in ongoing progress assessments.

RMHP will target resources to practices that demonstrate value through the delivery of advanced primary care. Providers that demonstrate greater levels of accountability for access for Health First Colorado Members and that achieve the higher transformation and performance levels, will receive higher reimbursement. Additionally, practices that are the medical home for higher acuity Members and/or Members that are of non-English speaking or of a minority group will receive higher reimbursement.

Practices have the option to participate at the highest tier for which they qualify or decide to participate at a lower tier. Practices also may opt to identify a higher tier and work towards achieving that tier.

**Payments for RAE Members Not Enrolled in RMHP Prime**

**Payments by the Department for Physical Health Services**

Physical health services will continue to be reimbursed at Health First Colorado fee-for-service rates by the Department. Providers will continue to submit physical health claims to the Department for covered health care benefits for Health First Colorado-eligible Members.

Please see information below regarding the Department’s new payment model to make differential fee-for-service payments based on provider’s performance, known as the Primary Care Alternative Payment Model (APM).

*See About Health First Colorado APM for more information.*

**RAE Attribution by the Department**

All RAE Members will be immediately attributed to a PCMP by the Department upon being determined eligible for Health First Colorado. Attribution is important because it:

- Determines the RAE enrollment for the Member
- Enables the Department to track provider and RAE performance
- The RAE may use it to calculate PCMP payments
- Is utilized for PCMPs participating in the Department’s Primary Care Alternative Payment Model

The Department will attribute Members using the following five methods:

1. **Utilization**: Used for Members with claims history with a participating PCMP. The Department will use historical claims data to identify the PCMP the Member has seen the most often during the past 18 months. Paid Evaluation and Management (E&M) claims will be prioritized over other types of claims. For children up to age 21, a set of ten preventive service codes will be prioritized. Attribution will be determined by the provider with the majority of claims.

2. **Family Connection**: In the absence of a utilization history with a PCMP, the Department will identify whether a family member of the Member has a claims history with a PCMP and determine if the PCMP is appropriate. Members will then be enrolled to the family member’s PCMP.
3. **Proximity:** Used for Members with no utilization history in the past 18 months. The Department will look for PCMPs within the region covering the Member’s county of residence and attribute the Member to the closest appropriate PCMP.

4. **Member Contact with the Enrollment Broker:** RAE Members can change their PCMP at any time by contacting the Health First Colorado Enrollment Broker at 888-367-6557 or online at [https://enroll.healthfirstcolorado.com](https://enroll.healthfirstcolorado.com/). Changes take effect the first of the following month.

5. **Ongoing Attribution: PCMP to PCMP Re-attribution:** If a RAE Member develops a stronger relationship with another provider, the Member will be attributed to that PCMP. If the Member requested a provider by calling the Health First Colorado Enrollment Broker within the past 18 months, the Member will continue to be attributed to that provider. This process typically occurs every six months.

As a result of the Coronavirus Disease 2019 (COVID-19) pandemic, the Department of Health Care Policy and Financing (the Department) is anticipating a significant increase in Health First Colorado enrollment. In an effort to ensure that new members can access quality primary care services quickly, the Department is revising its previous methodology for attributing members to a Primary Care Medical Provider (PCMP) based on geographic proximity. These changes apply only to the Department’s geographic proximity attribution methodology for new members without utilization history over the past 18 months or a family connection to an appropriate provider. No changes to the Department’s utilization (claims-based) or family connection attribution methodologies are being made at this time.

Instead of geographically attributing new members to the closest available PCMP, the Department will limit geographic attribution to a list of providers who have expertise in caring for large numbers of Health First Colorado Members and who have the capacity to accept new Members. In partnership with the RAES, the Department established the following criteria to identify applicable PCMPs:

- Include PCMPs who have capacity to accept new Members
- Include providers with Medicaid expertise: Federally Qualified Health Centers, Rural Health Centers and Department-designated Essential Community Providers
- Include key providers that are not designated Essential Community Providers, but who serve critical populations or regions, such as pediatric providers
- Exclude PCMPs that are currently closed, such as most School Based Health Centers
- Exclude family planning PCMPs that might not be appropriate for all new members
- Prioritize delivery of high-quality care to members

All Members have the ability to choose a different PCMP at any time. Members can change their PCMP at [Enroll.HealthFirstColorado.com](https://enroll.healthfirstcolorado.com) or by calling Health First Colorado 888-367-6557.

The Department will monitor the effect of this new process to ensure Members have access to care and make adjustments as necessary. In the future, the Department may expand the criteria to include consideration of PCMP performance on quality and cost outcomes, as well as population expertise.

For more information, refer to the [COVID-19 ACC Member Attribution Fact Sheet](https://enroll.healthfirstcolorado.com) or visit the [ACC Phase 2 Provider and Stakeholder Resource Center](https://enroll.healthfirstcolorado.com). If you have questions about how the revised geographic attribution methodology may affect your practice, please contact Matthew Sundeen at [matthew.sundeen@state.co.us](mailto:matthew.sundeen@state.co.us).

**PCMP Panel Configuration**

- PCMPs may limit / adjust their panel size at any time by contacting their RAE Network Representative, Nicole Konkoly at [nicole.konkoly@rmhp.org](mailto:nicole.konkoly@rmhp.org).
- Once a panel limit is reached, no further attributions will be made.
- PCMPs may turn auto-assignment (geographically based attributions) on or off at any time by contacting their RAE Network Representative.
  - All Tier 1 practices must accept geographic-proximity auto attributions, also known as auto-assignment, for all quarters in which they intend to operate as a Tier 1. If geographic auto-assignment exceeds a panel limit set by the practice, the practice must adjust it in the Department’s PCMP system appropriately in order to receive additional member assignments — no later than the first day of the
next calendar quarter. The practice should consult in advance with RMHP if it reasonably expects a panel limit to affect auto-attribution and tier status.

How Practices Can Manage Attribution
PCMPs can configure their RAE Member attribution panel in the following ways:
- Auto-Assignment
- Panel Limit
- Population Parameters

<table>
<thead>
<tr>
<th>Description</th>
<th>Definition</th>
<th>Instructions</th>
<th>Implications</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auto-Assignment</strong></td>
<td>Each practice has the option to opt-in or opt-out of auto-assignment (aka geographic proximity auto-attribution). This is configured at the individual service location/Medicaid Provider ID level. <strong>RMHP Tier 1 practices are required to be open to auto-assignment.</strong></td>
<td>If neither a RAE member nor a family member has a utilization/claims history with a PCMP, the system will determine the closest appropriate PCMP within the member’s region and attribute (“auto-assign”) the member to that practice. Upon initial PCMP contracting/panel configuration, each clinic can opt “in” (Y) or “out” (N) of auto-assignment via the PCMP Contract Workbook XLS. Subsequently, practices can update their designation/selection by contacting their RAE Network Representative, Nicole Konkoly. If a practice sets auto-assignment to ‘N’, they can still receive claims based attributions and can still have clients select them via the enrollment broker; however they will not receive any geographic-proximity attributions (“auto-assignments”); in other words, members without an established relationship with the practice will not be attributed to them.</td>
<td>Practices can see their auto-assignment status on the “Practice Summary” tab of their monthly RAE Attribution Report from RMHP.</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** Practices will receive a $2 base PMPM payment for patients attributed to them via auto-assignment. Practices are strongly encouraged to establish PCMP relationship with auto-assigned patients, which effectively increases the PMPM payment. See the PMPM Comparison Chart on page 17 for additional details.

<table>
<thead>
<tr>
<th>Description</th>
<th>Definition</th>
<th>Instructions</th>
<th>Implications</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panel Limit</strong></td>
<td>Each practice has the ability to set a panel limit. This is configured at the individual service location/Medicaid Provider ID level. <strong>Practices in Tiers 1 and 2 are strongly encouraged not to set panel limits for auto-assignment.</strong> This allows patients who lack an established medical home to be more equitably and appropriately attributed to practices in their respective communities, via the State’s auto-assignment process.</td>
<td>Maximum number of RAE enrollees a practice wishes to receive on its attribution panel. Upon initial PCMP contracting/panel configuration, each clinic can set a panel limit via the PCMP Contract Workbook XLS. Subsequently, practices can update and adjust (add or remove) their panel limit by contacting their RAE Network Representative, Nicole Konkoly. When a panel limit is reached, members will not be able to be attributed to the practice unless the panel limit is raised or removed. <strong>Note:</strong> The panel limit applies to all attributions including claims and choice-based attributions.</td>
<td>Practices can view their panel limit on the “Practice Summary” tab of their monthly RAE Attribution Report from RMHP.</td>
<td></td>
</tr>
</tbody>
</table>

**Population Parameters**
Each practice has the ability to indicate population parameters. Current options are: Children Only, Adults Only, and Women Only. This is configured at the individual service location/Medicaid Provider ID level.

Children are defined as age 20 and under; adults are defined as age 21 and older.

Upon initial PCMP contracting/panel configuration, each clinic can designate this information via the PCMP Contract Workbook XLS.

Practices will only receive attribution of members in their selected populations, if applicable.

Practices can contact their RAE Network Representative, Nicole Konkoly to check their current configuration.

---

**How to Identify Your RAE Member Attribution Panel**

RMHP provides PCMPs with a monthly report detailing their RAE Member attribution panel. There are two tabs on the report:

- **Practice Summary:** Summary of attributed RAE Members by aid category, payment tier, and corresponding PMPM payment information, including adjustments
- **Patient List:** RAE Member information including address and phone number, which can be used for outreach purposes

**Note:** these reports do not include RMHP Prime Member attribution information, which is shared via the monthly RMHP Prime practice reports.

RMHP shares the reports with practices via ECG Quick Connect typically during the last week of the month. Practices can then download the report from their inbox folder. **You must download the report within 30 days or it will automatically be deleted.**

**How to Identify a RAE Member’s Attributed PCMP**

The Health First Colorado provider web portal allows providers to see a RAE Member’s PCMP attribution and RAE enrollment information under the *Managed Care Assignment Details* panel. For instructions on performing eligibility verification and accessing the *Managed Care Assignment Details* panel, click [here](#).

**Payments for RAE Members Enrolled in RMHP Prime**

For RAE Members enrolled in RMHP Prime, PCMPs participating in RMHP Prime will continue to be paid following RMHP’s existing agreement with the practice. Payment for claims and global payment follow the current contract. Continue to submit RMHP Prime claims to RMHP.

**RMHP Prime Attribution**

RAE Members enrolling with RMHP as part of the RAE Payment Reform Initiative, RMHP Prime, will be immediately enrolled with RMHP upon eligibility determination from Health First Colorado. RMHP Prime Members will be attributed to RMHP Prime participating PCMPs following RMHP’s attribution methodology. The Department enrolls individuals into RMHP Prime based on the Member’s county of residence and Health First Colorado eligibility status. This includes most adults with full Health First Colorado benefits and a few children who qualify for Health First Colorado, based on disability status who reside in RMHP Prime counties.

**Department RAE KPIs**

KPIs are designed to assess the functioning of the overall system to support population health. RMHP, as the RAE, is eligible to earn additional funding from the Department for improved KPIs. Performance is measured at the RAE’s regional performance level, not at the individual practice level. **RMHP plans to share any KPI incentive dollars earned with its providers based on the practice’s tier.**

It is an expectation that all RAE PCMPs participate in developing and implementing care compacts regardless of RAE Tier.
The following pages provide details about the KPIs. Please reach out to your RMHP Quality Improvement Advisor (QIA) for more information.

# KPI: BEHAVIORAL HEALTH ENGAGEMENT

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Behavioral Health Engagement.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Behavioral Health Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of unique ACC members who received at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit within the 12-month evaluation period.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of unique members in the denominator who have received at least one behavioral health service billed within the rolling 12-month evaluation period.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of unique members enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period.</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>Multiple behavioral health visits (“numerator events”) in the evaluation period for one unique member will only be counted once. All diagnosis codes on the claim will be considered, not just the primary diagnosis. This measure will be manually calculated by the Department until systems can correctly adapt and calculate behavioral health encounters. Only the fee-for-service (FFS) portion of the measure will be displayed in the data analytics portal.</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email <a href="mailto:practice.transformations@rmhp.org">practice.transformations@rmhp.org</a>.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>Short-Term BH Services Fact Sheet</td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>Uniform Coding Standards Manual for Behavioral Health</td>
</tr>
<tr>
<td>RAE Region 1 Baseline</td>
<td>Baseline calculation still in process. Level 1 Target: 1%-5% increase above baseline receives 75% of payment Level 2 Target: &gt;5% increase above baseline receives 100% of payment</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>RAE Behavioral Health claims &amp; State claims — calculated by IBM Watson for a rolling 12 months (90 days claims run out); some claims will come from BH capitated payment; some will come from six visits in primary care practices and behavioral health delivery in Federally Qualified Health Center settings</td>
</tr>
<tr>
<td><strong>Practice interventions for Improvement</strong></td>
<td>Screen all patients for behavioral health (BH) conditions, using evidence-based screening tools (PHQ9, GAD-7, AUDIT, etc.) to determine appropriate behavioral health services to be offered within primary care or elsewhere in the community. Engage with BH providers to develop care compacts for optimal care coordination and collaboration. Develop talking points to discuss the importance of a signed release of information for primary care and BH providers to close referral loops &amp; discuss treatment progress. Track referrals to ensure patient followed through on the referral to a behavioral health provider; reach out to patients to identify barriers preventing follow-through with the BH service. Code the behavioral health visits properly to ensure accurate data capture for this measure in the data analytics tool.</td>
</tr>
<tr>
<td><strong>Tips for Using Data</strong></td>
<td>Using data from your EMR on positive screens, track referrals to integrated behavioral health or external behavioral health providers to monitor patient visit attendance (i.e. close the referral loop). Using the IBM Watson Data Analytics Portal dashboard for this measure, identify patients in the “not served” list who either have been referred to behavioral health and did not complete the visit, or who could benefit from a behavioral health service. Using the IBM Watson Data Analytics Portal dashboard for ER visits, identify patients with frequent ER visits to determine whether the ER visits are related to an unmet BH need and how to craft an intervention tailored to this patient.</td>
</tr>
</tbody>
</table>

