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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. Changes to RAE content and administration are subject to change upon notice.

Guide Components

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


- Page 18: Key Performance Indicator (KPI) information with updated measure specifications, definitions, etc.
- Page 22: New APM information for 2020. This includes the timeline, expectations, RMHP’s role, etc.
- Page 27: Updated Get Involved Section. This includes information on PIACs, webinars, learning events, and the RMHP Podcast: Destination RMHP.
- Page 32: Tier Profiles updated which includes removal of HET/CHW program information for Tier 1 and Tier 2.
- Page 34: Updated timeline to reflect 2020.
- Page 45: Tier 1-3 assessments updated to reflect 2020 MUST PASS element and PCMH Auto-Credits.
- Page 49: Updated clinical quality measure (eCQM) measure suite for 2020 including benchmarks. These benchmarks were derived from the 2019 CMS benchmarks.
- Page 91: New exhibit on ECG Quick Connect. This is the file transfer system to receive and send protected health information (PHI) from/to RMHP.
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 (AHCM)** – As deployed by RMHP and its regional partners, the mission of the AHCM is to develop a more effective network to support the social, emotional, and physical health of Western Colorado. Participating primary care, behavioral health, and hospital partners will screen patients of all ages for social needs including transportation, utilities, housing, food, interpersonal violence, and social isolation. In connection with the Community Resource Network (CRN) — a division of Quality Health Networks (QHN) that focuses on information exchange with social service organizations — patients will be connected to community organizations that target their unmet social needs. Patients with at least one unmet social 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 – “Payment Reform Initiative for Medicaid Enrollees” – a payment reform initiative under the ACC Program in which RMHP functions as a payer for Medicaid physical health services. Within RMHP Prime, the Department pays a fixed global payment to RMHP for medical services provided to RMHP Prime Members. RMHP Prime operates within RMHP’s RAE contract with the Department. As such, all RMHP Prime Members are also enrolled with RMHP as a RAE Member for behavioral health services and other applicable services provided by the RAE. This aligned administration of behavioral and medical services, along with community social determinant of health activities supports a whole person, community-connected approach to care.

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

RMHP Prime Member – an individual who qualifies for Health First Colorado and is enrolled by the
Department with RMHP under an ACC program payment reform initiative known as RMHP Prime. Eligible individuals must reside in an RMHP Prime county 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.

What should PCMPs expect from RMHP?

- RMHP will serve as a central point of contact regarding Health First Colorado services and programs, regional resources, clinical tools, and general administrative information.
- RMHP will support providers that are interested in integrating primary care and behavioral health services; addressing social determinants of health; enhancing the delivery of team-based care by leveraging all staff and incorporating patient navigators, peers, promotoras, and other lay health workers; advancing business practices and use of health technologies; participating in APM; and other activities designed to improve Member health and experience of care.
RMHP will offer general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support.

RMHP will provide care coordination services for providers Health First Colorado Members, with support from integrated community care teams, where available.

Understanding RAE Processes

Please contact RMHP with any questions about the below information.

<table>
<thead>
<tr>
<th>Process</th>
<th>RAE Fast Facts</th>
</tr>
</thead>
</table>
| **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. |
| **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?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>RMHP RAE Members without RMHP Prime</th>
<th>RMHP RAE Members with RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health Services</strong></td>
<td>Bills sent to and paid by Department following Department claims and authorization methodology</td>
<td>Bills sent to and paid by RMHP following Provider-RMHP agreement</td>
</tr>
<tr>
<td><strong>Behavioral Health Services Outside of PCMP Practice</strong></td>
<td>Bills sent to and paid by RMHP under the RAE behavioral health benefit</td>
<td>Bills sent to and paid by RMHP under the RAE behavioral health benefit</td>
</tr>
<tr>
<td><strong>Six Behavioral Health Sessions at PCMP Practice</strong></td>
<td>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</td>
<td>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.</td>
</tr>
<tr>
<td><strong>PCMP Medical Home Payments</strong></td>
<td>Paid by RMHP for RMHP RAE Members attributed by the Department to Region 1 PCMP</td>
<td>Paid by RMHP following RMHP attribution methodology and Provider-RMHP Prime agreement.</td>
</tr>
</tbody>
</table>
# RAE Payment Umbrella: A Quick Reference for Primary Care Medical Practices (PCMPs)

## RAE non-PRIME

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Medicaid FFS</th>
<th>RAE Medical Home Payments</th>
<th>KPI Quarterly Performance Payments</th>
<th>APM FFS% Reduction</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who Pays?</strong></td>
<td>State</td>
<td>RMHP</td>
<td>RMHP</td>
<td>State</td>
<td>State/RMHP</td>
</tr>
<tr>
<td><strong>How much?</strong></td>
<td>HCPF Fee Schedule</td>
<td>Tier 1 - $3.50 Tier 2 - $3.00 Tier 3 – $2.25 Tier 4 - $2.00 Geo - $2.00</td>
<td>Up to: Tier 1 - $4.25 Tier 2 - $2.50 Tier 3 - $1.00 Tier 4 – $0.25 (Providers receive the tier based payment for their geo-assigned members)</td>
<td>Up to 4% FFS Reduction on APM Code Set (Eligible practices must participate to avoid FFS Reduction)</td>
<td>HCPF Fee Schedule/ RMHP Contracted Rates</td>
</tr>
<tr>
<td><strong>How often?</strong></td>
<td>Practice Billing</td>
<td>Monthly</td>
<td>Quarterly (Exact payment timing is contingent upon RMHP’s receipt of final performance data/payment files from HCPF)</td>
<td>Practice Billing</td>
<td>Practice Billing</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>This is RMHP RAE Region 1 (driven by the VBCRC)</td>
<td>These dollars are passed from the State to RMHP to the practices based upon RAE Region 1 performance</td>
<td>This is a State program but RAE assists practices with measure support, success, etc.</td>
<td>First 6 BH visits are paid by the State from physical health benefit; RMHP pays claims after the 6 from BH benefit</td>
<td></td>
</tr>
</tbody>
</table>

## RAE PRIME

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

**RMHP Medical Home Payment – Payment Beyond the $2PMPM**

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 has implemented 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 or online at [https://enroll.healthfirstcolorado.com/](https://enroll.healthfirstcolorado.com/). Changes take effect the first of the following month.

