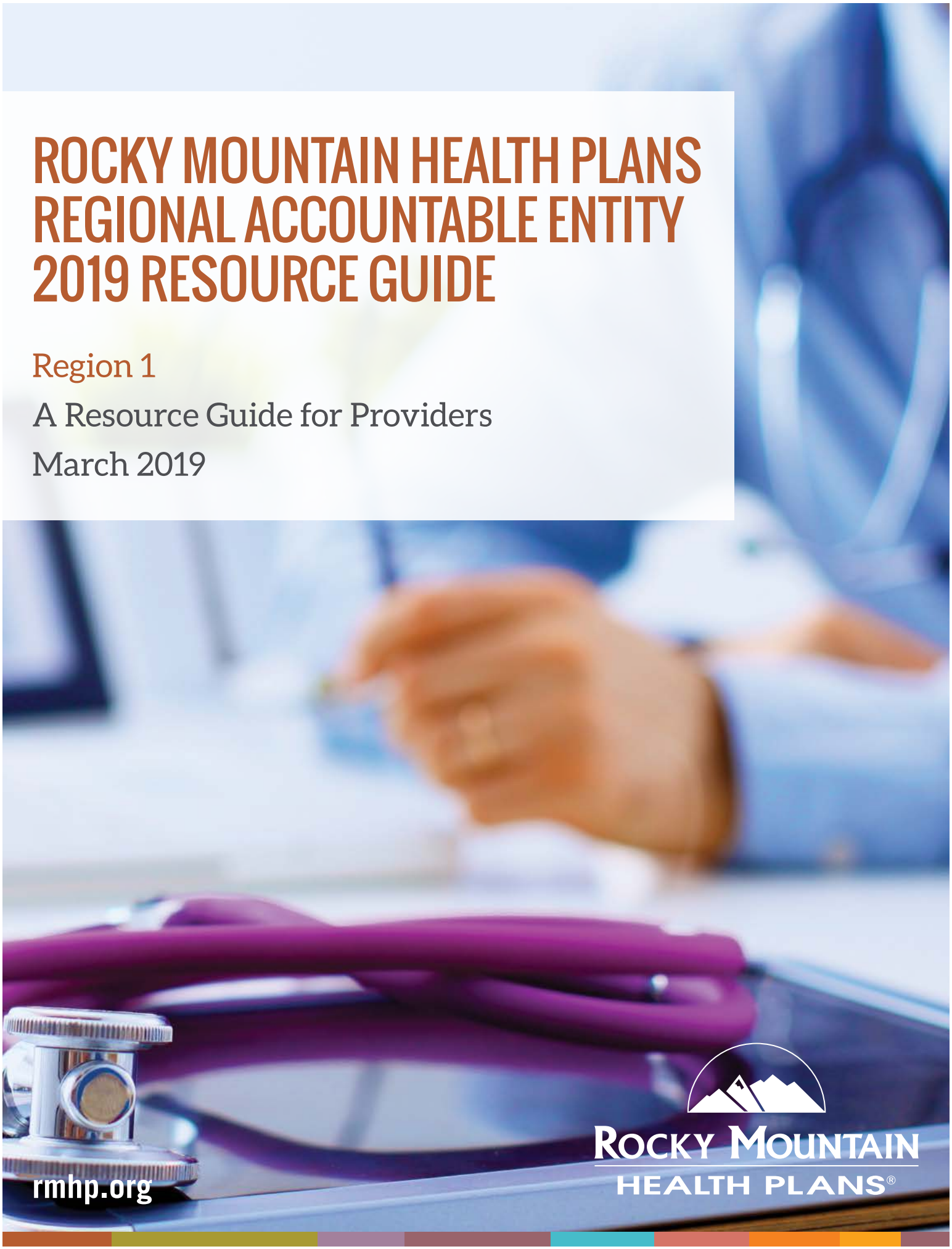
ROCKY MOUNTAIN HEALTH PLANS REGIONAL ACCOUNTABLE ENTITY 2019 RESOURCE GUIDE

Region 1

A Resource Guide for Providers

March 2019



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ROCKY MOUNTAIN HEALTH PLANS®

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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.

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)

Changes from the 2018 RAE Orientation Guide to the 2019 RAE Resource Guide

- Reference to new RAE Behavioral Health Manual, which can be found by visiting **rmhp.org**, then choosing *I am a Provider > Provider Resources > Commonly Used Forms*
- Expanded explanation of KPIs
    - Inclusion of information on the Health First Colorado Data Analytics Portal (DAP) to view KPI performance
    - There is no Total Cost Relativity (TCR) calculation as a component of KPI earnings, if applicable
- Removal of ACC Enhanced Primary Care Medical Provider (ePCMP) content. This program has sunset as the Colorado Department of Health Care Policy and Financing (the Department) prepares for the implementation of the Alternative Payment Model (APM)
- Clarification of geographic-proximity auto-attribution/auto-assignment expectations for Tier 1 practices
- Update of general RAE contact email address from support@rmhpcommunity.org to **raesupport@rmhp.org**
- Update of RAE attribution information to include additional detail on the Department's methodology and available options for PCMP panel configuration
- Explanation of ongoing tier demonstration
    - New Value Based Contracting Review Committee (VBCRC) email: **VBCRC@rmhp.org**
    - Process if demonstration critieria is not met throughout the performance year
    - Updated Clinical Quality Measure (CQM) Suite with Benchmarks
        - Expanded Pediatric CQMs
    - Practice Transformation Program Placement Information

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, that 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 (ACHM) – 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 needs 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 electronically 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 Engagement Team (HET) / Community Health Worker (CHW) – a program available to RMHP RAE Tier 1 and 2 practices. This program assigns a CHW to specific practices as an extension of the practices' care teams to assist high risk and/or complex Members with access to services and promote healthy behavior change.

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 and 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 includes 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 – **"P**ayment **R**eform **I**nitiative for **M**edicaid **E**nrollees**" –** 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.

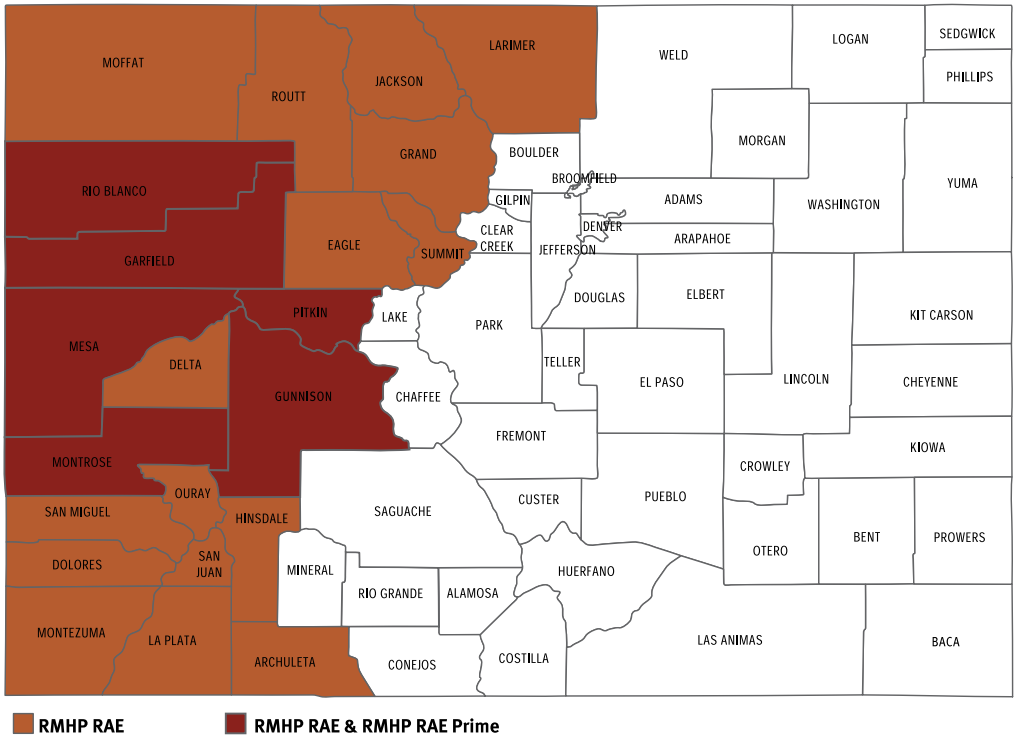
RMHP Prime Counties – Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties.