Revised January 2021
## KPI: DENTAL VISITS

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Dental Visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Dental Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of members who received professional dental services, including services from both medical and dental claims</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Distinct count of members who received at least one dental service within the 12-month evaluation period</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Distinct count of members enrolled in the ACC on the last day of the last month of the 12-month evaluation period</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>Dental visits counted in the numerator are included in CDT codes (D0000 to D9999)</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Population exclusion: Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing's KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email practice <a href="mailto:trasformation@rmhp.org">trasformation@rmhp.org</a>.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td></td>
</tr>
<tr>
<td>Coding for Dental Services</td>
<td></td>
</tr>
<tr>
<td>Cavity Free at Three Training (free)</td>
<td></td>
</tr>
<tr>
<td>Smiles For Life Training (free)</td>
<td></td>
</tr>
<tr>
<td>RAE Dental Benefits (DentaQuest)</td>
<td></td>
</tr>
<tr>
<td>Dental Resources</td>
<td></td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>RAE Region 1 Baseline SFY 18-19 performance for members with full Medicaid residing in each RAE Region: 37.53%</td>
</tr>
<tr>
<td>Level 1 Target:</td>
<td>1%-5% increase above baseline (&gt;37.91%)</td>
</tr>
<tr>
<td>Level 2 Target:</td>
<td>&gt;5% increase above baseline (&gt;39.41%)</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Calculated monthly by IBM Watson using fee-for-service claims; data is reported monthly for a rolling 12-month period (90 days claims run out)</td>
</tr>
</tbody>
</table>
| **Practice Interventions for Improvement** | • Educate patients on importance of dental care  
• Educate staff and providers on the link between oral health and physical health  
• Complete the dental training programs for primary care providers, enabling the provision of oral screenings, oral exams, fluoride, etc. in the primary care setting  
• Develop a referral loop workflow for patients referred out to dental service; review list of patients not obtaining dental services and seek to identify and address barriers for patients not obtaining appropriate dental care  
• Develop a resource list for the practice including dental providers, types insurances accepted, clinic hours, emergency dental services, etc. |
| **Tips for Using Data**        | • Using the IBM Watson Data Analytics Portal for this measure, identify patients on the “not served” list to identify patients who have not had a dental service during the evaluation period  
• Use a referral tracking mechanism in your practice to close the loop, address no-shows, etc., if referring out for dental services |

Revised January 2021
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Well Visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI: Well Visits</td>
<td>Percentage of distinct members who received a well visit within the 12-month evaluation period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of members in the denominators who had at least one well visit during the 12 month evaluation period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of members enrolled in the ACC as of the last month of the rolling 12 month evaluation period</td>
</tr>
</tbody>
</table>

| Notes                          | Multiple numerator events in an evaluation period for a unique member will only be counted once. All diagnosis codes on the claim will be considered, not just the primary diagnosis. Paid claims and encounters will be considered as part of the numerator/denominator/exclusion criteria. Only claims submitted through the MMIS (interchange) will be used for this measure. |

| Exclusions                    | Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period are excluded from the denominator |

| Measure Specifications | The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email practice.transformation3@rmhp.org. |

<table>
<thead>
<tr>
<th>Resources</th>
<th>Patient Education Materials</th>
<th>Preventive Health Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
<td>Level 1 Target: 1%-5% increase above baseline (&gt;32.37%)</td>
</tr>
<tr>
<td></td>
<td>SFY 18-19 performance for members with full Medicaid residing in each RAE region: 32.05%</td>
<td>Level 2 Target: &gt;5% increase above baseline (&gt;33.65)</td>
</tr>
</tbody>
</table>

| Data Source | Calculated monthly by IBM Watson using fee-for-service data for a rolling 12 month period (90 days claims run out) |

| Practice Interventions for Improvement | • Evaluate your organization’s current guideline and/or workflow to support standardizing well visits  
• Identify gaps in care specific to this measure and reach out to patients who have not had a well visit during the evaluation period  
• Identify patients who have engaged with the practice recently, versus those who have not; strategies for well visit reminders may differ based on level of patient engagement  
• Review the patient schedule in advance to identify patients who are coming in for another type of visit, but have not had a well visit recently; consider changing the visit type to incorporate a well visit while the patient is in the office  
• Educate patients on differences between types of visits and the importance of each (e.g. sports physicals are not well visits)  
• Identify barriers to completing well visits and make accommodations where feasible (e.g. open clinic outside of regular work hours) |

| Tips for Using Data | • Use the IBM Watson Data Analytics Portal for this measure to identify patients who have not had a well visit during the evaluation period  
• Build an internal registry or tracking system to support well visits, including a flagging system  
• Review patient history of engagement with the practice in your EMR to inform reminder strategy (e.g. review active patient list, analyze patient visit types for individual patients)  
• Gather quantitative/qualitative data from patients on potential barriers to completing well visits (e.g. surveys, PFAC) |

Revised January 2021
# KPI: Prenatal Engagement

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Prenatal Engagement.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Prenatal Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of members who received a prenatal visit during pregnancy</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of deliveries where the member had at least one prenatal visit prior to delivery. In the event that a delivery claim contains bundled services, the prenatal visits will be counted in the numerator as long as prenatal falls within the 40 weeks prior to the delivery date, including the delivery date.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Unduplicated number of deliveries for members who are enrolled in the ACC as of the last month of the evaluation period and have gender code=F. Members can have multiple deliveries within an evaluation period, but only one within a 60-day period. Delivery logic will incorporate the earlier delivery date if two claims fall within 60 days of each other.</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Excludes pregnancies not ending with a live birth, excludes members who were enrolled in any physical health managed care plan for more than 3 months any time during the evaluation period.</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>All diagnosis codes on the claim will be considered, not just the primary diagnosis. Paid claims and encounters will be considered part of the numerator/denominator/exclusion criteria. Only claims submitted through the MMIS (Interchange) will be used for this measure.</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email <a href="mailto:practice_transformation3@rmhp.org">practice_transformation3@rmhp.org</a>.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>Prenatal Care Statistics</td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>RAE Region 1 Baseline SFY 18-19 performance for members with full Medicaid residing in RAE Region: 55.50%</td>
</tr>
<tr>
<td><strong>Level 1 Target</strong></td>
<td>1%-5% increase above baseline (&gt;55.05%)</td>
</tr>
<tr>
<td><strong>Level 2 Target</strong></td>
<td>&gt;5% increase above baseline (&gt;58.27%)</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Calculated monthly by IBM Watson using fee-for-service claims for a rolling 12 month period (90 days claims run out)</td>
</tr>
</tbody>
</table>
| **Practice Interventions for Improvement** | • For women of child-bearing age in your practice, provide education on the importance of prenatal care  
• Coordinate with your county’s community health services, such as the Healthy Communities program, B-4 Babies, RMHP Care Managers, etc. to identify pregnant women for potential outreach to receive prenatal care  
• If referring patients to a specialty clinic for prenatal care, track the referrals to ensure the loop is closed  
• Ensure the prenatal services that you are providing in your practice are coded appropriately |
| **Tips for Using Data**        | • Using a registry or referral tracking mechanism, track referrals to women’s health clinics to ensure the loop was closed  
• On a regular basis, run reports from the EMR for positive HcG tests to ensure a follow-up appointment is scheduled with the patient |

Revised January 2021
# KPI: Emergency Department Visits

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Emergency Department visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Emergency Department Visits per Thousand Member Months per Year (PKPY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Number of emergency department visits per thousand Members per year (PKPY), risk adjusted</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of actual ED visits PKPY (# of ED visits/# Member months * 12,000)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Members will be counted in the denominator if they are enrolled in the ACC any month in the rolling 12 month evaluation period; to normalize this measure the denominator is measured in terms of Member months (PKPY). The PKPY is then risk adjusted using a RAE risk weight.</td>
</tr>
<tr>
<td>Notes</td>
<td>An ED visit will be counted in the numerator if it does not result in an inpatient admission. The per-thousand member months per-year rate is risk adjusted using Vercend’s Diagnostic Cost Group software, which calculates a raw cost risk score and an aggregated diagnostic cost grouper per Member. Raw cost risk scores are then converted into an ED visit risk weight by RAE region.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email <a href="mailto:practice.transformation3@rmhp.org">practice.transformation3@rmhp.org</a></td>
</tr>
<tr>
<td>Resources</td>
<td>Return Visits to the ED</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td>Data Source</td>
<td>SFY 18-19 performance for Members with full Medicaid residing in RAE region 1: 608,926</td>
</tr>
</tbody>
</table>

## Practice Interventions for Improvement

- Reduce unnecessary ED utilization
  1. Track ED utilization to identify frequent users and trends that may be contributing to unnecessary ED use in your practice.
  2. Based on utilization trends, develop strategies to address the factors contributing to unnecessary ED visits.
    - Common reasons for utilization stem from a lack of patient education on the appropriate use of the ED and lack of patient awareness on options to consult providers first. One strategy to reduce inappropriate ED use is to implement more patient education in these areas.
    - Underlying social or behavioral health issues may also contribute to unnecessary ED utilization. Identifying these conditions and addressing them with a behavioral health provider would potentially reduce further inappropriate ED use.
- Ensure patient risk is reflected as accurately as possible
  1. Patient diagnoses are up-to-date
  2. Conditions are coded correctly and to the highest level of specificity

## Tips for Using Data

- Using the data analytics portal, review the list of members who have visited the ED to determine frequency and nature of the visits; using this data, identify trends that would inform strategies for reducing ED visits
- Using an internal tracking mechanism (e.g. a registry), track ED follow-ups to ensure there is an opportunity to address an individual patient's underlying reasons for inappropriate ED use, thus reducing frequency of visits in the future

Revised January 2021
KPI: HEALTH NEIGHBORHOOD PART 2

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Health Neighborhood.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of members who had an outpatient visit with a specialist who saw a PCMP within 60 days prior to the specialist visit and included a referring PCMP on the claim</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of specialty claims in the denominator with at least one PCMP visit within 60 days prior to the specialty visit and a referring PCMP listed on the specialty claim</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of specialty claims for Members enrolled in the ACC as of the end of the rolling 12-month evaluation period (multiple specialist visits on a single date of service will be counted once in the denominator)</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Members who were enrolled in any physical health managed plan for more than 3 months anytime during the evaluation period are excluded from the denominator</td>
</tr>
<tr>
<td>Notes</td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 2 accounts for 75% of the performance rate for this KPI. This portion of the Health Neighborhood KPI is calculated monthly and paid out quarterly</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email <a href="mailto:practice.transformation3@rmhp.org">practice.transformation3@rmhp.org</a>.</td>
</tr>
<tr>
<td>Resources</td>
<td>Instructions for Referring Claim Submissions</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated by IBM Watson Health using only claims submitted through the MMIS (InterChange); data is available in the Data Analytics Portal</td>
</tr>
</tbody>
</table>

**Practice Interventions for Improvement**

- Complete patient education and shared decision before referral to determine if the referral is the patient’s preference; this reduces likelihood of no-shows and creates access for more appropriate specialty visits
- Determine if the referral is clinically appropriate, or can it be handled in primary care
- Make the appointment for the patient, in order to monitor the timeliness of the appointment
- Complete pre-work to optimize efficient appointment scheduling; care compacts are a good channel for outlining appropriate pre-work specific to the specialist
- Work with specialty providers to ensure they are including the referring PCMP on the claim

**Tips for Using Data**

- Using the IBM Watson Data Analytics Portal for this measure, identify trends for individual specialists (e.g., is it a scheduling issue, lack of indication of the referring PCMP on the claim) and address issues accordingly
- Using an internal referral tracking mechanism (e.g., a registry), track referrals to ensure the visits are completed at the initially scheduled time (i.e., if the patient reschedules, visit may fall outside of KPI timeframe; if they no-show, will need to determine barriers to completing the visit and ensure proper coordination of care for the condition referred for

Revised January 2021
KPI: HEALTHNEIGHBORHOODPART1

At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Health Neighborhood.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of RAE PCMPs with new/renewed care compacts in effect with specialty care providers, that adhere to the Colorado Medical Society’s Primary Care Compacts criteria.</td>
</tr>
<tr>
<td>Numerator</td>
<td>PCMPs in the denominator who have at least one primary care/specialty care compacts in place within the 12-month rolling evaluation period.</td>
</tr>
<tr>
<td>Denominator</td>
<td>PCMPs that are contracted with a RAE during the last month of the 12-month evaluation period.</td>
</tr>
<tr>
<td>Notes</td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 1 accounts for 25% of the performance rate for this KPI. This component is calculated manually by the State and is paid out annually. Due to manual calculation, this component will not be displayed in the Data Analytics Portal. Note that the denominator for FY Quarter 4 expands to require at least two care compacts in effect, one being with behavioral health.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>The full measure specifications are outlined in the Department of Health Care Policy and Financing’s KPI Methodology document. To request this document, please reach out to your Quality Improvement Advisor (QIA) or email <a href="mailto:practice.transformation3@rmhp.org">practice.transformation3@rmhp.org</a>.</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CQI Medical Society Care Compact Guidelines                                                   Care Compact Examples                          Care Compact Facilitation Guide</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>Quarter 1: 50%+ of PCMP network has 2+ executed care compacts in place. Care Compacts with behavioral health providers can be included but are not required. (Eval. Period: 7.1.2020-9.30.2020)</td>
</tr>
<tr>
<td></td>
<td>Quarter 2: 50%+ of PCMP network has 2+ executed care compacts in place. Care Compacts with behavioral health providers can be included but are not required. (Eval. Period: 10.1.2020-12.31.2020)</td>
</tr>
<tr>
<td>Data Source</td>
<td>RAEs will submit to the State a detailed list that includes the number of new/renewed compacts, PCMP and specialist names, and the signed date of the compacts.</td>
</tr>
<tr>
<td>Practice Interventions for Improvement</td>
<td>1. Identify high volume/high cost specialists with which to engage in care compact development. 2. Collaborate with the specialty practice when creating care compacts, ensuring that both parties’ needs are represented in the agreement and that the document promotes meaningful care coordination. 3. Ensure that the care compacts adhere to the criteria required by the State, using guidelines from the Colorado Medical Society. 4. Establish a mechanism for renewing care compacts at least annually, revising as needed.</td>
</tr>
<tr>
<td>Tips for Using Data</td>
<td>• Using payer data (e.g. specialty visits in the IBM Watson Data Analytics Portal) identify high volume or high cost specialists that your practice refers patients to, in order to select specialty practices to engage with in care compact discussions. • Track referrals using a registry or review care coordination process measures such as “closing the referral loop” to monitor referrals and the success of the care compact.</td>
</tr>
</tbody>
</table>

Revised January 2021
Other Program Measures
The measures below are not utilized for incentive payments, but are used as an indicator of performance within the Health First Colorado DAP.