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 and includes adults who receive full Health First Colorado benefits, and children with disability status. **All RMHP Prime Members are also enrolled with RMHP as the RAE for behavioral health services. RMHP Prime Members also 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), growing our community-oriented approach for Health First Colorado Members as **RMHP Community**.



The RAE (pronounced "RAY") for Region 1 includes:

- the services previously performed by RMHP as the *Regional Care Collaborative Organization (RCCO)*, including the primary care medical provider network and care coordination services;
- the services previously performed by the regional *Behavioral Health Organization (BHO)*, including managing covered services under the Medicaid Capitated Behavioral Health Benefit;
- the Western Colorado payment reform initiative known as RMHP Prime; and
- 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.

Understanding RAE Processes

Please contact RMHP with any questions about the below information.

Process	RAE Fast Facts
Members	
Mandatory Enrollment	Enrollment is mandatory. No opt out. All Health First Colorado Members must enroll.
Enrollment Effective Date	Enrollment begins upon Member's Health First Colorado eligibility determination.
Member Enrollment Region	Member enrollment in the RAE is based on the physical location of the Member's attributed PCMP site, not the Member's residence.
Member Attribution	RAE Members are immediately attributed to a PCMP upon being determined eligible for Health First Colorado benefits. RAE Members are attributed to a PCMP, even when there is no prior claim or patient choice history. For RAE Members enrolled in RMHP Prime, attribution follows current RMHP attribution methodology and process.
Member Re-Attribution	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. If the Member's new attributed PCMP is in a different region, the Member's RAE enrollment will change to the PCMP's region. For RAE Members in RMHP Prime, re-attribution follows RMHP's current process.
PCMPs	
PCMP Agreement	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.
PCMP Payments	RAE pays at least $2 PMPM to PCMPs for attributed RAE Members. Additionally, incentive payments for higher performing practices are available.
Physical Health Reimbursement	Physical health claims for RAE Members are paid Health First Colorado fee-for-service rates by the Department. Physical health claims for RAE Members enrolled in RMHP Prime are paid by RMHP.
RMHP Prime	RMHP Prime continues. Additionally, as the RAE, current Prime services and RAE behavioral health services are covered by RMHP.

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 Revalidate 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 revalidated with Health First Colorado will not need to revalidate again until their next revalidation cycle.

Initial enrollment/revalidation

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

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

Ongoing requirement for revalidation

Once your initial enrollment/revalidation is complete, you will be required to revalidate every 3–5 years depending on your risk-level. The Department and its fiscal agent, DXC, will notify you when you need to revalidate. 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 revalidation for all participating providers. These regulations are designed to increase compliance and quality of care, and to reduce fraud.

Step 2: Use Service Location Address When Billing for Accurate Attribution

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 service location address of the billing provider.** Claims should not use one billing address for all locations. **A unique nine (9)-digit zip code or taxonomy code is required to identify the Health First Colorado Medicaid Site ID, if the provider shares an NPI with multiple locations or multiple provider types.** 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.

Please review the Department's *Multiple Service Locations: Enrollment and Claims Submission* **policy document**.

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. PCMP administrative medical home payments are paid at a minimum $2 per member per month

- 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 an RMHP Prime advanced payment model. Physical health care services and behavioral health care services are paid by RMHP

Who Pays?

Service Type	RMHP RAE Members <u>without</u> RMHP Prime	RMHP RAE Members <u>with</u> RMHP Prime
Physical Health Services	Bills sent to and paid by Department following Department claims and authorization methodology	Bills sent to and paid by RMHP following Provider-RMHP agreement
Behavioral Health Services Outside of PCMP Practice	Bills sent to and paid by RMHP under the RAE behavioral health benefit	Bills sent to and paid by RMHP under the RAE behavioral health benefit
Six Behavioral Health Sessions at PCMP Practice	Up to six Behavioral Health sessions per RAE Member provided by a Behavioral Health Provider are 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	Up to six Behavioral Health sessions per RMHP Prime Member provided by a Behavioral Health Provider are 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. Paid by RMHP under the RAE behavioral health benefit following RMHP-Provider agreement
PCMP Medical Home Payments	Paid by RMHP for RMHP RAE Members attributed by the Department to Region 1 PCMP	Paid by RMHP following RMHP attribution methodology and Provider-RMHP Prime agreement.

PCMP Payments and Attribution

RMHP's RAE Value-Based PCMP Payment Model – Payment Beyond the $2 PMPM

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.

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.

Administrative Medical Home Payments

RMHP will pay administrative medical home payments to PCMPs for their attributed RAE Members. PCMPs will have the option to receive *at least* $2 per member per month (PMPM). RMHP is implementing a value-based payment model for PCMPs for an opportunity to receive **higher** PMPM. The model includes a clear delineation of provider responsibilities and resources available for different levels of participation and accountability (tiers).

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 by the Department 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 that 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, Health First Colorado Enrollment at 888-367-6557. The Department anticipates an online option for this process will be available soon.
5. **Ongoing Attribution: PCMP to PCMP Reattribution:** 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.

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**.
- Once a panel limit is reached, no further attributions will be made, even if a Member requests a practice by calling Health First Colorado Enrollment.
- PCMPs may turn auto-assignment (geographically based attributions) on or off at any time by contacting their RAE network representative.
    - All Tier 1 and 2 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 or 2 practice. If geographic auto-attribution 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 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, see the Department's **Verifying Member Eligibility and Co-Pay Quick Guide**.

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.

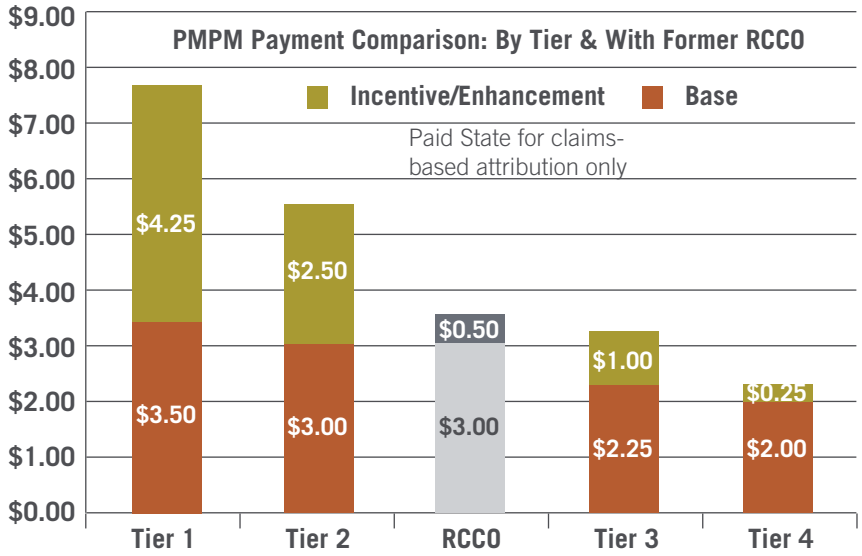
RMHP Prime Attribution

RAE Members enrolling with RMHP as part of the RAE payment reform initiative, RMHP Prime, will be immediately enrolled with RMHP upon eligibility determination for 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 estimated that the funding distributed to the practices for KPI earnings will be broken up by tier, as shown in the chart below. The RCCO column reflects the funding earned in ACC Phase 1, and the Tier 1 - 4 columns show the anticipated dollars passed through to the practices from the RAE if KPI metrics are met at the region level.



(+$2 PMPM paid for auto assigned / "geo attributed" Members)

Notably, there is an opportunity for all RAE PCMPs to earn more funding for actively engaging and performing well on KPI metrics.

KPI Measures

The KPI measures below are utilized for potential incentive payments and are based upon Paid Claims and Encounters.

Behavioral Health Engagement

- Measure Description: The denominator for Behavioral Health Engagement is all Members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, Members must receive 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.
- Timing: RMHP reports quarterly to the Department
- RAE Region 1 Baseline: .829%
- RAE Region 1 Target(s):
  - Level 1 Performance Improvement: 1.0% - <5.0% increase above baseline
  - Level 2 Performance Improvement: >5.0% increase above baseline

Dental Visits

- Measure Description: The denominator for Dental Visits includes all Members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, Members must receive at least one dental service (medical or dental claim) within the 12-month evaluation period.
- Timing: RMHP calculates and reports monthly for a rolling 12-month period
- RAE Region 1 Baseline: 33.38%
- RAE Region 1 Target(s):
  - Level 1 Performance Improvement: 1.0% - <5.0% increase above baseline
  - Level 2 Performance Improvement: >5.0% increase above baseline

Well Visits

- Measure Description: The denominator for Well Visits includes all Members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, Members must have at least one well visit within the 12-month evaluation period.
- Timing: RMHP calculates and reports monthly for a rolling 12-month period
- RAE Region 1 Baseline: 31.32%
- RAE Region 1 Target(s):
  - Level 1 Performance Improvement: 1.0% - <5.0% increase above baseline
  - Level 2 Performance Improvement: >5.0% increase above baseline

Prenatal Engagement

- Measure Description: The denominator for Prenatal Engagement includes all deliveries for Members enrolled in the ACC as of the end of the rolling 12-month evaluation period. Members may have multiple deliveries within the evaluation period. To be counted in the numerator, Members must have at least one prenatal visit within 40 weeks prior to the delivery and be enrolled in Health First Colorado at least 30 days prior to the delivery.
- Timing: RMHP calculates and reports monthly for a rolling 12-month period
- RAE Region 1 Baseline: 60.19%
- RAE Region 1 Target(s):
  - Level 1 Performance Improvement: 1.0% - <5.0% increase above baseline
  - Level 2 Performance Improvement: >5.0% increase above baseline

Emergency Department Visits PKPY (Risk Adjusted)

- Measure Description: Member months for all Members within the population are included in the denominator for this measure. An ED visit will be counted in the numerator if it does not result in an inpatient admission. To normalize this measure, it is expressed as a per thousand Member months per year (PKPY), meaning the rate is multiplied by 12,000 for the evaluation period. The PKPY is then risk adjusted using a RAE risk weight. The risk adjusted ED Visits PKPY will be used for payment.
- Timing: RMHP calculates and reports monthly for a rolling 12-month period
- RAE Region 1 Baseline: 597.431 (ER Risk Adjusted/Actual ER Visits PKPY)
- RAE Region 1 Target(s):
  - Level 1 Performance Improvement: 1.0% - <5.0% decrease below baseline
  - Level 2 Performance Improvement: >5.0% decrease below baseline

Health Neighborhood

- Measure Description: Health Neighborhood is a composite measure made up of two parts. Part 1 calculates the percentage of RAE's PCMP's with Colorado Medical Society's Primary Care-Specialty Care Compacts in effect with specialty care providers. Part 2 calculates the 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. The denominator for Part 2 of the Health Neighborhood measure includes all specialty visits for Members enrolled in the ACC as of the end of the rolling 12-month evaluation period. Members may have multiple visits within the evaluation period. To be counted in the numerator, Members must have at least one PCMP visit within 60 days prior to the specialty visit and a PCMP must be listed as the referring provider on the specialty claim (denominator claim).

- Part 1

Quarter	Measure	Evaluation Period	Target: Number of PCMPs	Region Final Submission
1	25%+ of PCMP network has 1+ executed care compacts in place	July 1, 2018 – Sept 30, 2018	50	35.8%
2	50%+ of PCMP network has 1+ executed care compacts in place	October 1, 2018 – Dec 31, 2018	99	51.5%
3	75%+ of PCMP network has 1+ executed care compacts in place	Jan 1, 2019 – March 31, 2019	149	
4	50%+ of PCMP network has 2+ (1 must be with behavioral health) executed care compacts in place	April 1, 2019 – June 30, 2019	99	

- Part 2
  - Timing: RMHP reports annually
  - RMHP Baseline: 2.098%
  - RMHP Target: RAE Region 1 Target(s):
    - Level 1 Performance Improvement: 1.0% - <5.0% increase above baseline
    - Level 2 Performance Improvement: >5.0% decrease below baseline

Potentially Avoidable Costs (PAC)

- Measure Description: An algorithm that uses historical claims to identify complications that are potentially avoidable. Based upon the episode of care, costs are divided into two categories: typical and PAC. RMHP's goal is to reduce PAC for diabetes, substance use disorders, and anxiety and depression.
- RMHP Focus: Diabetes, Substance Use Disorders, and Anxiety and Depression
- Timing: RMHP calculates and reports monthly for a rolling 12-month period
- RAE Region 1 Baseline: TBD
- RAE Region 1 Target: TBD

The KPI 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; 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

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**

Support and resources are available to all RMHP RAE Region 1 PCMPs. This includes understanding the KPI measures, developing or refining workflows, connecting with other practices, and more. To learn more or become engaged, email the RMHP Practice Transformation team at **practice.transformation3@rmhp.org**.

About Health First Colorado's Primary Care Alternative Payment Model 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 providers: Federally Qualified Health Centers (FQHCs) and non-FQHC PCMPs. These models make **differential fee-for-service payments** based on provider's performance with an aim to:

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

Department Primary Care Reforms (for non-FQHCs – PC APM 1)

Under the APM, PCMPs can earn higher reimbursement when designated as meeting specific criteria or by performing well on quality metrics. Progress within this framework not only encourages higher organizational performance, but also helps the ACC achieve its respective programmatic goals.

The model consists of a set of structural (characteristics of a practice) and performance (clinical processes or outcomes) measures, and each measure has been assigned a point value by the Department. PCMPs will select which measures they would like to be measured on and at the end of the performance year, their performance on each measure will generate an APM score. The APM score will, in turn, dictate the percent by which their fee schedule rates will be enhanced for a defined set of primary care services (see the **APM Code Set** for more details).

RMHP Support to PCMPs for APM

RMHP will:

- Support PCMPs in the selection of appropriate structural and performance APM measures
- Assist PCMPs in completing all required documentation for the Department by December of each year
- Provide ongoing education and support to PCMPs to ensure successful participation in the Department's APM for Primary Care

Primary Care APM Eligibility and Exclusions

- Only participating PCMPs in the ACC Program are eligible for the enhanced payments
- PCMPs must have more than $30,000 in annual *paid* claims associated with APM services (see the **APM Code Set** for more details). PCMPs who do not meet the billing volume threshold will be excluded from the APM program and experience no adjustments to their fee schedule rates.

- The Department will award "credit" in the APM model for PCMPs that are in good standing with SIM and/or CPC+ and that are certified or recognized as a PCMH practice, meaning these practices will receive the full enhanced reimbursement when rates change in July 2020. The measure selection timeline is deferred for these practices. Additional details can be found on the Department's **APM webpage**.
- Rural Health Centers (RHCs) are not a part of the APM

Primary Care APM Timeline

The Department's Primary Care APM Timeline is as follows:

- Calendar Year (CY) 2019 is the first performance year for eligible practices
- January 1, 2020 through June 30, 2020 will be the calculation period for CY2019
- Measure selection for performance year two (CY2019) will begin in December 2019

APM rate changes will go into effect starting in State Fiscal Year 2020–2021 / July 1, 2020. These rate adjustments will be effective until July 1, 2021. You may view the full APM timeline on the **Department APM webpage.**

Department FQHC Reforms (FQ APM 1)

Similar to, and aligned with, the primary care payment reforms described above, the Department is engaged in payment reforms with FQHCs to improve access to high quality care by offering alternative payment methodologies that are designed to increase provider flexibility in delivering care while holding providers accountable for client outcomes.