Postpartum Follow-Up Care
- Measure Description: The denominator for Postpartum Follow-Up Care includes the number of live deliveries for Members enrolled in the ACC as of the end of the evaluation period. Members may have multiple deliveries within the evaluation period. The evaluation period for this KPI is offset by 56 days from the current rolling 12-month period to allow up to 56 days following the delivery for a follow-up visit to occur. For example, if the evaluation period ends 12/31/2016, the delivery date range utilized would be 11/05/2015 to 11/06/2016. Due to some inconsistencies in coding that were discovered, delivery visits are consolidated in the following manner: service dates that occurred within 60 days of each other were assumed to have occurred within the same delivery and service dates that were more than 60 days apart were considered separate deliveries. In these cases, the first service date in the chain of claims is considered the delivery date.
  - Timing: N/A
  - RAE Region 1 Baseline: 28.262%
  - RAE Region 1 Target: N/A

Well-Child Checks (Ages 3-9)
- Measure Description: The denominator for Well-Child Checks includes children ages 3-9 years old as of the end of the evaluation period, who are enrolled in the ACC on the snapshot date to meet the numerator. The child must have a well-child check during the measurement year.
  - Timing: N/A
  - RAE Region 1 Baseline: 48.55%
  - RAE Region 1 Target: N/A

30-Day Follow-Up Care Following Inpatient Discharge
- Measure Description: The denominator for this measure is the count of inpatient discharges for those members enrolled in the ACC at the end of the evaluation period. A single Member may have multiple inpatient discharges counted towards the denominator. However, inpatient discharges that result in a readmission within 30 days or death will not be counted in the denominator. Following discharge, an evaluation and management (E&M) claim within 30 days will fulfill the numerator requirement (only one is needed, multiple follow-up E&M visits will not count multiple times in the numerator).
  - Timing: N/A
  - RAE Region 1 Baseline: 54.82%
  - RAE Region 1 Target: N/A

SFY 20-21 Performance Pool Metrics
Extended Care Coordination
- Measure Description: Percentage of members with complex needs (defined as members costing at least $25,000 over a rolling 12-month period) who received extended care coordination within the performance period.
  - RAE Region 1 Baseline: 13.93%
  - RAE Region 1 Target: 22.41%

Premature Birth Rate
- Measure Description: Number of premature births (< 37 weeks) per total live births within the measurement period.
  - RAE Region 1 Baseline: 9.88%
  - RAE Region 1 Target: 9.88%

Behavioral Health Engagement for Members Releasing from State Prisons
• Measure Description: Percentage of members releasing from a Department of Corrections (DOC) facility with at least one billed behavioral health capitated service or short-term behavioral health visit within 14 days.
  • RAE Region 1 Baseline: 10.66%
  • RAE Region 1 Target: 13.39%

Inpatient Psychiatric Discharges
• Measure Description: Number of discharges from a non-state psychiatric hospital for treatment of a covered mental health diagnosis per 1000 full-time equivalent members.
  • RAE Region 1 Baseline: 11.72
  • RAE Region 1 Target: 11.15

Asthma Medication Ratio
• Measure Description: The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
  • RAE Region 1 Baseline: 47.73%
  • RAE Region 1 Target: 50.16%

Pharmacology for COPD Exacerbation
• Measure Description: This measure assesses the percentage of COPD exacerbations for patients 40 years of age and older who had an acute inpatient discharge or ED visit on or between July 1–June 30 of the measurement year and who were dispensed appropriate medications.

  Two rates are reported.
  1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event
  2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

  Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on patients. It is possible for the denominator to include multiple events for the same individual.
  • RAE Region 1 Baseline: 40.71%; 54.66%
  • RAE Region 1 Target: 44.35%; 58.19%

Pharmacy Quality Alliance: Portion of Days Covered: Diabetes All Class
• Measure Description: The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year. Report a rate for Diabetes All Class (PDC-DR). A higher rate indicates better performance.
  • RAE Region 1 Baseline: 61.51%
  • RAE Region 1 Target: 65.06%

How Practices Can Monitor their KPI Performance
To support the ACC’s goal of improving Member health and reducing costs, the Department has contracted with IBM Watson Health (formerly Truven) to host the Health First Colorado DAP. This data analytics tool for PCMPs and RAEs includes population and performance information. The portal allows for drill downs and drill ups, data exports, and provider-level comparisons. The portal includes several dashboards that display information including: member rosters, Key Performance Indicator performance, and other program performance measures. The portal is refreshed monthly with claims, eligibility and enrollment data.

Access must be granted and can be arranged by contacting Nicole Konkoly at nicole.konkoly@rmhp.org.

Additional information, including a fact sheet and user guide can be accessed at colorado.gov/pacific/hcpf/health-first-colorado-data-analytics-portal-dap.
Other RMHP data dashboards or tools that are available to RAE practices are a Potentially Avoidable Cost (PAC) Diabetes dashboard and a RMHP KPI dashboard. To learn more about these, email practice.transformation3@rmhp.org.

Support and resources are available to all RMHP RAE Region 1 PCMPs to support KPI performance. This includes:

- understanding the KPI measures,
- developing or refining workflows,
- networking with other practices,
- toolkits and user guides that includes diabetes management best practices, the Data Analytics Portal, behavioral health, etc.
- & more!

To learn more or become engaged, email the RMHP Practice Transformation Team at practice.transformation3@rmhp.org or reach out to your RMHP Quality Improvement Advisor or Clinical Informaticist.

**KPI Payment Process**

After HCPF completes its calculations for the KPI measures, RMHP will calculate KPI payments for each PCMP participating in the RAE. Each PCMP’s payment will be based on the practice’s validated tier (1-4) in RMHP’s value based payment model, the number of RAE members attributed to the PCMP during the performance period, and the amount of KPIs earned by the RAE for a given quarter. Payments are calculated on a PMPM basis. KPI payments will be sent through the same financial channels as a PCMP’s normal monthly PMPM payments and RMHP will send each PCMP a report summarizing the KPI calculations and payments. RMHP will make one payment to each PCMP for each quarter. As with the monthly PMPM payments, KPI payments are subject to reconciliation if HCPF changes a payment amount to RMHP.
Department of Healthcare Policy and Financing (HCPF) Alternative Payment Model (APM) for Primary Care

As part of the Department's efforts to shift provider reimbursement from volume to value, the Department, along with stakeholders, is implementing two Alternative Payment Models (APMs) for Primary Care services delivered by two types of practices: Federally Qualified Health Centers (FQHCs) and non-FQHC Primary Care Medical Providers (PCMPs). The goals of the APM are:

- Provide long-term sustainable investment in primary care
- Reward performance and introduce accountability for outcomes and access to care with granting flexibility of choice to PCMPs
- Align with other payment reforms across the delivery system

Non-FQHC and FQHC PCMP Program Basics

- The APM is a point-based system
- Eligibility: All FQHCs are eligible. Non-FQHCs must have either more than $30,000 in historical annual paid claims associated with the services defined in the APM Code Set or 200 ACC enrollees Geotargeted members are also included in the eligibility attribution for this APM.
- Each PCMP is responsible for selecting 10 quality measures each year
- PCMPs earn points by reporting and demonstrating performance or improvement
- The number of points earned determines the impact of payment for that PCMP in the following year

Measure Options

- **Structural Measures**: These measures focus on the practices’ capacity and ability to deliver high-quality care. The measures are intended to improve processes and deliver documentation to show the transformation of care delivery. These are pass/fail measures.
- **Claims Measures**: These measures are calculated based upon the practices’ processed Medicaid claims.
- **Electronic Clinical Quality Measures (eCQM)**: These measures are calculated directly from practices electronic medical record (EMR). Practices that select eCQMs can earn half credit for reporting the eCQM. If the performance goals are met or partially met, then a higher point value will be given. Practice performance will be based upon the “Close the Gap” Calculation (see below).

Measure Reporting

- **Structural Measures**: Measure achievement and Patient Centered Medical Home (PCMH) status will be collected by the Regional Accountable Entities (RAEs) within the first quarter following the measurement year. These are pass/fail measures.
- **Claims Measures**: The Department automatically collects the baseline and performance year’s data from the Medicaid submitted claims. The practice performance will be based upon the “Close the Gap” Calculation (see the HCPF APM website for more information).
- **eCQMs**: Health Data Colorado (HDCo) will collect eCQMs from practices automatically via an interface from the EMR to HDCo for baseline and performance rate calculations. If a practice does not have an interface in which to send continuity of care documents (CCDs), then HDCo will help practices manually report their measures. HDCo is an entity that is comprised of three partners: Quality Health Network (QHN), Colorado Regional Health Information Organization (CORHIO), and Colorado Community Managed Care Network (CCMCN). Based upon your practice type, existing interfaces with these organizations and geographical location, one of the partners will be working with your practice.

RMHP HCPF APM Support

RMHP is committed to helping practices succeed in the APM. Each APM eligible practice will be assigned an RMHP Quality Improvement Advisor (QIA) and Clinical Informaticist (CI) that will be reaching out and providing support regularly. RMHP will:

- Help practices align their measures with work the practice is already doing and with existing payment models, while also considering the practice’s patient panel and community goals.
• Assist practices in workflow development and process improvement to achieve the goal of the measures selected. This also includes EMR workflow and reporting support for eCQMs.
• Provide ongoing education and support for the APM.
• Be the single point of contact for the practice. If your practice has questions or comments for the Department regarding the APM, RMHP will be the communication vehicle.
• Attest to the practice’s achievement on the Structural Measures and PCMH status.

For FQHCs, CCHN will be the main point of contact for the resources above; however, RMHP is also available to assist your practice.

Questions? Email practice.transformation3@rmhp.org.

HCPF APM Resources
• Department email: HCPF_primarycarepaymentreform@hcpf.state.co.us.
• Alternative Payment Model Website
Get Involved

Statewide Program Improvement Advisory Committee (PIAC) and Subcommittees

The Accountable Care Collaborative Program Improvement Advisory Committee (PIAC) is made up of stakeholders who provide guidance and make recommendations to help improve health, access, cost and satisfaction of members and providers in the Accountable Care Collaborative (ACC).

The committee typically meets the third Wednesday of each month at the Department of Health Care Policy and Financing in Denver, with a call-in option. All meetings are open to the public.

PIAC subcommittees provide technical assistance, guidance and recommendations on issues that impact the ACC. Subcommittees are made up of PIAC committee members as well as clients, providers and other stakeholders. All meetings are open to the public and have a virtual option.

Current PIAC Subcommittees are:

- Behavioral Health and Integration Strategies
- Performance Measurement and Member Engagement (formerly Health Impact on Lives)
- Provider and Community Experience

For additional information about the Statewide PIAC and its subcommittees, visit: [https://colorado.gov/pacific/hcpf/accountable-care-collaborative-program-improvement-advisory-committee](https://colorado.gov/pacific/hcpf/accountable-care-collaborative-program-improvement-advisory-committee)

Regional RAE 1 PIAC

The goals of the Regional RAE 1 Performance Improvement Advisory Committee are:

- Strengthen relationships across the region;
- Share information and feedback;
- Collaboratively develop solutions for critical health issues; and
- Prioritize our work as the RAE.

The RAE 1 PIAC currently meets quarterly, typically with a Front Range and West Slope in-person location, and always with an option for remote participation. The committee has a formal voting membership structure. All meetings are open to the public. For additional information, including the charter and meeting materials, visit: [www.rmhp.org/medicaid-chp-plus/get-involved](http://www.rmhp.org/medicaid-chp-plus/get-involved).

Additional Resources are Available via Multiple Methods:

- View Department provider webinars and additional information at [colorado.gov/pacific/hcpf/accphase2](https://colorado.gov/pacific/hcpf/accphase2)
- Visit the Provider Resources section at [rmhp.org](http://rmhp.org). Select I am a Provider > Provider Resources
- Contact your local RMHP provider representative, Susan Hall at [susan.hall@rmhp.org](mailto:susan.hall@rmhp.org) or Rhonda Blankenship at [rhonda.blankenship@rmhp.org](mailto:rhonda.blankenship@rmhp.org)
- Email [raesupport@rmhp.org](mailto:raesupport@rmhp.org)
- Call RMHP Customer Service at 888-282-8801

Monthly Newsletters

Receive a monthly newsletter that has information about upcoming RAE events, KPI information, payment updates, etc. To receive these newsletters, email Mindy Patton at [mindy.patton@rmhp.org](mailto:mindy.patton@rmhp.org).

Monthly Value Based Contracting Office Hours

Participate in these monthly webinars to learn about various RAE topics, upcoming events, etc. You also have the opportunity to ask questions!