One of the alternative payment methodologies the Department is developing will put a portion of the FQHC encounter rate at-risk based on performance, to give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system. Under the proposed model, 4 percent of an FQHC's physical health and specialty behavioral health rates are at risk and can be earned back when the FQHC is designated as meeting specific criteria and/or performing on quality metrics. Progress within this framework not only encourages higher organizational performance but also helps the ACC achieve its respective programmatic goals.

If you have questions about the FQHC APM, contact Marija Weeden at CCHN at **marija@cchn.org** or the APM team at the Department at **HCPF_primarycarepaymentreform@hcpf.state.co**.

The timeline for the FQHC APM 1 is the same as for Primary Care APM 1.

Learn More

To learn more, please visit the Department's **APM webpage**. You may send questions by email to: **HCPF_primarycarepaymentreform@hcpf.state.co.us**

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 new policy for behavioral health services provided in a primary care clinic?

The Department now 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**.

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.

What resources are available?

Additional resources are available via multiple methods:

- View Department provider webinars and additional information at **colorado.gov/pacific/hcpf/accphase2**
- Visit the *Provider Resources* section at **rmhp.org**. Select *I am a Provider > Provider Resources*

- Contact your local RMHP provider representative, Susan Hall at **susan.hall@rmhp.org** or Tressa Sporhase at **tressa.sporhase@rmhp.org**
- Email **raesupport@rmhp.org**
- Call RMHP Customer Service at 888-282-8801
- Attend the quarterly VBCRC RAE Webinar Series (register **here**)
  - May 21, 2019
  - August 20, 2019
  - November 19, 2019
- Read the RMHP quarterly RAE newsletters. Email Mindy Patton at **mindy.patton@rmhp.org** to be added to the mailing list

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
- Performs satisfactorily (80%) RMHP Tier Assessment and passes **all** 'MUST PASS' elements by Quarter 1 2020 Assessment
- 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**.

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 Tressa Sporhase at **tressa.sporhase@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: 2019 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 algorhythmic 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).

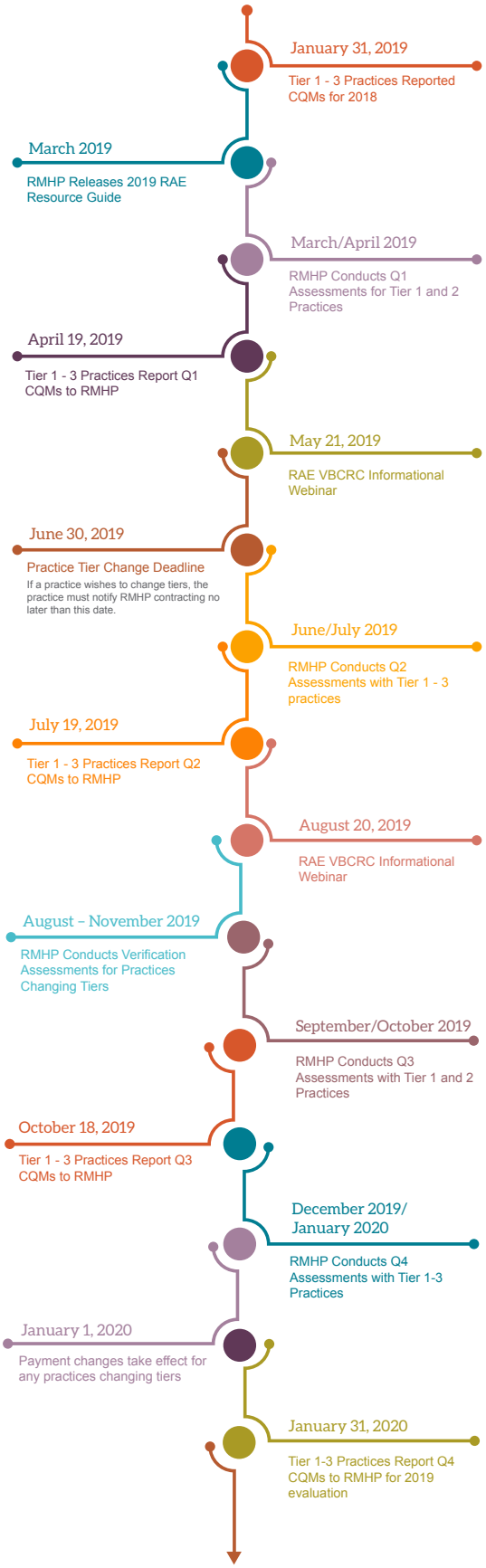
PCMP Tiering Appendix G: Tier Assessment Elements

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 2019 benchmarks in which practices will have to meet by early 2020 for their appropriate tier.

PCMP Tiering Appendix A: 2019 Timeline



PCMP Tiering Appendix B: Tier Descriptions

Tier 1 – Comprehensive RMHP Population Health Partner
Profile
CPC+ Participant Track 2 or PCMH Level 3 / 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%) 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)[1] • 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 = $3.50 PMPM • Medicaid APM percent FFS Enhancement on the Department FFS = 3 – 4%+ (or as per Medicaid APM Score) or FQHC Value Based APM/ percent FFS reduction • RAE Geographic Attribution Payments: $2.00 PMPM • 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 RMHP assistance in placing complex, resource intensive patients • Attribution and Feedback reports • Eligible for Consultative Practice Transformation resources • Eligible for Health Engagement Team/Community Health Worker resource • Eligible for RMHP designated applications with technical assistance • Eligible for $5 to $10K bonus for AHCM screening participation

[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-attribution 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 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%) 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 [1] • Medicaid APM/ FQHC APM Score = (at least) 51 – 75%
Reimbursement Enhancement
• RMHP RAE Medical Home Payment = $3 PMPM • Medicaid APM percent FFS Enhancement on the Department FFS = 2 – <3%+ (or as per Medicaid APM Score) or FQHC Value Based APM/ percent FFS reduction • RAE Geographic Attribution Payments = $2.00 PMPM
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 Health Engagement Team/Community Health Worker resource • Eligible for RMHP designated applications with technical assistance • Eligible for $5 to $10K bonus for AHCM screening participation

[1] All Tier 2 practices must accept geographic-proximity auto attributions, also known as auto-assignment, for all quarters in which they intend to operate as a Tier 2 practice. If geographic auto-attribution 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.

Tier 3 – Foundations Participation

Profile

Graduate of RMHP Foundations or SIM

(For Larimer County practices where RMHP practice transformation programs have been unavailable, other structured foundational work will be considered)

Demonstration

- Able to report minimum of 6 CQMs from the RMHP eCQM Measurement Suite from a certified EMR Dashboard (FQHCs may report from Azara)
- Meet benchmark performance (CMS 70th percentile) on 2/6 *(See Measurement suite for Benchmarks)*
- Performs satisfactorily (80%) on RMHP Tier 3 Assessment performed every 6 months
- Open to Health First Colorado Members. Intermittent or limited availability for new Health First Colorado Members
- Medicaid APM/ FQHC APM Score = (at least) 26 – 50%

Reimbursement Enhancement

- RMHP RAE Medical Home Payments = $2.25 PMPM
- Medicaid APM percent FFS Enhancement on the Department FFS = 1% – <2%+ (or as per Medicaid APM Score) or FQHC Value Based APM/ percent FFS reduction
- RAE Geographic Attribution Payments = $2.00 PMPM

Incentive Eligibility

- Eligible for KPI Pool distributions — relative to tier

Resource Supplementation

- Attribution reports
- Feedback reports upon request
- Practice Transformation resources with $10K incentive for Masters 1 and Masters 2 successful program participation