- Registration Link: [https://us02web.zoom.us/meeting/register/vJckf-isrDsjQ_hcLkLvz8YX8CulcADSIA](https://us02web.zoom.us/meeting/register/vJckf-isrDsjQ_hcLkLvz8YX8CulcADSIA)
- January 25, 2021 – December 27, 2021
- Fourth Monday every month from 12:15-12:45PM

Podcast Series
At RMHP, the Practice Transformation Team is committed to helping practices on their journeys to advanced care and value-based payments by offering tools and resources, as we all work together to better serve our Members.

Join the conversation as the RMHP Practice Transformation Team, along with guest speakers, explore advanced care in these insightful podcasts.

Listen now at [http://destinationrmhp.org/](http://destinationrmhp.org/) or download and follow us on PodBean!

**Clinical and Operational Insights: A Webinar Series**
This monthly series will assist you in capitalizing on and managing clinical operations within your practice. Topics will be anchored to evidenced-based clinical skills and can be leveraged to reinvent operational workflows.

- Third Friday every month from 8:00-9:00AM
- To register, contact Mindy Patton, mindy.patton@rmhp.org

**2021 RMHP Collaborative Learning Series**

**Leadership in Healthcare** - April 23, 2021 - Virtual
This free interactive and informative conference is appropriate for healthcare leaders at all levels. The content will focus on developing skills to guide collaborative teams through challenging times, why you should continue to invest in your culture, as well as implementing efficiency strategies to promote a healthy work-life balance.

**5th Annual Behavioral Health Skills Training** - June 11, 2021 - Virtual
This training covers a variety of hot topics related to behavioral health and is designed to support healthcare teams in providing whole-person care for patients across the lifespan. Rather than siloing behavioral health to a singular role in a practice, this training empowers a variety of clinicians and staff members, including licensed behavioral health providers, to form effective collaborative care teams.

**8th Annual Care Management Training** - September 10, 2021 - Virtual
Have you been thinking about implementing care management strategies into your practice or looking for additional training for your care management staff? This training is free and open to all professionals who are performing any care management responsibilities.

**Professional Skills Development for Motivated Clinical Staff** - October 29, 2021 - TBD
This (hopefully) in-person event will provide the opportunity for clinical staff to advance their professional development, clinical knowledge, examine best practices, and practice hands-on skills in order to improve job performance and build competencies.

**Practice Transformation Resources**
Need assistance with a workflow, behavioral health, data, EMRs, etc.? Contact the Practice Transformation Team! RMHP has free resources and tools to help your practice succeed! Not only will the programs and services assist with advancing care delivery but also support your success in the RAE.

RMHP has many toolkits available for free to your practice. They include:

- Colorado Data Analytics Portal Guide
- Follow-Up for a Positive Depression Screening
- A Toolkit for Getting Started with Telehealth
- Proactive Diabetes Disease Management
- Accountable Health Communities Model (AHCM) Social Determinants of Health Toolkit
- eCQM Toolkits
- Measurement for Integrated Behavioral Health
- Other medical home resources, including behavioral health

To learn more, email practice.transformation3@rmhp.org.
Supplemental Resources for Patient Care

**EasyCare: Virtual Care Platform**
RMHP is committed to working with our valued providers to help our Members get the care they need, when they need it. EasyCare is a virtual care program on the EasyCare Colorado platform that allows eligible RMHP Members to connect to a doctor through their computer or mobile device. Members can message, share photos, or video chat. Doctors are available on EasyCare 24/7.

EasyCare is available at no cost to RMHP Medicare, RAE, Prime and CHP+ Members. Members may be referred back to you, allowing for high-quality and informed care. It is designed to complement the care provided within the medical home setting and help reduce unnecessary emergency room visits.

RMHP Medicare, RAE, Prime, and CHP+ Members can download the EasyCare Colorado app at the App Store or Google Play, or visit www.easycareco.com/carenow.

**Rural Auxiliary Services (RAS): Free American Sign Language (ASL) Interpreting Services**
The Rural Auxiliary Services (RAS), formerly called the Rural Interpreting Services Project (RISP) Pilot, provides qualified American Sign Language interpreters for individuals who are deaf, hard of hearing, or deafblind in rural areas of Colorado at no cost to consumers or service providers. Areas outside of the Front Range (including Grand Junction and Pueblo) are included in RAS.

Interpreting services are available for a variety of needs, including medical appointments (doctors, dentists and mental health services). Either clients or providers can submit an interpreter request.

- A request can be submitted in any of the following ways:
  - Online through RAS website: colorisp.com. Select Request Form tab
  - On paper (interpreter request form) via email, fax, or mail
  - Call CCDHHDB office at 720-457-3679
  - It is best to make requests at least 72 business hours in advance (2 weeks is ideal).
  - For additional information, visit the RAS website at colorisp.com
Primary Care Frequently Asked Questions (FAQs)

Can a PCMP continue to see Health First Colorado Members if they are not attributed to the PCMP?
Yes. Primary care practices can provide services to Health First Colorado Members and receive fee-for-service reimbursement, even if the Member is not attributed to the practice. The Department’s established fee schedule applies.

What is the policy for behavioral health services provided in a primary care clinic?
The Department allows and encourages the provision of up to six sessions of short-term behavioral health services in a primary care setting per episode of care. These short-term behavioral health services must be provided by a licensed behavioral health provider and the primary care clinic must be contracted as a PCMP. The services will be reimbursed fee-for-service as a Health First Colorado covered physical health benefit when billed by a primary care provider.

The intent of the policy is to provide additional access to behavioral health services for short-term episodes of care of low-acuity conditions. This may include grief and adjustment conditions, as well as medical conditions where behavioral interventions can support treatment adherence and wellness (such as obesity and diabetes).

If it is necessary to provide more than six behavioral health visits, the visits will be reimbursed from the Capitated Behavioral Health Benefit and require a covered diagnosis. Covered diagnoses can be found in the RMHP RAE Behavioral Health Provider Manual, as well as the Uniform Service Coding Standards Manual, located on the Department’s website.

For additional information, view the Department’s Short-term Behavioral Health Services in Primary Care Fact Sheet on the ACC Provider and Stakeholder Resource Center.
RMHP RAE ATTESTATION PROCESS AND ONGOING TIER DEMONSTRATION
RAE Attestation Directions & Ongoing Tier Demonstration

The value-based payment model for PCMPs encompasses clear delineation of provider responsibilities and resources available for different levels of accountability and participation.

These levels of accountabilities, called Tiers, impact the resources available to the practice and activities the practice must demonstrate through ongoing assessments.

Practices have the option to participate at the highest tier for which they qualify, or may choose to participate at a lower tier. Practices also may opt to identify a higher tier and work towards achieving that tier. Within Tiers 1-3 are criteria that the practice must demonstrate on an ongoing basis. These elements include:

- Openness to Health First Colorado Members
- eCQM submission to RMHP quarterly and meeting benchmark thresholds annually
- Care compacts
- By Quarter 1 2021, perform satisfactorily (80%) on RMHP Tier Assessment and pass all 'MUST PASS' elements.
- Participation and performance on the Department’s Alternative Payment Model (APM)
- Other demonstration criteria based upon tier

What happens if my practice does not meet the demonstration criteria?

With the movement from volume-based payments to value-based payments, RMHP remains dedicated to strengthening primary care and rewarding high-quality, high-value care and to reimburse through a payment structure designed to achieve better care, more efficient spending and healthier communities.

The Value Based Contracting Review Committee (VBCRC) will provide the venue for a consistent process through which to evaluate practice performance in any of the value-based contracting relationships of CPC+, RAE, and Prime.

The VBCRC is responsible for reviewing practice performance and outcomes for RMHP value-based contracts and determining eligibility for funding support to practices. The VBCRC meets at least quarterly to discuss and approve all Tier 1 - 3 practice performance documentation. If a practice does not meet demonstration criteria for more than two quarters out of the year, then the practice will be reviewed by the VBCRC and may drop a tier for the following year.

If during the review by VBCRC and opportunities for improvement are discovered, then the practice can anticipate receiving a certified letter from the VBCRC reflecting their decisions and outreach from the RMHP Practice Transformation Team.

If you have questions about this process or suggestions, email VBCRC@rmhp.org.

My Practice is Changing Electronic Medical Records (EMRs), what should I do?

Changing EMRs may impact performance on meeting the RAE Tier Ongoing Demonstration Criteria. RMHP will evaluate how the change in EMRs may impact the practice’s performance in the RAE on a practice by practice basis dependent on old and new EMR capabilities. In order to begin this process, email your RMHP Clinical Informaticist OR practice.transformation3@rmhp.org at least 60 days prior to the go-live date for your new EMR.

New RAE PCMP Attestation

If you are a newly contracted RAE PCMP, utilize the information below to complete the RMHP RAE Tier Attestation process by the date agreed upon with RMHP Provider Relations. Contact your local RMHP Provider Representative, Susan Hall at susan.hall@rmhp.org or Rhonda Steinkirchner at rhonda.steinkirchner@rmhp.org

Submit the Attestation Documents to RMHP

- Submit these documents to the RMHP Practice Transformation Team:
  - Practice Information Form
  - Attestation Tree
Attestation Tree Determination

- Documents may be submitted in the following manner:
  - Mail to PO Box 10600, Grand Junction, CO 81502
  - Email practice.transformation3@rmhp.org
  - Fax at 970-244-7827

For questions about RAE contracting or to change RAE tiers, contact Greg Coren at greg.coren@rmhp.org or 970-255-5673.

For questions about the attestation process, contact the RMHP Practice Transformation Team at practice.transformation3@rmhp.org or call 970-263-5535.
New RAE PCMP Attestation & Ongoing Demonstration Materials

PCMP Tiering Appendix A: 2021 Timeline
PCMP Tiering Appendix B: Tier Descriptions
This document describes the criteria for each tier.

PCMP Tiering Appendix C: Practice Information Form
This document provides high level demographics about the practice. Submit this to RMHP if you are a new PCMP in the attestation process.

PCMP Tiering Appendix D: New RAE PCMP Attestation Tree
This document is an algorithmic progression towards an appropriate tier based on practice’s experience and capabilities. Submit this to RMHP if you are a new PCMP in the attestation process.

PCMP Tiering Appendix E: Attestation Tree Determination
This document identifies the practice’s tier, the required elements to remain in tier, and the practice’s attestation. Submit this to RMHP if you are a new PCMP in the attestation process.

PCMP Tiering Appendix F: Care Compact Criteria
The Care Compact Criteria is guidance to get credit for your care compact(s).

PCMP Tiering Appendix G: Tier Assessment Elements
The Tier Assessment Elements reviews the concepts that will be covered with the practice based upon the appropriate tier.

PCMP Tiering Appendix H: Electronic Clinical Quality Measures Suite
This is the electronic Clinical Quality Measure (eCQM) suite that will be utilized for RAE. It encompasses CPC+, RMHP Practice Transformation Programs, Uniform Data System (UDS), and PRIME measure suites. Also included are the 2021 benchmarks, in which practices will have to meet by early 2022 for their appropriate tier.
PCMP Tiering Appendix A: 2021 Timeline

January 31, 2021
Tier 1-3 practices report CQMs for PY2020 evaluation

March/April 2021
RMHP Conducts Q1 Assessments for Tier 1 and 2 Practices

April 16, 2021
Tier 1 - 3 Practices Report Q1 CQMs to RMHP

June 30, 2021
Practice Tier Change Deadline
If a practice wishes to change tiers, the practice must notify RMHP no later than this date.

June/July 2021
RMHP Conducts Q2 Assessments with Tier 1 - 3 practices

July 16, 2021
Tier 1 - 3 Practices Report Q2 CQMs to RMHP

August – November 2021
RMHP Conducts Verification Assessments for Practices Changing Tiers

September/October 2021
RMHP Conducts Q3 Assessments with Tier 1 and 2 Practices

October 15, 2021
Tier 1 - 3 Practices Report Q3 CQMs to RMHP

December 2021/January 2022
RMHP Conducts Q4 Assessments with Tier 1-3 Practices

January 1, 2022
Payment changes take effect for any practices changing tiers

January 31, 2022
Tier 1-3 practices report CQMs for PY2021 evaluation

PCMP Tiering Appendix B:

Tier Descriptions
## Tier 1 – Comprehensive RMHP Population Health Partner

### Profile

**CPC+ Participant Track 2 or PCMH Level 3/PCMH 2017 Recognized**

### Demonstration

- Able to report a minimum of 6 CQMs from RMHP eCQM Measurement Suite from a certified EMR Dashboard (FQHCs may report from the Azara registry)
- Meet performance benchmarks on 6/6 measures (See Measurement Suite for benchmarks)
- Performs satisfactorily (80%) including all MUST PASS elements on RMHP Tier 1 Assessment performed quarterly
- Provides current documented executed care compact with at least three major or critical specialties
- Open to Health First Colorado Members (RAE and RAE-PRIME Members)
- Medicaid APM/ FQHC APM Score = (at least) 76 – 100%
- Use of RMHP designated applications required for Reunion FQHCs and available to others

### Reimbursement Enhancement

- RMHP RAE Medical Home Payment (see page 12 for methodology/PMPM amounts)
- Potential FFS enhancement on the APM Code Set per the Medicaid APM
- Eligible for RMHP Community Integration Agreement to fund behavioral health, SDoH and related services

### Incentive Eligibility

- Eligible for KPI Pool distributions – relative to tier

### Resource Supplementation

- Enhanced care coordination services provided by RMHP
- Attribution and Feedback reports
- Eligible for Consultative Practice Transformation resources
- Eligible for RMHP designated applications with technical assistance