Tier 4 – Basic Participation
Profile
No historical practice transformation work completed; may be engaged in RMHP Foundations or SIM
Demonstration
• None, or • Current involvement in Foundations or SIM • Medicaid APM/ FQHC APM Score = (at least) 0 – 25%
Reimbursement Enhancement
• RMHP RAE = $2 PMPM base program reimbursement • RMHP RAE Geographic Attribution Payments = $2.00 PMPM • Medicaid APM percent FFS Enhancement on the Department FFS = <1% or as per Medicaid APM Score or FQHC Value Based APM/ percent FFS reduction
Incentive Eligibility
• Eligible for KPI Pool distributions – relative to tier
Resource Supplementation
• Attribution reports • Feedback reports upon request • Practice Transformation resources with $10K incentive for Foundations program participation

PCMP Tiering Appendix C: Practice Information Form

Submit if New RAE PCMP

Practice Name _____

Type of Practice: Family PracticePediatrics 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*

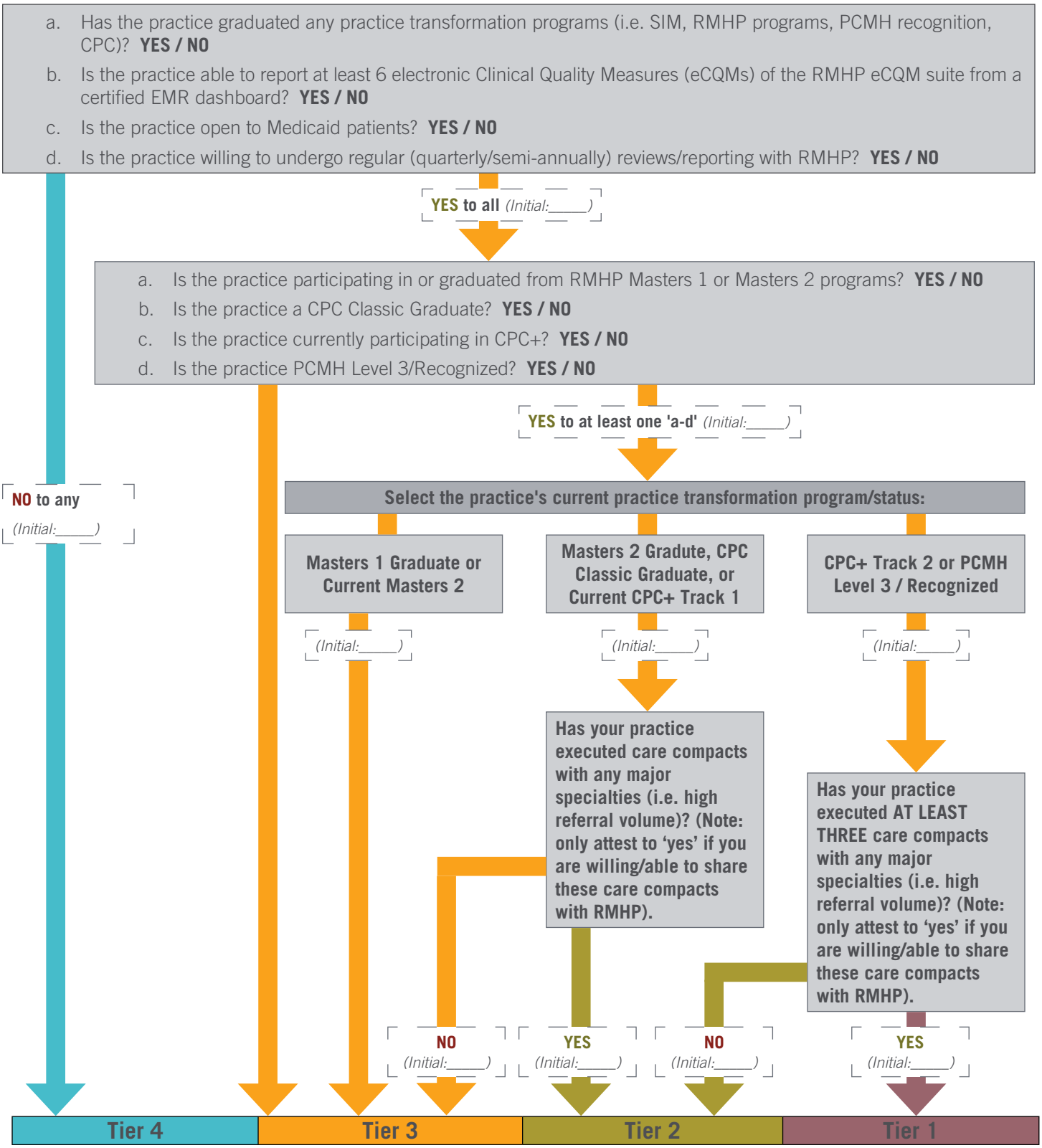
_____ _____ _____

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 Program



RAE Attestation Tree for Non-RMHP Practice Transformation Practices

a. Does the practice have a multidisciplinary Quality Improvement Team that meets at least monthly that utilizes agendas and minutes? **YES / NO**

b. Does the practice utilize the Model for Improvement by utilizing and documenting Plan-Do-Study-Act (PDSA) cycles? **YES / NO**

c. 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**

d. Is at least 60% of the practice's active patient population empaneled to the appropriate care team/provider? **YES / NO**

e. Does the practice spread and sustain QI work by utilizing a QI spread and sustainability plan? **YES / NO**

f. Is the practice open to Health First Colorado Members? **YES / NO**

g. Is the practice willing to undergo regular (quarterly/semi-annually) reviews/reporting with RMHP? **YES / NO**

YES to all *(Initial:_____)*

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

Not a participant and/or completed in CPC+, CPC Classic and/or PCMH Level 3/Recognized

a. Does the practice provide care management for high risk patients (i.e. use of risk stratification, patient screening tools, care plans, use of HIE, etc.)? **YES / NO**

b. Does the practice actively engage in the medical neighborhood by following up with patient and medical neighbors about ED visits and hospital discharges? **YES / NO**

c. Does the practice use Patient Feedback and Advisory Council (PFAC) and/or patient surveys to improve patient care and improve practice operations? **YES / NO**

d. Does the practice use shared decision making tools and track utilization of the tool? **YES / NO**

CPC Classic Graduate or Current CPC+ Track 1

(Initial:_____)

YES to all *(Initial:_____)*

CPC+ Track 2 or PCMH Level 3/Recognized

(Initial:_____)

NO to any *(Initial:_____)*

NO to any *(Initial:_____)*

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).

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 *(Initial:_____)*

YES *(Initial:_____)*

NO *(Initial:_____)*

YES *(Initial:_____)*

Tier 4 | **Tier 3** | **Tier 2** | **Tier 1**

PCMP Tiering Appendix E: Attestation Tree Determination

Submit if New RAE PCMP

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
  - 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, 2019. 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 2020 (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 2020 assessment, the practice will be reviewed by the Value Based Contracting Review Committee (VBCRC). This information is given to you in 2019 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. The elements that will qualify for auto-credits are still under consideration, but will be released prior to the end of 2019.

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	
2019 MUST PASS Criteria	
Participation in quarterly assessments	
Fully open to Health First Colorado Members (RAE and RAE-PRIME Members)	
Six eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation)	
Minimum of three care compacts that meet the criteria above	
Medicaid APM Score 76-100%	
Access and Continuity	
1.1	(2020 MUST PASS) Practice is fully open to Health First Colorado Members and maintains at least 95% empanelment to practitioner and/or care teams
1.2	Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR
1.3	Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice
1.4	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	
2.1	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
2.2	(2020 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
2.3	(2020 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
2.4	Provide short-term (episodic) care management, including medication reconciliation to patients following hospital admission/discharge/transfer,* and, as appropriate, following an ED discharge
2.5	(2020 MUST PASS) Ensure patients with ED visits receive a follow-up interaction within one week of discharge
2.6	(2020 MUST PASS) Contact at least 75% of patients who were hospitalized in target hospital(s),* within two business days
Cohesiveness and Care Coordination	
3.1	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
3.2	(2020 MUST PASS) Enact collaborative care agreements with at least three groups of high volume/critical specialists that meet minimum requirements for RAE KPI

Tier 1 – Comprehensive Participation Assessment Elements	
3.3	(2020 MUST PASS) Establish at least one collaborative care agreement with a community behavioral health entity that supports and meets patients' psychosocial needs
3.4	(2020 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**
3.5	(2020 MUST PASS) Routinely assess patients' psychosocial needs (AHCM, as an example)
3.6	Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs
3.7	Define at least one subpopulation of patients with specific complex needs, develop capabilities necessary to better address those needs, and measure and improve the quality of care and utilization of this subpopulation
Patient and Caregiver Engagement	
4.1	Convene a PFAC at least quarterly, and integrate recommendations into care and quality improvement
4.2	Implement self-management support (such as PAM) for at least three high-risk conditions
4.3	Identify and engage a subpopulation of patients and caregivers in advance care planning (peds exception)
Planned Care & Population Health	
5.1	(2020 MUST PASS) Practice reviews data on at least two utilization measures at the practice level to set goals to improve population health management
5.2	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
5.3	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

Tier 2 – Advanced Participation Assessment Elements	
2019 MUST PASS Criteria	
Participation in quarterly assessments	
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	
Four eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation)	
Minimum of one care compacts that meet the criteria in the previous Appendix	
Medicaid APM Score 51-75%	
Provide Care Management for High Risk Patients	
1.1	Practice has equitable panel management processes and an empanelment rate at or above 90%
1.2	Practice measures continuity of care and has set a continuity of care target
1.3	(2020 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.
1.4	(2020 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)
1.5	(2020 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
1.6	(MUST PASS) Practice creates care plans for its high risk patients
1.7	Practice has completed a Team-based Care Assessment and has implemented a strategy to address gaps (i.e. huddles, standing orders, etc.)
1.8	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.)
1.9	Pactice has implemented Self-Management Support for for at least one high-risk condition
1.10	The practice assesses patient activation levels and/or readiness to change
1.11	The practice uses Coaching for Activation or Motivational Interviewing Techniques
Demonstrate Active Engagement and Care Coordination Across the Medical Neighborhood	
2.1	Practice has defined timely fashion follow up for ED and hospital discharge workflows and has reviewed necessary improvements or changes to the process
2.2	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)
2.3	Practice follows up with at least 70% of patients discharged from hospital within their definition of timely fashion (must report numerator and denominator)
2.4	Practice has established a Care Compact with at least one high volume specialist that meets the minimum requirements of the RAE KPI

Tier 2 – Advanced Participation Assessment Elements	
Assess and Improve Patient Experience of Care	
3.1	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.
3.2	The practice has completed at least two QI projects with data collected from either patient surveys or PFAC.
Develop a Plan for Sustainability and Spread	
4.1	Practice has plan for sustainability and spread
4.2	Practice has an internal and external communication plan to inform practice and patients of QI work
Quality Improvement	
5.1	Practice has multidisciplinary QI team that meets regularly
5.2	(2020 MUST PASS) Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement
5.3	Practice has completed at least a single PDSDA cycle for each of the identified CQMs.

Tier 3 – Foundations Participation Assessment Elements	
2019 MUST PASS Criteria	
Limited, intermittent availability for new Health First Colorado Members	
Two eCQMs at the 70th benchmark reported out of a certified tool (quarterly reporting; annual evaluation)	
Medicaid APM score 26-50%	
Create a High Functioning QI Team	
1.1	Practice Identified multidisciplinary staff members for QI team
1.2	Practice has assigned QI team members specific duties
1.3	(2020 MUST PASS) Practice uses agendas and minutes in QI team meetings
Population Health, Practice Transformation, and Process Improvement	
2.1	Practice evaluates patient flow for identification of gaps and opportunities for improvement in efficiency (i.e., cycle times study, patient access evaluation, etc.)
2.2	Practice implemented a QI project supporting an area of improvement impacting patient flow and/or office efficiency
2.3	(2020 MUST PASS) Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement
2.4	Practice has completed at least a single PDSA cycle for each of the CQMs (minimum of two CQMs)
2.5	(2020 MUST PASS) Practice has established a Care Compact with at least one high volume specialist that meets the minimum requirements of the RAE KPI

Tier 3 – Foundations Participation Assessment Elements	
Empanelment, Continuity of Care and Team-Based Care	
3.1	(2020 MUST PASS) Practice has a defined panel management process and an empanelment rate at or above 60%
3.2	Practice has set a continuity of care target
3.3	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	
4.1	Practice has plan for sustainability and spread
4.2	Practice has an internal and external communication plan to inform practice and patients of QI work

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
4	137v7	Process / complex care	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: 1) Percentage of patients who initiated treatment within 14 days of the diagnosis; 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Patients age 13 years and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period.**	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis. Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	2.72%	QPP - MIPS
18	165v7	Outcome	**CONTROLLING HIGH BLOOD PRESSURE:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.**	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg) during the measurement period.	70.94%	QPP - MIPS
22	156v7	Process / complex care	**USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY:** Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported: 1) Percentage of patients who were ordered at least one high-risk medication; 2) Percentage of patients who were ordered at least two different high-risk medications.	Patients 66 years and older who had a visit during the measurement period.	Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.	0.01%	QPP - MIPS

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
28	**138v7**	Process	**TOBACCO USE - SCREENING AND CESSATION INTERVENTION:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	All patients aged 18 years and older seen for at least two visits or at least one preventative visit during the measurement period.**	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	94.64%	**QPP - MIPS**
32	**124v7**	Process	**CERVICAL CANCER SCREENING:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every 3 years; 2) Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Women 23-64 years of age with a visit during the measurement period.**	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: 1) Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years of age at the time of the test; 2) Cervical cytology/HPV co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test.	47.76%	**QPP - MIPS**
34	**130v7**	Process	**COLORECTAL CANCER SCREENING:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Patients 50-75 years of age with a visit during the measurement period.**	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following: 1) Fecal occult blood test (FOBT) during the measurement period; 2) Flexible signoidoscopy during the measurement period or the 4 years prior; 3) Colonoscopy during the measurement period or the 9 years prior.	63.64%	**QPP - MIPS**
41	**147v8**	Process	**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	Equals Initial Population and seen for a visit between October 1 and March 31	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	86.06%	**QPP - MIPS**

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
55	**131v7**	Process	**DIABETES - EYE EXAM:** Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Patients 18-75 years of age with diabetes with a visit during the measurement period.	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: 1) A retinal or dilated eye exam by an eye care professional in the measurement period, or 2) a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior the measurement period.	99.18%	**QPP - MIPS**
59	**122v7**	Outcome	**DIABETES HEMOGLOBIN A1C (HbA1c) POOR CONTROL:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Patients 18-75 years of age with diabetes with a visit during the measurement period.	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.	27.27%	**QPP - MIPS**
62	**134v7**	Process	**DIABETES: 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.	Patients 18-75 years of age with diabetes with a visit during the measurement period**	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period	87.37%	**QPP - MIPS**
68	**164v7**	Process	**ISCHEMIC VASCULAR DISEASE: USE OF ASPIRIN OR ANOTHER ANTIPLATELET:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	Patients 18 years of age and older with a visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement year	Patients who had an active medication of aspirin or another antiplatelet during the measurement year	80.61%	**QPP - MIPS**

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
101	**139v7**	Process / complex care	**FALLS - SCREENING FOR FUTURE FALL RISK:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patients aged 65 years and older with a visit during the measurement period.**	Patients who were screened for future fall risk at least once within the measurement period.	81.77%	**QPP - MIPS**
418	**2v8**	Process	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN:** Percentage of patients aged 12 years and older screened for depression on 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 positive screen	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period**	Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen	42.31%	**QPP - MIPS**
712	**160v7**	Process	**DEPRESSION UTILIZATION OF THE PHQ-9 TOOL:** The percentage of 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 visit	Patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during the four month period**	Patients who have a PHQ-9 tool administered at least once during the four-month period	8.33%	**QPP - MIPS**
2372	**125v7**	Process	**BREAST CANCER SCREENING:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Women 51-74 years of age with a visit during the measurement period.**	Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period.	63.13%	**QPP - MIPS**
N/A	**127v6**	Process	**PNEUMOCOCCAL VACCINATION STATUS FOR OLDER ADULTS:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	Patients 65 years of age and older with a visit during the measurement period**	Patients who have ever received a pneumococcal vaccination	65.53%	**QPP - MIPS**