---

¹ For RAE attribution, a practice must accept geographic-proximity auto attributions, also known as auto-assignment, for all quarters in which they intend to operate as a Tier 1 practice. If geographic auto-attribute exceeds a panel limit set by the practice, the practice must adjust it in the Department’s PCMP system appropriately in order to receive additional member assignments—no later than the first day of the next calendar quarter. The practice should consult in advance with RMHP if it reasonably expects a panel limit to affect auto-assignment and Tier 1 status.
## Tier 2 – Advanced Participation

### Profile

**Masters 2 Graduate or CPC Classic Graduate or Current CPC+ Track 1 Participant**

### Demonstration

- Able to report minimum of 6 CQMs from the RMHP eCQM Measurement Suite from a certified EMR Dashboard
  (FQHCs may report from the Azara registry)
- Meet benchmark performance (CMS 70th percentile) on 4/6 *(See Measurement suite for Benchmarks)*
- Performs satisfactorily (80%) including all MUST PASS elements on RMHP Tier 2 Assessment performed quarterly
- Provides current copy of executed care compact with at least **one** major or critical specialty
- Open to Health First Colorado Members with equitable panel management across all RMHP lines of business. All policies, procedures, patient applications, etc. will be subject to RMHP review
- Medicaid APM/ FQHC APM Score = (at least) 51 – 75%

### Reimbursement Enhancement

- RMHP RAE Medical Home Payment (see page 12 for methodology/PMPM amounts)
- Potential FFS enhancement on the APM Code Set per the Medicaid APM

### Incentive Eligibility

- Eligible for KPI Pool distributions – relative to tier

### Resource Supplementation

- Attribution and Feedback reports
- Eligible for Practice Transformation resources for NCQA PCMH recognition with application fee reimbursement
- Eligible for Consultative Practice Transformation resources
- Eligible for RMHP designated applications with technical assistance
<table>
<thead>
<tr>
<th>Tier 3 – Foundations Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Profile</strong></td>
</tr>
<tr>
<td>Graduate of RMHP Foundations or SIM</td>
</tr>
<tr>
<td>(For Larimer County practices where RMHP Practice Transformation Programs have been unavailable, other structured foundational work will be considered)</td>
</tr>
<tr>
<td><strong>Demonstration</strong></td>
</tr>
<tr>
<td>• Able to report minimum of 6 CQMs from the RMHP eCQM Measurement Suite from a certified EMR Dashboard (FQHCs may report from Azara)</td>
</tr>
<tr>
<td>• Meet benchmark performance (CMS 70th percentile) on 2/6 (See Measurement suite for Benchmarks)</td>
</tr>
<tr>
<td>• Performs satisfactorily (80%) including all MUST PASS elements on RMHP Tier 3 Assessment performed every 6 months</td>
</tr>
<tr>
<td>• Open to Health First Colorado Members. Intermittent or limited availability for new Health First Colorado Members</td>
</tr>
<tr>
<td>• Medicaid APM/ FQHC APM Score = (at least) 26 – 50%</td>
</tr>
<tr>
<td><strong>Reimbursement Enhancement</strong></td>
</tr>
<tr>
<td>• RMHP RAE Medical Home Payments (see page 12 for methodology/PMPM amounts)</td>
</tr>
<tr>
<td>• Potential FFS enhancement on the APM Code Set per the Medicaid APM</td>
</tr>
<tr>
<td><strong>Incentive Eligibility</strong></td>
</tr>
<tr>
<td>• Eligible for KPI Pool distributions – relative to tier</td>
</tr>
<tr>
<td><strong>Resource Supplementation</strong></td>
</tr>
<tr>
<td>• Attribution reports</td>
</tr>
<tr>
<td>• Feedback reports upon request</td>
</tr>
<tr>
<td>• Practice Transformation resources with $10K incentive for Masters 1 and Masters 2 successful program participation</td>
</tr>
<tr>
<td>Tier 4 – Basic Participation</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td><strong>Profile</strong></td>
</tr>
<tr>
<td><strong>Demonstration</strong></td>
</tr>
<tr>
<td>• None, or</td>
</tr>
<tr>
<td>• Medicaid APM/ FQHC APM Score = (at least) 0 – 25%</td>
</tr>
<tr>
<td><strong>Reimbursement Enhancement</strong></td>
</tr>
<tr>
<td>• RMHP RAE Medical Home Payments (see page 12 for methodology/PMPM amounts)</td>
</tr>
<tr>
<td>• Potential FFS enhancement on the APM Code Set per the Medicaid APM</td>
</tr>
<tr>
<td><strong>Resource Supplementation</strong></td>
</tr>
<tr>
<td>• Attribution reports</td>
</tr>
<tr>
<td>• Feedback reports upon request</td>
</tr>
<tr>
<td>• Practice Transformation resources with $10K incentive for Foundations Program participation</td>
</tr>
</tbody>
</table>
PCMP Tiering Appendix C: Practice Information Form
Submit if New RAE PCMP

Practice Name

Type of Practice: Family Practice, Pediatrics, Internal Medicine, FQHC, Other

Mailing Address

Physical Address

If you have multiple locations, please list other addresses. Use another sheet if necessary

Main Phone

Office

Manager

Main Contact

Email/Phone

Best way to get in touch with you: Email, Phone, Email

Number of providers
Number of staff
Total number of patients

Do you use paper charts? Yes No
EMR system:
PM System:

Length of time on EMR
EMR version

If you are an FQHC, does your practice use Azara? Yes No

On Health Information Exchange (HIE)? Yes No If yes, which one? QHN, CORHIO

Participating in MIPS or an Advanced APM? Yes No If yes, which one?

Printed Name of Practice Representative
Signature of Practice Representative
Date

Printed Name of Practice Representative
Signature of Practice Representative
Date

PCMP Tiering Appendix D: RAE Attestation Tree
Submit if New RAE PCMP

RAE Attestation Tree for Practices that have participated in RMHP Practice Transformation Programs
a. Has the practice graduated any practice transformation programs (i.e. SIM, RMHP programs, PCMH recognition, CPC)?  YES / NO
b. Is the practice able to report at least 6 electronic Clinical Quality Measures (eCQMs) of the RMHP eCQM suite from a certified EMR dashboard?  YES / NO
c. Is the practice open to Medicaid patients?  YES / NO
d. Is the practice willing to undergo regular (quarterly/semi-annually) reviews/reporting with RMHP?  YES / NO

[Diagram showing decision tree]

- YES to all

- NO to any

Select the practice's current practice transformation program/status:

- Masters 1 Graduate or Current Masters 2
- Masters 2 Graduate, CPC Classic Graduate, or Current CPC+ Track 1
- CPC+ Track 2 or PCMH Level 3 / PCMH 2017 Recognized

Has your practice executed care compacts with any major specialties (i.e. high referral volume)? (Note: only attest to 'yes' if you are willing/able to share these care compacts with RMHP).

- NO
- YES

Has your practice executed AT LEAST THREE care compacts with any major specialties (i.e. high referral volume)? (Note: only attest to 'yes' if you are willing/able to share these care compacts with RMHP).

- NO
- YES

Tier 4  Tier 3  Tier 2  Tier 1
RAE Attestation Tree for Non-RMHP Practice Transformation Practices

- Does the practice have a multidisciplinary Quality Improvement Team that meets at least monthly that utilizes agendas and minutes? **YES / NO**
- Does the practice utilize the Model for Improvement by utilizing and documenting Plan-Do-Study-Act (PDSA) cycles? **YES / NO**
- Is the practice able to report at least 6 electronic Clinical Quality Measures (eCQMs) of the RMHP eCQM suite from a certified EMR dashboard? **YES / NO**
- Is at least 60% of the practice’s active patient population empaneled to the appropriate care team/provider? **YES / NO**
- Does the practice spread and sustain QI work by utilizing a QI spread and sustainability plan? **YES / NO**
- Is the practice open to Health First Colorado Members? **YES / NO**
- Is the practice willing to undergo regular (quarterly/semi-annually) reviews/reporting with RMHP? **YES / NO**

Select the practice’s current practice transformation program/status:

- **Tier 4**
- **Tier 3**
- **Tier 2**
- **Tier 1**
Based upon Attestation Tree above, our practice attests that we are Tier _________.

In order to stay in Attested Tier, practice must demonstrate all of the following:

- Achieve ≥80% on appropriate assessment and pass all 'MUST PASS' elements
  - Tier 4 Assessment – none
  - Tier 3 Assessment – semi-annually
  - Tier 2 Assessment – quarterly
  - Tier 1 Assessment – quarterly

- Achieve Medicaid APM scoring thresholds
  - Tier 4 – Medicaid APM score of 0–25%
  - Tier 3 – Medicaid APM score of 26–50%
  - Tier 2 – Medicaid APM score of 51–75%
  - Tier 1 – Medicaid APM score of 76–100%

- Submit six CQMs quarterly and annually meet or exceed the RAE benchmarks
  - Tier 4 – none
  - Tier 3 – 2/6 eCQMs must meet or exceed the RAE benchmarks
  - Tier 2 – 4/6 eCQMs must meet or exceed the RAE benchmarks
  - Tier 1 – 6/6 eCQMs must meet or exceed the RAE benchmarks

- Be open to Health First Colorado Members
  - Tier 4 – Not open to new Health First Colorado Members
  - Tier 3 – Limited, intermittent availability for new Health First Colorado Members
  - Tier 2 – Open to Health First Colorado Members with equitable panel management across all RMHP lines of business. All policies, procedures, patient applications, etc. will be subject to RMHP review
  - Tier 1 – Fully open to new Health First Colorado Members (RAE and RAE-PRIME Members)

Practices have an option to participate at a tier level lower than their attested tier. If a practice desires to participate at a lower tier, please indicate below.

By signing below, I attest, to the best of my knowledge, that this practice is Tier ___________. My practice wishes to participate at Tier ___________. I understand that RMHP will conduct a verification process of the tier by December 1, 2021. At that time, RMHP reserves the right to make tier modifications as deemed necessary based on documentation provided by the practice.

_____________________________  ___________________________  ____________
Printed Name of Practice Representative  Signature of Practice Representative  Date

Supporting Documentation — Appendix F: Care Compact / Collaborative Care Criteria
As part of the RAE attestation process, it is important to evaluate the practice’s existing care compacts, or collaborative care agreements, for comprehensiveness and sustainability. In order to receive credit for care compacts, the care compact includes the following elements:

- Practice information for all practices entering the agreement (i.e. practice name, phone numbers, etc.).
- Created within the last 12 months OR reviewed/updated within the last 12 months.
- Clear expectations for both primary/specialty care practices for all of the following elements:
  - Define the types of referral and co-management agreements.
  - Define the timeliness of patient appointments and address other access workflows.
  - Specify who is accountable for which processes and outcomes of care within (any of) the consultation or co-management arrangements.
  - Specify the content of a patient transition record/core data set, which is to go with the patient in all care transitions.
  - Expectations regarding the information content requirements as well as the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting provider.
  - Specify how secondary referrals are to be handled.
  - Maintain a patient centered approach including consideration of patient/family choices and ensuring explanation and clarification of reasons for referral, the subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family.
  - Clarify in-patient processes including: notification of admission, secondary referrals, data exchange and transitions into and out of hospital.
- The term of the agreement and mechanisms for renewal.
- Period for regular review of the agreement by the primary and specialty practice.
- Mechanism for documentation and communication of real or perceived breaches of the agreement.
- Signatures from key stakeholders in practices (i.e. providers, managers, system leadership).

Supporting Documentation — Appendix G: Assessments
Below are the elements for each Tier Assessment. For Tier 1 and 2 practices, these assessments will be conducted with RMHP Quarterly. For Tier 3, the assessment will be conducted semi-annually.

It is expected that practices pass the ‘MUST PASS’ elements by their first assessment in 2021 (Q1 for Tier 1 and Tier 2; Q2 for Tier 3). These competencies are core concepts within each of the tiers that demonstrates comprehension and implementation. If a practice does not pass a ‘MUST PASS’ element in their first 2021 assessment, the practice will be reviewed by the Value Based Contracting Review Committee (VBCRC). This information is given to you in 2020 in order to allow your practice time to ensure the implementation of the ‘MUST PASS’ competencies. If you need assistance, RMHP has resources available.

For efficiency purposes, practices that are PCMH 2017 Recognized will receive “auto-credit” for certain elements that overlap between PCMH Standards and the Tier assessment. PCMH practices that receive auto-credits will still be responsible for submitting documentation for MUST PASS elements.

RMHP is committed to helping practices succeed. RMHP Practice Transformation can help practices with implementation and demonstration of all elements. Opportunities for improvement will be discussed with the practice after each assessment to ensure success in the Q4 assessment.

Want to get started with RMHP Practice Transformation? Email practice.transformation3@rmhp.org.
## Tier 1 – Comprehensive Participation Assessment Elements

### Ongoing Demonstration Criteria

<table>
<thead>
<tr>
<th>Participation in quarterly assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully open to Health First Colorado Members (RAE and RAE-PRIME Members)</td>
</tr>
<tr>
<td>Six eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation)</td>
</tr>
<tr>
<td>Minimum of three care compacts that meet the criteria above</td>
</tr>
<tr>
<td>Medicaid APM Score 76-100%</td>
</tr>
</tbody>
</table>

### Access and Continuity

(2021 MUST PASS) Practice is fully open to Health First Colorado Members and maintains at least 95% empanelment to practitioner and/or care teams

(PCMH Auto-Credit) Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR

Regularly deliver care in at least one way that is an alternative to traditional office visit-based care, meets the needs of your patient population, and increases access to the care team/practitioner, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits

### Care Management

(2021 MUST PASS) Use a two-step risk stratification process for all empaneled patients, addressing medical needs, behavioral diagnoses, and health related social needs:

- Step 1 – use an algorithm based on defined diagnoses, claims, or other electronic data allowing population level stratification; and
- Step 2 – add the care team's perception of risk to adjust the risk-stratification as needed

(2021 MUST PASS) Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management

(2021 MUST PASS) For high risk patients receiving longitudinal care management, use a whole person plan of care containing at least patients’ goals, needs, and self-management activities that can be routinely accessed and updated by the care team

(PCMH Auto-Credit) Provide short-term (episodic) care management, including medication reconciliation to patients following hospital admission/discharge/transfer,* and, as appropriate, following an ED discharge

(2022 MUST PASS) Reduce ED utilization. The expectation is practices will dive into their ED utilization data and determine areas of opportunity to decrease unnecessary utilization and then act upon that data. This could mean expanding same day visits or telehealth access, marketing campaigns, re-vamped ED follow-up processes, evaluate care management processes, etc. The goal is for each practice to determine the best strategies to reduce ED utilization for their population. The RMHP Practice Transformation Team is here to help and monitor progress.