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
N/A	**347v2**	Process	**STATIN THERAPHY FOR THE PREVENTION AND TREATMENT OF CARDIOVASCULAR DISEASE:** 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: *Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR *Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR *Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	All patients aged 21 years and older at the beginning of the measurement period with a patient encounter during the measurement period. All patients who meet one or more of the following criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines): 1) Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis 2) Patients aged >= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia 3) Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period**	Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period	77.22%	**QPP - MIPS**

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
N/A	**149v7**	Process / complex care	**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.	All patients, regardless of age, with a diagnosis of dementia.**	Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	86.90%	**QPP - MIPS**
N/A	**50v7**	Process	**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.	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.	63.79%	**QPP - MIPS**
0033	**153v7**	Process	**CHLAMYDIA SCREENING FOR 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.	Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.	Women with at least one chlamydia test during the measurement period.	48.15%	**QPP - MIPS**
formerly 0036	**126v5**	Process	**ASTHMA -** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.*	Patients 5-64 years of age with persistent asthma and a visit during the measurement year.*	Patients who were ordered at least one prescription for a preferred therapy during the measurement period.*	83.87%	**QPP - MIPS**
formerly 0064	**163v5**	Process	**DIABETES LDL CONTROL:** Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Patients 18-75 years of age with diabetes with a visit during the measurement period.	Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL.	50.20%	**QPP - MIPS**
2908	**144v7**	Process	**BETA-BLOCKER THERAPY:** Percentage of patients ages 18 years and older with a diagnosis of heart failure with a current or prior left ventricular ejection fraction (LVEF) less than 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.*	All patients ages 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40%.*	Patients who were prescribed a beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.*	90.80%	**QPP - MIPS**

2019 RMHP RAE Adult and Family Practice eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
0419	**68v8**	Process	**MEDICATION RECONCILIATION:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration.*	All visits occurring during the 12 month reporting period for patients ages 18 years and older before the start of the measurement period.*	Eligible professional attests to documenting, updating or reviewing the patients current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosages, frequency and route of administration.*	98.88%	**QPP - MIPS**
0421	**69v7**	Process	**ADULT BMI:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous 6 months AND with a BMI outside of normal parameters a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal parameters: 65+ ≥ 23 and < 30; 18-64 ≥ 18.5 and <25.*	All patients 18 and older won the date of the encounter with at least one eligible encounter during the measurement period.*	Patients with a documented BMI during the encounter or during the previous 6 months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 6 months of the current encounter.*	49.19%	**QPP - MIPS**
0056	**123v7**	Process	**DIABETES FOOT EXAM:** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year	Patients who received visual, pulse and sensory foot examinations during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	59.09%	**QPP - MIPS**
2152	N/A	Process	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling** - Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user. *	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user. *	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period. *	92.67%	**QPP-MIPS**

**Exclusions apply*

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
4	137v7	Process / complex care	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: 1) Percentage of patients who initiated treatment within 14 days of the diagnosis; 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Patients age 13 years and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period.**	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis. Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	2.72%	QPP - MIPS
41	147v8	Process	**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	Equals Initial Population and seen for a visit between October 1 and March 31	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	86.06%	QPP - MIPS
418	2v8	Process	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN:** Percentage of patients aged 12 years and older screened for depression on 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 positive screen	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period**	Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen	42.31%	QPP - MIPS
N/A	50v7	Process	**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.	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.	63.79%	QPP - MIPS

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
formerly 0002	**146v7**	Process	**TESTING FOR PHARYNGITIS IN CHILDREN-** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Children 3-18 years of age who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on three days after the visit.	Children with a group A streptococcus test in the 7-day period from the 3 days prior through 3 days after the diagnosis of pharyngitis.	84.44%	**QPP - MIPS**
0024	**155v7**	Process	**CHILDHOOD BMI/ NUTRITION/PHYSICAL ACTIVITY:** Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician or an OB/GYN, and who had evidence of the following during the measurement period. Three rates are reported. Percentage of patients with height, weight and BMI percentile documentation; percentage of patients with counseling for nutrition; percentage of patients with counseling for physical activity.*	Patients 3-17 years of age with at least one outpatient visit with a primary care physician or OB/GYN during the measurement period.*	Numerator 1: Patients who had a height, weight and BMI percentile recorded during the measurement period. Numerator 2: Patients who had counseling for nutrition during a visit that occured during the measurement period. Numerator 3: Patients who had counseling for physical activity during a visit that occured during the measurement period.*	32.66%	**QPP - MIPS**
0033	**153v7**	Process	**CHLAMYDIA SCREENING FOR 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.	Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.	Women with at least one chlamydia test during the measurement period.	48.15%	**QPP - MIPS**
formerly 0036	**126v5**	Process	**ASTHMA -** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.*	Patients 5-64 years of age with persistent asthma and a visit during the measurement year.*	Patients who were ordered at least one prescription for a preferred therapy duringthe measurement period.*	83.87%	**QPP - MIPS**

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
0038	**117v7**	Process	**CHILDHOOD IMMUNIZATIONS:** 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 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.	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.	31.26%	**QPP - MIPS**
0069	**154v7**	Process	**UPPER RESPIRATORY TREATMENT IN CHILDREN (URI) -** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Children age 3 months to 18 years who had an outpatient or emergency department (ED) visit with a diagnosis of upper respiratory infection (URI) during the measurement period.	Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.	96.00%	**QPP - MIPS**
0108	**136v8**	Process	**FOLLOW UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION -** 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. 1) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. 2) Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Initial Population 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period Initial Population 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSD, and who had a visit during the measurement period.	Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.	49.80%	**NCQA**

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
0576	N/A	Process	**HOSPITAL FOLLOW UP MENTAL ILLNESS -** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: 1) The percentage of discharges for which the patient received follow-up within 30 days of discharge 2) The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.	47.50%	**NCQA**
1346	N/A	Outcome	**SECONDHAND SMOKE EXPOSURE TO CHILDREN -** Determines the percentage of children who live with a smoker and if that smoker smokes inside the child´s house	Children age 0-17 years	Percentage of children who live in a household with someone who smokes and smoking occurs inside home	28.00%	**CDPHE**
1365	**177v7**	Process	**CHILD AND ADOLESCENT SUICIDE RISK -** 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	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder.	Patient visits with an assessment for suicide risk.	56.00%	**HCPF APM**
1392	N/A	Process	**WELL CHILD VISITS IN THE FIRST 15 MONTHS -** The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	Children 15 months old during the measurement year.	Children who received the following number of well-child visits with a PCP during their first 15 months of life: - No well-child visits; One well-child visit; Two well-child visits; Three well-child visits; Four well-child visits; Five well-child visits; Six or more well-child visits	56.00%	**HCPF APM**

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
formerly NQF 1401	**82v6**	Process	**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.	Children with a visit who turned 6 months of age in the measurement period.	Children with documentation of maternal screening or treatment for postpartum depression for the mother.	63.00%	**HCPF APM**

2019 RMHP RAE Pediatric and SBHC eCQM Suite							
NQF#	**CMS#**	**Measure Type**	**Description**	**Denominator**	**Numerator**	**70th percentile**	**Benchmark Source**
1448	N/A	Process	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS** - The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	Children who meet the following eligibility requirement: Age: Children who turn 1, 2 or 3 years of age between January 1 and December 31 of the measurement year. Continuous Enrollment: Children who are enrolled continuously for 12 months prior to child's 1st, 2nd or 3rd birthday. Allowable Gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators. Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday Numerator 2: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their second birthday Numerator 3: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their third birthday Numerator 4: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday.	54.00%	**CDPHE**
1516	N/A	Process	**WELL CHILD VISITS (AGES 3-6**) - The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Children 3-6 years of age during the measurement year.	Children who received at least one well-child visit with a PCP during the measurement year.	56.00%	**HCPF APM**

**Exclusions apply*

RMHP Practice Transformation Program Placement

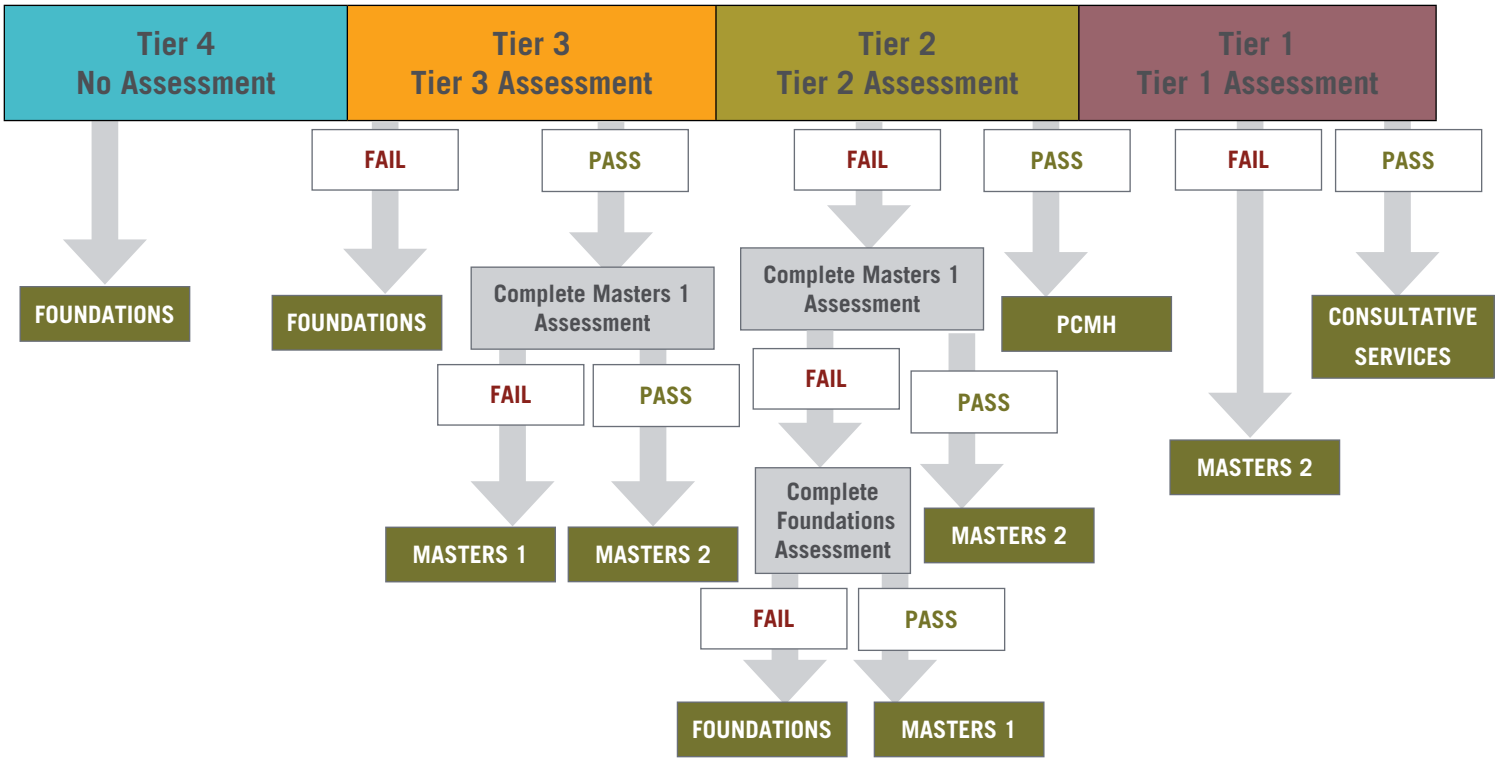
RMHP Practice Transformation is committed to supporting practices achieve the level of tier they desire. This document assists with determining which RMHP Practice Transformation program is most appropriate for the practice based upon your previous practice transformation work and sustainability efforts.

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 Foundations
- 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.

Wraparound 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, 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 Members

Care Coordination services for RAE Members are provided through RMHP with support from participating PCMP providers and integrated community care teams (where available). For assistance, please call RMHP at 888-282-8801, option 5.

Pre-Authorization Requirements

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**.

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**

All PARs processed by the ColoradoPAR program are submitted through the Colorado PAR website portal at **coloradopar.com/PARPortaleQSuite.aspx**.

The ColoradoPAR provider phone line is 888-801-9355.

RMHP PRIME: PAYMENT REFORM INITIATIVE FOR MEDICAID EXPANSION

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 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

Process	RAE	RMHP Prime
Members		
Mandatory/ Passive Enrollment	Enrollment is mandatory. All Health First Colorado Members must enroll. No opt out.	RMHP Prime is passive enrollment. Members can opt-out to receive physical health benefits through Health First Colorado FFS.
Enrollment Effective Date	Enrollment begins upon Member's Health First Colorado eligibility determination.	Enrollment begins upon Member's Health First Colorado eligibility determination.
Member Enrollment Region	Member enrollment in the RAE is based on the physical location of the Member's attributed PCMP site, not the Member's residence.	Member enrollment in RMHP Prime is based on county of residence and Health First Colorado eligibility.
Member Attribution	RAE Members are immediately attributed to a PCMP upon being determined eligible for Health First Colorado benefits. RAE Members are attributed to a PCMP, even when there is no prior claim or patient choice history. For RAE Members enrolled in RMHP Prime, attribution follows usual RMHP attribution methodology and process.	Member attribution follows RMHP's attribution methodology, using claims and Patient Choice.
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
PCMPs		
PCMP Agreement	Each PCMP site has an agreement, either directly or via their IPA participation, with the RAE in that site's region.	RMHP Prime participating provider agreement
PCMP Payments	RAE pays at least $2 PMPM to PCMPs for attributed RAE Members. Additionally, incentive payments for higher performing practices are available.	Payment per terms of RMHP Prime participating agreement
Physical Health Reimburse-ment	Physical health claims for RAE Members are paid FFS by the Department. Physical health claims for RAE Members enrolled in RMHP Prime are paid by RMHP.	PCMPs and physical health claims paid by RMHP.
Six Behavioral Health Sessions at PCMP Practice	Allows primary care practices to bill up to six sessions behavioral health sessions to the Department, not to the RAE.	For RMHP Prime Members, these six primary care behavioral health sessions are billed to RMHP.

For RMHP Prime PCMPs: RMHP RAE Members without RMHP Prime & RMHP RAE Members with RMHP Prime

	RMHP RAE Members without RMHP Prime	RMHP RAE Members with RMHP Prime
Population	Most individuals covered by Health First Colorado are RAE Members	
	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.	RMHP RAE Members with RMHP Prime include: RAE Members who are adults with full Health First Colorado benefits, and a few children who have a disability status, and Who reside in an RMHP Prime county (Garfield, Gunnison, Mesa, Montrose, Rio Blanco, Pitkin)
Enrollment Process	Mandatory RAE enrollment by Department based on the site of the Member's attributed PCMP RAE Members attributed to a PCMP practice site within Region 1 are enrolled with RMHP as the RAE.	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	RMHP calculates attribution following RMHP's methodology for RMHP Prime Members. 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 that will be enrolled in the RMHP Prime program. The value of the federal and state Medicare equivalency 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 that providers would receive from the Department.

Risk Adjustment 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 and 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. Ask your RMHP Provider Relations representative for a copy of the template form and instructions.

Completing and Submitting the Patient Choice Form

Background

RMHP provides this information to assist primary care practices that are participating in RMHP Prime to 1) tailor the patient choice form for each practice, 2) complete the form accurately, and 3) 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, and
  - Adding the practice's name, address and phone number to the bottom
- Contact your RMHP Provider Relations representative if you have any questions about adapting 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.
- Finally, 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: 1) a patient and primary care practice sign a patient choice form, 2) all necessary parts of the form are completed, and 3) 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.

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