(2021 MUST PASS) Contact at least 75% of patients who were hospitalized in target hospitals within two business days and the practice has a process to complete medication reconciliation within 30 days.

### Comprehensiveness and Care Coordination
| (2021 MUST PASS) Using data review (gap analysis) the timeliness of notification and information transfer from hospitals and EDs responsible for the majority of patients’ hospitalizations and ED visits |
| (2021 MUST PASS) Enact collaborative care agreements with at least three groups of high volume/critical specialists that meet minimum requirements for RAE KPI |
| Establish at least one collaborative care agreement with a community behavioral health entity that supports and meets patients’ psychosocial needs |
| (2021 MUST PASS) Implement an Integrated Behavioral Health Strategy that includes workflows for the following: |
| I. Screening for behavioral health conditions (i.e., depression, substance use disorder, anxiety, etc.) |
| II. Tracking and monitoring patients with identified behavioral health conditions inclusive of care coordination needs |
| III. Treatment algorithms, including: |
| a) Services offered by PCMPs and/or Integrated BH provider(s) and intervention plan when patient is not responsive to treatment |
| b) Referral to specialty behavioral health treatment services |
| IV. Measuring and monitoring of treatment outcomes |

*NCQA’s Distinction in BH Integration will meet the elements in 3.4*

| (2021 MUST PASS) Routinely assess patients’ psychosocial needs (AHCM, as an example) |
| Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs |
| Practice reviews data on psychosocial needs of the population derived from results of the screening tool to set goals to improve performance. |

**Patient and Caregiver Engagement**

| (2022 MUST PASS) Practice demonstrates monitoring and improving patient experience on access, communication, coordination, and/or whole person care. |
| Implement self-management support (such as PAM) for at least three high-risk conditions |
| (PCMH Auto-Credit) Identify and engage a subpopulation of patients and caregivers in advance care planning (peds exception) |

**Quality Improvement**

<p>| (2021 MUST PASS) Practice reviews data on at least two utilization measures at the practice level to set goals to improve population health management |
| Practice reviews data on at least six CQM measures derived from the certified EHR on practice and provider level to set goals to improve performance |
| (PCMH Auto-Credit) Conduct Quality Improvement team meetings at least monthly to review practice- and panel-level data for internal monitoring; use this data to guide testing of tactics to improve care and achieve practice goals |</p>
<table>
<thead>
<tr>
<th>Tier 2 – Advanced Participation Assessment Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing Demonstration Criteria</strong></td>
</tr>
<tr>
<td>Participation in quarterly assessments</td>
</tr>
<tr>
<td>Open to Health First Colorado Members with equitable panel management across all RMHP lines of business. All policies, procedures, patient applications, etc. will be subject to RMHP review.</td>
</tr>
<tr>
<td>Four eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation).</td>
</tr>
<tr>
<td>Minimum of one care compacts that meet the criteria in the previous Appendix</td>
</tr>
<tr>
<td>Medicaid APM Score 51-75%</td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice has equitable panel management processes and an empanelment rate at or above 90%</td>
</tr>
<tr>
<td>(PCMH Auto-Credit) Practice measures continuity of care and has set a continuity of care target</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice has developed and deployed a risk stratification workflow (includes process for reassessing patients’ risk scores and assessing risk of new patients). 80% of active patients have an assigned risk score.</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice has documented and deployed a care management workflow (includes who on the team manages high risk patients and which patients receive care management services)</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice uses a patient needs assessment tool (assess at minimum the 9 Domains of Need) to develop care plans for high risk patients</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice creates care plans for its high risk patients</td>
</tr>
<tr>
<td>(PCMH Auto-Credit) Practice has completed a Team-based Care Assessment and has implemented a strategy to address gaps (i.e. huddles, standing orders, etc.)</td>
</tr>
<tr>
<td>Practice has evaluated progress on their Care Management Plan and developed a strategy to address gaps (i.e. monitoring patient outcomes, penetration rate, operational metrics, etc.)</td>
</tr>
<tr>
<td>Practice has implemented Self-Management Support for at least one high-risk condition</td>
</tr>
<tr>
<td>The practice assesses patient activation levels and/or readiness to change</td>
</tr>
<tr>
<td>The practice uses Coaching for Activation or Motivational Interviewing Techniques</td>
</tr>
<tr>
<td><strong>Comprehensiveness and Care Coordination</strong></td>
</tr>
<tr>
<td>(PCMH Auto-Credit) Practice has defined timely fashion follow up for ED and hospital discharge workflows and has reviewed necessary improvements or changes to the process</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice follows up with at least 70% of their patients seen at the ED within their definition of timely fashion (must report numerator and denominator)</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice follows up with at least 70% of patients discharged from hospital within their definition of timely fashion (must report numerator and denominator)</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice has established a Care Compact with at least one high volume specialist that meets the minimum requirements of the RAE KPI</td>
</tr>
<tr>
<td><strong>Patient and Caregiver Engagement</strong></td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>(PCMH Auto-Credit) The practice has completed at least two rounds of patient surveys OR has established a Patient Feedback and Advisory Council (PFAC) that has met at least twice. The practice uses the survey or meeting to obtain feedback from their patient population for purposes of informing their QI work.</td>
</tr>
<tr>
<td>(PCMH Auto-Credit) The practice has completed at least two QI projects with data collected from either patient surveys or PFAC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sustainability and Spread</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice has plan for sustainability and spread</td>
</tr>
<tr>
<td>Practice has an internal and external communication plan to inform practice and patients of QI work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Quality Improvement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(PCMH Auto-Credit) Practice has multidisciplinary QI team that meets regularly</td>
</tr>
<tr>
<td>(2021 MUST PASS) Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement</td>
</tr>
<tr>
<td>(PCMH Auto-Credit) Practice has completed at least a single PDSDA cycle for each of the identified CQMs.</td>
</tr>
</tbody>
</table>
## Tier 3 – Foundations Participation Assessment Elements

### Ongoing Demonstration Criteria
- Limited, intermittent availability for new Health First Colorado Members
- Participation in bi-annual assessments
- Two eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation)
- Medicaid APM score 26-50%

### Quality Improvement
- *(PCMH Auto-Credit)* Practice Identified multidisciplinary staff members for QI team
- *(PCMH Auto-Credit)* Practice has assigned QI team members specific duties
- *(2021 MUST PASS)* Practice uses agendas and minutes in QI team meetings
- Practice evaluates patient flow for identification of gaps and opportunities for improvement in efficiency (i.e., cycle times study, patient access evaluation, etc.)
- *(PCMH Auto-Credit)* Practice implemented a QI project supporting an area of improvement impacting patient flow and/or office efficiency
- *(2021 MUST PASS)* Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement
- *(PCMH Auto-Credit)* Practice has completed at least a single PDSA cycle for each of the CQMs (minimum of two CQMs)

### Comprehensiveness and Care Coordination
- *(2021 MUST PASS)* Practice has established a Care Compact with at least one high volume specialist that meets the minimum requirements of the RAE KPI

### Access and Continuity
- *(2021 MUST PASS)* Practice has a defined panel management process and an empanelment rate at or above 60%
- Practice has set a continuity of care target
- *(PCMH Auto-Credit)* Practice has completed a Team-based Care Assessment and has implemented a strategy to address gaps (i.e., huddles, standing orders, etc.)

### Sustainability and Spread
- Practice has plan for sustainability and spread
- Practice has an internal and external communication plan to inform practice and patients of QI work
<table>
<thead>
<tr>
<th>NQF</th>
<th>CMS</th>
<th>DESCRIPTION</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF-0036</td>
<td></td>
<td><strong>Use of Appropriate Medications for People with Asthma:</strong> Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately ordered medication during the measurement period.*</td>
<td>35.00%</td>
</tr>
<tr>
<td>NQF-1799a</td>
<td></td>
<td><strong>Medication Management for People with Asthma (Medication Adherence 50%):</strong> The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.</td>
<td>35.00%</td>
</tr>
<tr>
<td>NQF-1799b</td>
<td></td>
<td><strong>Medication Management for People with Asthma (Medication Adherence 75%):</strong> The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.</td>
<td>35.00%</td>
</tr>
<tr>
<td>NQF-2152</td>
<td></td>
<td><strong>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling:</strong> Percentage of patients 18 years of age or older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.</td>
<td>93.52%</td>
</tr>
<tr>
<td>NQF-0418</td>
<td>CMS-002</td>
<td><strong>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan:</strong> Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter</td>
<td>56.83%</td>
</tr>
<tr>
<td></td>
<td>CMS-050</td>
<td><strong>Closing the Referral Loop: Receipt of Specialist Report:</strong> Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred</td>
<td>60.25%</td>
</tr>
<tr>
<td>NQF-0419</td>
<td>CMS-068</td>
<td><strong>Documentation of Current Medications in the Medical Record:</strong> Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. *</td>
<td>99.58%</td>
</tr>
<tr>
<td>NQF-0421</td>
<td>CMS-069</td>
<td><strong>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:</strong> Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if most recent BMI was outside of normal parameters</td>
<td>60.31%</td>
</tr>
<tr>
<td>NQF-0059</td>
<td>CMS-122</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
<td>25.87%</td>
</tr>
</tbody>
</table>
| NQF-0032 | CMS-124 | Cervical Cancer Screening (CCS): Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:  
* Women age 21-64 who had cervical cytology performed within the last 3 years  
* Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years | 48.31% |
| CMS-125 | Breast Cancer Screening: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period | 65.68% |
| CMS-127 | Pneumococcal Vaccination for Older Adults: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine | 71.82% |
| CMS-130 | Colorectal Cancer Screening: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. | 64.01% |
| CMS-131 | Comprehensive Diabetes Care: Eye Exam (Retinal) Performed: Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period | 95.65% |
| CMS-134 | Comprehensive Diabetes Care: Medical Attention for Nephropathy: The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period. | 91.11% |
| CMS-137a | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (within 14 Days of Diagnosis): Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. | 2.24% |
| CMS-137b | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (within 30 Days of Diagnosis): Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. | 2.24% |
| CMS-138a | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Screened): Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user  
Three rates are reported. | 94.64% |
<p>| CMS-138b | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Received Intervention Counseling): Percentage of patients aged 18 years and older who were screened for tobacco use | 94.64% |</p>
<table>
<thead>
<tr>
<th>NQF-CMS Code</th>
<th>NQF-CMS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Screened and Received Intervention Counseling): Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.</td>
<td>Three rates are reported.</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Screened and Received Intervention Counseling): Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.</td>
<td>Three rates are reported.</td>
</tr>
<tr>
<td>Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.</td>
<td>78.60%</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.</td>
<td>56.02%</td>
</tr>
<tr>
<td>Dementia: Cognitive Assessment: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.</td>
<td>73.33%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women: Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.</td>
<td>44.78%</td>
</tr>
<tr>
<td>Use of High-Risk Medications in Older Adults: Percentage of patients 65 years of age and older who were ordered at least two of the same high-risk medications.</td>
<td>0.04%</td>
</tr>
<tr>
<td>Depression Remission at Twelve Months: The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.</td>
<td>7.14%</td>
</tr>
<tr>
<td>Depression Utilization of the PHQ-9 Tool (Jan - April): The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.</td>
<td>22.09%</td>
</tr>
<tr>
<td>Depression Utilization of the PHQ-9 Tool (May - August): Percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.</td>
<td>22.09%</td>
</tr>
<tr>
<td>Depression Utilization of the PHQ-9 Tool (September - December): Percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.</td>
<td>22.09%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period.</td>
<td>72.01%</td>
</tr>
<tr>
<td>CMS-347a</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Previous or Current Diagnosis): Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period</td>
</tr>
<tr>
<td>CMS-347b</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (LDL &gt;= 190 mg/dL): Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period</td>
</tr>
<tr>
<td>CMS-347c</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Diabetes Diagnosis and LDL-C 70-189 mg/dL): Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period</td>
</tr>
<tr>
<td>NQF</td>
<td>CMS</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>NQF-0036</td>
<td></td>
</tr>
<tr>
<td>NQF-0576a</td>
<td></td>
</tr>
<tr>
<td>NQF-0576b</td>
<td></td>
</tr>
<tr>
<td>NQF-1346</td>
<td></td>
</tr>
<tr>
<td>NQF-1392a</td>
<td></td>
</tr>
<tr>
<td>NQF-1392b</td>
<td></td>
</tr>
<tr>
<td>NQF-1448a</td>
<td></td>
</tr>
<tr>
<td>NQF-1448b</td>
<td></td>
</tr>
<tr>
<td>NQF-1448c</td>
<td></td>
</tr>
<tr>
<td>NQF-1448d</td>
<td>Developmental Screening in the First Three Years of Life (by First, Second, and Third Birthday): The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday</td>
</tr>
<tr>
<td>NQF-1516a</td>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life: The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.</td>
</tr>
<tr>
<td>NQF-1516b</td>
<td>Adolescent Well Care Visits (Ages 12-21): Adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.</td>
</tr>
<tr>
<td>NQF-1799a</td>
<td>Medication Management for People with Asthma (Medication Adherence 50%): The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.</td>
</tr>
<tr>
<td>NQF-1799b</td>
<td>Medication Management for People with Asthma (Medication Adherence 75%): The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.</td>
</tr>
<tr>
<td>NQF-0418</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter</td>
</tr>
<tr>
<td>CMS-050</td>
<td>Closing the Referral Loop: Receipt of Specialist Report: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred</td>
</tr>
<tr>
<td>CMS-074</td>
<td>Primary Caries Prevention Intervention as Offered by Primary Care Providers/Dentists: Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period</td>
</tr>
</tbody>
</table>
### Children who have Dental Decay or Cavities:
Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period

<table>
<thead>
<tr>
<th>NQF</th>
<th>CMS</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1401</td>
<td>075</td>
<td>Maternal Depression Screening: The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child’s first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.</td>
<td>63.00%</td>
</tr>
<tr>
<td>0038</td>
<td>117</td>
<td>Childhood Immunization Status: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (Hib); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday</td>
<td>37.23%</td>
</tr>
<tr>
<td>0108a</td>
<td>136a</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication (ADD) (within 30 Days): Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.</td>
<td>49.80%</td>
</tr>
<tr>
<td>0108b</td>
<td>136b</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication (ADD) (within 270 Days): Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.</td>
<td>49.80%</td>
</tr>
<tr>
<td>0004a</td>
<td>137a</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (within 14 Days of Diagnosis): Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported.</td>
<td>2.24%</td>
</tr>
<tr>
<td>0004b</td>
<td>137b</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (within 30 Days of Diagnosis): Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported.</td>
<td>2.24%</td>
</tr>
<tr>
<td>0002</td>
<td>146</td>
<td>Appropriate Testing for Children with Pharyngitis (CWP): The percentage of episodes for patients 3 years and older with a diagnosis of pharyngitis that resulted in an antibiotic dispensing event and a group A streptococcus (strept) test</td>
<td>87.63%</td>
</tr>
<tr>
<td>0041</td>
<td>147</td>
<td>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>56.02%</td>
</tr>
<tr>
<td>0033</td>
<td>153</td>
<td>Chlamydia Screening in Women: Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.</td>
<td>44.78%</td>
</tr>
<tr>
<td>0069</td>
<td>154</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI): Percentage of episodes for patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.</td>
<td>96.88%</td>
</tr>
<tr>
<td>0024a</td>
<td>155a</td>
<td>Weight Assessment for Children/Adolescents: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had</td>
<td>38.73%</td>
</tr>
<tr>
<td>NQF-CMS</td>
<td>Description</td>
<td>Rate</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>NQF-0024b CMS-155b</td>
<td>Counseling for Nutrition for Children/Adolescents: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.</td>
<td>38.73%</td>
<td></td>
</tr>
<tr>
<td>NQF-0024c CMS-155c</td>
<td>Counseling for Physical Activity for Children/Adolescents: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.</td>
<td>38.73%</td>
<td></td>
</tr>
<tr>
<td>NQF-0710 CMS-159</td>
<td>Depression Remission at Twelve Months: The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.</td>
<td>7.14%</td>
<td></td>
</tr>
<tr>
<td>NQF-0712a CMS-160a</td>
<td>Depression Utilization of the PHQ-9 Tool (Jan - April): The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter</td>
<td>22.09%</td>
<td></td>
</tr>
<tr>
<td>NQF-0712b CMS-160b</td>
<td>Depression Utilization of the PHQ-9 Tool (May - August): Percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter</td>
<td>22.09%</td>
<td></td>
</tr>
<tr>
<td>NQF-0712c CMS-160c</td>
<td>Depression Utilization of the PHQ-9 Tool (September - December): Percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter</td>
<td>22.09%</td>
<td></td>
</tr>
<tr>
<td>NQF-1365 CMS-177</td>
<td>Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.</td>
<td>56.00%</td>
<td></td>
</tr>
</tbody>
</table>

For more eCQM information and measure specifications, please contact your RMHP Clinical Informaticist or visit the eCQI Website.

RMHP Practice Transformation Program Placement

RMHP Practice Transformation is committed to supporting practices to help achieve the level of tier they desire. This document assists with determining which RMHP Practice Transformation Program is most appropriate for the practice, based upon your previous practice transformation work and sustainability efforts.

Some practices may require more than one assessment in order to correctly place them in the most appropriate program. By utilizing the tree below, you can determine which assessments the practice will have to pass and the suggested program placement. A RMHP Quality Improvement Advisor will assist in this process. Contact RMHP Practice Transformation Programs at practice.transformation3@rmhp.org.
For example, if you are a practice with no historical RMHP Practice Transformation Program completion, you are a Tier 4 practice. However, your goal is to be a Tier 3 practice and believe that you can already demonstrate a majority of the Tier 3 competencies. This is the list of assessments your practice may undergo to be placed in the correct Practice Transformation Program that is most fitting for your practice goals:

- Step 1: Tier 3 Assessment Completion
- Step 2: If you pass, you will complete the Masters 1 Assessment. If you do not pass, you will be placed in the Foundations Program.
- Step 3: If you pass Masters 1 Assessment, you will be placed in Masters 2 OR you can take the Tier 2 Assessment to see if you are actually eligible for Tier 2. If you do not pass Masters 1 Assessment, you will be placed in the Masters 1 Program.

The above example is only one scenario. Each practice has unique starting places and the RMHP Practice Transformation Team will help your practice through this process to support your practice meeting its goals. To get started with RMHP Practice Transformation Programs, email practice.transformation3@rmhp.org.
RMHP RAE PROVIDER NETWORK PARTICIPATION
RMHP RAE Provider Network Participation

Where to Submit Claims

Submission of claims for RMHP RAE Covered Services

Effective July 1, 2018, RMHP is responsible for the behavioral health services historically covered under the Behavioral Health Organization. For RAE Members also enrolled with RMHP in RMHP Prime, RMHP continues responsibility for covering pharmacy and medical claims for RMHP Prime Members.

For Health First Colorado services covered by RMHP, including behavioral health services for RMHP RAE Members, and medical services for RMHP Prime Members, providers familiar with submitting claims to RMHP should continue to submit claims to RMHP following standard RMHP policies and procedures.

RMHP's provider manual also includes more information to providers about how to bill RMHP for services

Submission of Medical Claims for RAE Members Not Enrolled in RMHP Prime

Claims for RAE Members who are not enrolled in RMHP Prime should be created and submitted to DXC, the fiscal agent for the Department.

Wrap-around Services

Certain wrap-around services should continue to be billed to Health First Colorado or a Department-Contracted Vendor following Health First Colorado rules and regulations. These wrap-around services include, but are not limited to: most dental services, long-term care services, autism spectrum disorder services, non-emergent medical transportation, and hospice care. More information about these wrap-around services is available in RMHP’s provider manual.

For Questions about Submitting Claims

Providers are encouraged to contact your local RMHP Provider Relations Representative with questions.

Electronic Eligibility Verification

Providers will want to confirm eligibility of RAE Members before providing services. Determination of eligibility and enrollment in the Accountable Care Collaborative program is based on the State of Colorado eligibility standards, developed and applied by the Department of Health Care Policy and Financing. Health First Colorado eligibility should be verified by using the system available through the State of Colorado, the Colorado interChange. The Department’s interChange is updated in “real time” and serves as the most accurate method for determining eligibility. Documentation relating to eligibility verification for Members enrolled in the Medicaid Accountable Care Collaborative, including RAE Members and RAE Members also enrolled in RMHP Prime, should be retained by the RMHP network provider, as these documents will be required to support a provider appeal if a claim is denied due to patient eligibility and enrollment status. If the Department retroactively adjusts eligibility, claims payment may be retracted if you are unable to demonstrate eligibility was verified at the time of service.

The Department’s web portal can be found at https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider. A user name and password is required.

Care Coordination

Care Coordination for RAE and PRIME Members

RMHP employs care coordinators that are available to assist practices with care coordination. RMHP also works with community entities that do care coordination. Care Coordinators are aligned with counties or practices. RMHP and Community Care Coordinators are available to assist with support and referral coordination for any of the following:

- Scheduling Medical Appointments or Finding a Primary Care Provider
- Scheduling Behavioral Health Appointments or Finding a Behavioral Health Provider
- Mental Health Referral Coordination
- Substance Use Referral Coordination
- Interpersonal Relationship Support
• Housing Assistance
• Food Assistance
• Transportation

RMHP Care Coordinators are available Monday through Friday 8:00 AM – 5:00 PM. There is also a Care Coordinator on call after-hours for urgent needs. To contact RMHP Care Coordinators, use the OneCall number: Phone number: 888-282-8801 (TTY: 711), press Option 5, then Option 1

*Pre-Authorization Requirements*

**New! 2021 SUD Benefit for Medicaid Members**

Rocky Mountain Health Plans is responsible for authorizing inpatient and residential substance use disorder treatment stays as part of administering Health First Colorado’s capitated behavioral health benefit. On January 1, 2021, Health First Colorado, Colorado's Medicaid program, will expand its substance use disorder (SUD) benefit. Residential and inpatient treatment and withdrawal management services will be added to the Department of Health Care Policy & Financing existing list of covered SUD services, giving Members access to a full range of treatment options.

For more information go to: [https://www.rmhp.org/sud](https://www.rmhp.org/sud).

**Pre-authorization requirements for services covered by RMHP for RAE Members**

Pre-authorization requirements for services covered by RMHP for RAE can be found on the RMHP website at [rmhp.org](http://rmhp.org).

**Pre-authorization requirements for services NOT covered by RMHP for RAE Members**

For services covered by the Department, not RMHP, requests for prior authorizations are submitted to the ColoradoPAR Program following Health First Colorado rules. The link for the ColoradoPAR program is [coloradopar.com](http://coloradopar.com).

All PARs processed by the ColoradoPAR program are submitted through the Colorado PAR Website Portal at [coloradopar.com/PARPortaleQSuite.aspx](http://coloradopar.com/PARPortaleQSuite.aspx).

The ColoradoPAR provider phone line is 888-801-9355.
RMHP Payment Reform Initiative for Medicaid Enrollee (RMHP Prime)

The Department selected RMHP to participate in a payment reform initiative as part of Health First Colorado’s ACC program. This integrated health payment reform initiative uses a community-based, global payment model for high-risk Health First Colorado Members.

The goal of RMHP Prime is to build a model for Health First Colorado that is sustainable. RMHP Prime’s payment system enhances flexibility in the way care is delivered to the vulnerable low income population. The model reduces volume-reimbursement pressures on primary care physicians caring for this population with payment on a per-member-per-month basis. This allows practices to become more creative and efficient in meeting the health care needs of RAE Members, through proactive outreach, improved care coordination and other non-encounter based processes.

Objectives for the RMHP Prime Program include:
- Create an economic basis for system transformation and whole-person care
- Maximize flexibility, not spending
- Pay for value, not volume
- Create a durable model that is formed by local leadership
- Share data for transparent analysis and goal setting
- Prioritize resources and focus according to agreed-upon goals
- Share burden and benefits, equitably and timely, with partners in the program

RMHP Prime with ACC Phase II

RMHP Prime continues with Phase II of the ACC. This includes the following:
- The Department continues to pay RMHP a fixed global payment to RMHP for medical services provided to RMHP Prime Members
- The RMHP Prime counties are: Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco
- RMHP Prime Members are individuals who enroll in RMHP Prime due to county of residence and Health First Colorado eligibility. Health First Colorado-eligible adults and children with a disability status are enrolled by the Department into RMHP Prime
- Primary care providers participating in RMHP Prime continue to receive risk adjusted monthly global payments for attributed RMHP Prime Members

In the RAE, for RMHP Prime Members, RMHP is responsible for the physical health services historically covered under RMHP Prime and the behavioral health services covered under the Capitated Behavioral Health Benefit.

RAE and RMHP Prime Distinctions

<table>
<thead>
<tr>
<th>Process</th>
<th>RAE</th>
<th>RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory/Passive Enrollment</td>
<td>Enrollment is mandatory. All Health First Colorado Members must enroll. No opt-out.</td>
<td>RMHP Prime is passive enrollment. Members can opt-out to receive physical health benefits through Health First Colorado FFS.</td>
</tr>
<tr>
<td>Enrollment Effective Date</td>
<td>Enrollment begins upon Member’s Health First Colorado eligibility determination.</td>
<td>Enrollment begins upon Member’s Health First Colorado eligibility determination.</td>
</tr>
<tr>
<td>Member Enrollment Region</td>
<td>Member enrollment in the RAE is based on the physical location of the Member’s attributed PCMP site, not the Member’s residence.</td>
<td>Member enrollment in RMHP Prime is based on county of residence and Health First Colorado eligibility.</td>
</tr>
<tr>
<td>Member Attribution</td>
<td>RAE Members are immediately attributed to a PCMP, upon being determined eligible for Health First Colorado benefits.</td>
<td>Member attribution follows RMHP’s attribution methodology, using claims and patient choice.</td>
</tr>
</tbody>
</table>
| Member Re-Attribution | Every six months, the Department will run a re-attribution process to attribute RAE Members/PCMPs based on claims during the most recent 18 months.  
If the Member’s new attributed PCMP is in a different region, the Member’s RAE will change to the PCMP’s region.  
For RAE Members in RMHP Prime, re-attribution follows RMHP’s process. | RMHP determines attribution each month |

<table>
<thead>
<tr>
<th>PCMPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMP Agreement</strong></td>
</tr>
<tr>
<td><strong>PCMP Payments</strong></td>
</tr>
<tr>
<td><strong>Physical Health Reimbursement</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Six Behavioral Health Sessions at PCMP Practice</strong></td>
</tr>
</tbody>
</table>
# For RMHP Prime PCMPs: RMHP RAE Members without RMHP Prime & RMHP RAE Members with RMHP Prime

<table>
<thead>
<tr>
<th>Population</th>
<th>RMHP RAE Members without RMHP Prime</th>
<th>RMHP RAE Members with RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most individuals covered by Health First Colorado are RAE Members</td>
<td>RMHP RAE Members without RMHP Prime include: All Region 1 RAE Members who do not reside in an RMHP Prime County (Garfield, Gunnison, Mesa, Montrose, Rio Blanco, Pitkin) and most children who reside in an RMHP Prime County.</td>
<td>RMHP RAE Members with RMHP Prime include: RAE Members who are adults with full Health First Colorado benefits, a few children who have a disability status and who reside in an RMHP Prime county (Garfield, Gunnison, Mesa, Montrose, Rio Blanco, Pitkin).</td>
</tr>
</tbody>
</table>

| Enrollment Process | Mandatory RAE enrollment by the Department based on the site of the Member’s attributed PCMP. | Passive enrollment by Department based on Member’s county of record and eligibility category. |

| Attribution        | Department calculates attribution for RAE Members following Department’s methodology. | Department calculates attribution for RAE Members following Department’s methodology. |

| Primary Care       | RMHP contracts with PCMPs. RMHP pays at least $2 PMPM for attributed RAE Members. RMHP provides practice transformation activities. | RMHP contracts with PCMPs. RMHP pays global monthly PMPM for attributed RMHP Prime Members. RMHP provides practice transformation activities. |

| Behavioral Health Benefits | RMHP as RAE is responsible for administering covered services under the Capitated Behavioral Health Benefit (RMHP pays claims). | RMHP as RAE is responsible for administering covered behavioral health services (RMHP pays claims). |

| Physical Health Benefits | Department continues to pay for pharmacy and physical health care services following Health First Colorado FFS schedule. | RMHP responsible for pharmacy and physical health care services (RMHP pays claims). |

| Social Determinants of Health | Additional activities to screen, refer, and connect Members to community-based services. | Additional activities to screen, refer, and connect Members to community-based services. |

---

**Reimbursement Methodology for RMHP Prime: PCMPs**

**Monthly global payment for participating PCMPs**

Physicians who agree to participate as PCMPs for RMHP Prime Members will receive a monthly global payment for medical services provided to RMHP Prime Members. This global monthly payment will be paid to each primary care medical provider by RMHP on a monthly basis for each RMHP Prime Member attributed to the primary care medical provider.

The amount of the monthly global payment will be based upon historical fee-for-service payments for services provided for the populations enrolled in the RMHP Prime Program. The value of the federal and state Medicare

---

© 2021 ROCKY MOUNTAIN HEALTH PLANS
equivocacy requirement for primary care providers is included, as well as an additional enhancement set forth in the provider contract with RMHP. The global payment is also risk adjusted, so that reimbursement will be higher for patients with greater care complexities due to diagnostic and demographic factors.

The monthly global payment will be for a specific list of E&M codes, found in the provider’s RMHP contract. Any codes billed outside of that list will pay at the provider’s RMHP contractual fee-for-service rate unless they are considered a subset of a code that is on the list. Normal code edits apply. The monthly global payment is full compensation for the office visits included with the specific list of E&M codes.

Compensation for RMHP Prime Separate from the Monthly Global Payment
Medical services to attributed RMHP Prime Members for codes other than those listed in the provider’s RMHP contract as under the monthly global payment are reimbursed on a fee-for-service basis according to the Health First Colorado Department rate, plus an enhancement set forth in the provider contract with RMHP. This includes, but is not limited to: in-office procedures, injectable drug administration and medicines, HCPCs, inpatient care, nursing home or rehab visits, ER visits, OB delivery, and other non-E&M codes.

All medical services provided by PCMPs to RMHP Prime Members, who are not attributed to that PCMP, will be paid at 100 percent of the Health First Colorado Department rate. The Health First Colorado rate is the amount providers would receive from the Department.

Risk Adjustment Scores of RMHP Prime Members
Risk Adjustment scores are important to help determine the monthly global payment the practice and practitioner receives for each Health First Colorado Member enrolled in RMHP Prime. A Risk Adjustment score is a numerical representation of the medical “severity” of a patient’s condition; the higher the severity, the higher the Risk Adjustment score.

Medical severity is determined by the demographic factors, utilization history, and diagnosis codes submitted on claims sent to insurance carriers. The greater the complexity of these factors on submitted claims the higher the risk score for the attributed patients. The Risk Adjustment of the patient is determined using the Chronic Illness and Disability Payment System (CDPS), which is a risk-assessment model that was specifically designed for Medical Assistance populations such as Health First Colorado. CDPS is a transparent methodology in the public domain, which was designed by the University of California in San Diego, and is a combination model that incorporates both diagnoses and pharmacy utilization.

Attribution of RMHP Prime Members
The monthly global payment is paid to a primary care medical provider only for those RMHP Prime Members attributed to the practice. The attribution methodology reflects evidence of an active physician-patient relationship based on claims history or documentation of patient choice of medical home. For example, one claim in 15 rolling months of claims history or one signed patient choice form will result in the RMHP Prime Member being attributed to the primary care medical provider.

Assigned But Not Attributed Patient Population
The Assigned But Not Attributed patient population includes those patients who have been previously assigned to the physician either through the RMHP auto-assign process or the patient designating the physician as their primary care physician, and the patient is not yet attributed to the physician.

If the RMHP Prime Member has not been attributed to the primary care physician through the attribution process described previously, or if the patient has not completed and signed a patient choice form indicating that they are choosing a particular physician, the patient will appear on the Assigned But Not Attributed list of patients. Each month RMHP will provide a series of Production Reports including the current Assigned But Not Attributed list of patients to each primary care practice.
The physician will not receive the monthly global payment for RMHP Prime Members who are assigned but not attributed to the PCMP. It is very important for the practice to actively review the monthly Assigned But Not Attributed list of patients and consider taking steps to develop a patient-practice relationship, so the Members are attributed to the practice, either through a patient choice form or claims-based attribution.

**Patient Choice Form**

Patients use a patient choice form to indicate which PCMP is his/her medical home. The patient choice form must be completed in its entirety, signed and dated by the patient. Once the patient choice form is submitted to RMHP, the patient will be attributed to the physician indicated on the form for a period of 15 months. The attribution of the patient could change if the patient uses a patient choice form to pick a different PCMP during that 15-month period.

Attribution with the Patient Choice form is effective the first day of the month, following the month the form was submitted to RMHP, if the form is submitted to and processed by RMHP, prior to the 15th day of the month. For example, if the form is received and processed between January 16 and February 15, attribution of the patient would be effective March 1. However, if the Member is new to RMHP, attribution may be effective one month later, even if the form is received by the dates noted above.

Other details on the patient choice form:

- Patients attributed through a patient choice form can be identified easily on the practice’s attribution list by a “C” at the end of the practice’s TIN, in the TIN drop-down menu.
- Use of the patient choice form supersedes attribution through claims history, regardless of the prior attribution status of the Member.
- The patient choice form should be customized for each practice.

**Completing and Submitting the Patient Choice Form**

**Background**

RMHP provides this information to assist primary care practices that are participating in RMHP Prime to tailor the patient choice form for each practice, complete the form accurately, and submit the form to RMHP. It is essential this form is completed thoroughly and accurately in order for RMHP to process the form and for patient choice attribution to occur.

The purpose of a patient choice form is to allow the patient to express by his/her signature which practice is his/her medical home and to document this relationship. This documented relationship will be used for attribution and will supersede any claims-based attribution for 15 months. RMHP anticipates that there will be changes to the form or the process as this patient choice form is implemented. Updated instructions will be available.

Please see the instructions below to guide primary care practices in completing the form and submitting it to RMHP.

**Instructions for Adapting the Patient Choice Form for your Practice**

- RMHP provides a patient choice form template for each practice to use to develop a practice specific patient choice form. An instructional visual is attached to this document that shows what changes should be made to the form so it is tailored to each practice. This includes:
  - Inserting the practice’s logo
  - Adding the practice’s name at the top
  - Adding the practice’s name, address and phone number to the bottom
- Contact your RMHP Provider Relations Representative if you have any questions about changing the form for your practice.

**Instructions for Completing the Patient Choice Form**

All fields on the patient choice form must be completed, accurately. If the form is submitted with any missing or inaccurate information, it will be returned to the practice for completion. Attribution will be delayed until the form is complete. The only exception to this is the patient’s phone number. The patient’s phone number is not required and the form will not be returned to the practice if the patient is unwilling to provide a phone number.

- Print the patient’s name in the patient’s name box.
• Provide the patient’s date of birth in the box provided.
• Ask the patient to sign and date the form in the boxes provided. The form must include the patient’s signature and the patient’s date of signature (unless a parent or guardian signature is required).
• If a parent or guardian signature is required, the parent/guardian’s signature and date of signature must be present on the form.
• Obtain the patient’s phone number and if the phone number accepts texts. If the patient is unwilling to provide their phone number and text information, the patient choice form will not be returned to the practice for missing or incomplete data.
• Provide the Member’s RMHP or Health First Colorado ID in the box provided.
• The provider or office manager must sign the patient consent form.

Instructions for Submitting Form to RMHP
A practice may submit these forms to RMHP using any of the following processes.
• Mail to: Attention RMHP Customer Service, PO Box 10600, Grand Junction, CO 81502
• Fax: 970-263-5590
• RMHP is developing more automated ways for obtaining and processing electronic methods for obtaining this information. Changes to this process may be necessary to support automation and better data collection. Additional information about this process will be forthcoming.
• RMHP will attribute the patient to that practice for 15 months unless a different patient choice form is received from the patient if the following steps occur: a patient and primary care practice sign a patient choice form, all necessary parts of the form are completed, and the form is submitted to RMHP. This patient choice supersedes any claims-based attribution.
• A patient must be an active RMHP Member for attribution to be effective.

Templates of the patient choice form are available by contacting your local RMHP Provider Representative.
RMHP RAE KEY CONTACT INFORMATION
RMHP RAE Key Contact Information

Nicole Konkoly, RAE Network Relations Manager
nicole.konkoly@rmhp.org

Meg Taylor, VP of Community Integration
meg.taylor@rmhp.org

Dale Renzi, VP of Network Strategy
dale.renzi@rmhp.org

Lisa Latts, Chief Medical Officer
lisa.latts@rmhp.org

Greg Coren, Senior Manager, Provider Networks
greg.coren@rmhp.org

Patrick Gordon, Chief Executive Officer
patrick.gordon@rmhp.org

Kim Herek, Director, Clinical Program Development and Evaluation
kimberly.herek@rmhp.org

Jeremiah Fluke, Prime Contract Manager
jeremiah.fluke@rmhp.org

RMHP RAE Support
raesupport@rmhp.org

Value Based Contracting Review Committee (VBCRC)
VBCRC@rmhp.org

Practice Transformation
practice.transformation3@rmhp.org

RMHP Care Coordinators
888-282-8801 (TTY: 711), press Option 5, then Option 1
EXHIBIT A: EASYCARE Colorado
NEVER BE WITHOUT A DOCTOR

Did you know you can text a doctor for free with EasyCare Colorado from Rocky Mountain Health Plans?

Download the EasyCare Colorado app or connect online at easycareco.com and see how easy it is to connect to a doctor in seconds!

Use EasyCare Colorado for:

- SICK KIDS
- COUGHS, FEVERS, SORE THROAT
- EARACHES, STOMACH PAIN, DIARRHEA
- RASHES, ALLERGIC REACTIONS, ANIMAL/INSECT BITES
- BACK/ABDOMINAL PAIN
- SPORTS INJURIES, BURNS, HEAT-RELATED ILLNESS
- URINARY TRACT INFECTIONS
- GENERAL HEALTH QUESTIONS

Doctors are available 24/7. Learn more at easycareco.com.

Available to Rocky Mountain Health Plans regional organization (RAE), Prime, CHP+ and Medicare Members.
EXHIBIT B: RURAL AUXILIARY SERVICES (RAS)
Program for Rural Coloradans

Barriers to Effective Communication in Rural Areas

People on the Front Range have ready access to certified sign language interpreters and sign language interpreting agencies to provide needed services to deaf, hard-of-hearing, and deafblind individuals. In contrast, there are few certified sign language interpreters or sign language interpreting agencies in rural areas.

This shortage has contributed to barriers to providing effective communication for individuals who are deaf, hard-of-hearing, or deafblind. Thus, Colorado’s Joint Budget Committee funded the Rural Interpreting Services Project (RISP) pilot starting in 2018. In 2020, the pilot became a permanent program called Rural Auxiliary Services (RAS).

Rural Auxiliary Services (RAS) Coverage Area

For the purposes of RAS, “rural” is defined as all areas outside of the Front Range. Pueblo and Grand Junction are considered rural.

The Front Range is NOT included in RISP

Live Captioning Services

In 2021, RAS will be expanded to include Communication Access Realtime Translation (“CART,” or live captioning) services. Details will be posted to the CCDHHDB website when the service becomes available.

Sign Language Interpreters

Through RAS, rural communities have access to quality interpreting services for a variety of needs. RAS will arrange for and provide certified sign language interpreting services for rural areas of Colorado at no cost to consumers or service providers.

Contact RAS to request sign language interpreters for:

- Medical appointments: Hospitals, Medical Offices, Doctors, Dentists, Mental Health
- Legal settings: Municipal Court, Attorney-Client meetings, Law Enforcement settings (Police, Sheriff, State Patrol)
- Work settings: Job Site Meetings, Job Interviews, Employee Training
- PreK-12th grade school-related events: parent and teacher/principal meetings, school events. Note: educational or classroom interpreting for student’s is not covered. Also, interpreting services for colleges/universities are not covered.

And more!
Note: interpreting services for state agencies is not covered by RAS. Contact CCDHHDB for more information.

Sign Language Interpreter Certification

Colorado’s Consumer Protection Act currently requires “sign language interpreters” to be certified by the Registry of Interpreters for the Deaf (RID). Section 6-1-707(1)(e), C.R.S.