5. **Ongoing Attribution: PCMP to PCMP 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 auto-assignments will be made.
- PCMPs may turn auto-assignment (geographically based attributions) on or off at any time by contacting their RAE network representative.
  - All Tier 1 practices must accept geographic-proximity auto attributions, also known as auto-assignment, for all quarters in which they intend to operate as a Tier 1. If geographic auto-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 Practices Can Manage Attribution**

PCMPs can configure their RAE member attribution panel in the following ways:

- Auto-Assignment
- Panel Limit
- Population Parameters
Auto-Assignment

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

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

Panel Limit

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

Population Parameters

| Each practice has the ability to indicate population parameters. Current options are: Children Only, Adults Only, and Women Only. This is configured at the individual service location/Medicaid Provider ID level. | Children are defined as age 20 and under; adults are defined as age 21 and older. | Upon initial PCMP contracting/panel configuration, each clinic can designate this information via the PCMP Contract Workbook XLS. | Practices will only receive attribution of members in their selected populations, if applicable. | Practices can contact their RAE Network Representative Nicole Konkoly to check their current configuration. |
How to Identify Your RAE Member Attribution Panel

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

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

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

RMHP shares the reports with practices via ECG Quick Connect typically during the last week of the month. Practices can then download the report from their Box folder at their convenience.

**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.

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

\[
\begin{array}{cccccc}
\text{Tier 1} & \text{Tier 2} & \text{RCCO} & \text{Tier 3} & \text{Tier 4} \\
\$0.00 & \$2.00 & \$0.50 & \$1.00 & \$0.25 \\
\$3.50 & \$3.00 & \$3.00 & \$2.25 & \$0.00 \\
\$4.25 & \$2.50 & \$0.50 & \$1.00 & \$0.25 \\
\$9.00 & \$8.00 & \$7.00 & \$6.00 & \$5.00 \\
\end{array}
\]

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

It is an expectation that all RAE PCMPs participate in developing and implementing care compacts regardless of RAE Tier.

KPI Measures

The KPI measures below are utilized for potential incentive payments and are based upon Paid Claims and Encounters. **See Exhibit A for more information on each KPI.**

**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

<table>
<thead>
<tr>
<th>Quarter (FY19-20)</th>
<th>Measure</th>
<th>Evaluation Period</th>
<th>Target: Number of PCMPs</th>
<th>Region Final Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50%+ of PCMP network has 2+ (1 must be with behavioral health) executed care compacts</td>
<td>July 1, 2019 – Sept 30, 2019</td>
<td>101</td>
<td>56.2%</td>
</tr>
<tr>
<td>2</td>
<td>50%+ of PCMP network has 2+ (1 must be with behavioral health) executed care compacts</td>
<td>Oct 1, 2019 – Dec 31, 2019</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>TBD</td>
<td>Jan 1, 2020 – March 31, 2020</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>TBD</td>
<td>April 1, 2020 – June 30, 2020</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

- 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

Care compacts are beneficial to practices' entire patient population. The care compact is a catalyst to refine care transitions and expectations of practices in order to reduce unnecessary utilization and improve access and communication.

It is an expectation that all RAE PCMPs participate in developing and implementing care compacts regardless of RAE Tier.

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

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

Postpartum Follow-Up Care
- Measure Description: The denominator for Postpartum Follow-Up Care includes the number of live deliveries for Members enrolled in the ACC as of the end of the evaluation period. Members may have multiple deliveries within the evaluation period. The evaluation period for this KPI is offset by 56 days from the current rolling 12-month period to allow up to 56 days following the delivery for a follow-up visit to occur. For example, if the evaluation period ends 12/31/2016, the delivery date range utilized would be 11/05/2015 to 11/06/2016. Due to some inconsistencies in coding that were discovered, delivery visits are consolidated in the following manner: service dates that occurred within 60 days of each other were assumed to have occurred within the same delivery; 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

Other RMHP data dashboards or tools that are available to RAE practices are a Potentially Avoidable Cost (PAC) Diabetes dashboard and a RMHP KPI dashboard. To learn more about these, email practice.transformation3@rmhp.org.

Support and resources are available to all RMHP RAE Region 1 PCMPs. 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.

KPI Payment Process

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

Department of Healthcare Policy and Financing (HCPF) Alternative Payment Model (APM) for Primary Care

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

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

Non-FQHC and FQHC PCMP Program Basics

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

Measure Options

• **Structural Measures**: These measures focus on the practices’ capacity and ability to deliver high-quality care. The measures are intended to improve processes and deliver documentation to show the transformation of care delivery. These are pass/fail measures.

• **Claims Measures**: These measures are calculated based upon the practices’ processed Medicaid claims.

• **Electronic Clinical Quality Measures (eCQM)**: These measures are calculated directly from practices electronic medical record (EMR). Practices that select eCQMs can earn half credit for reporting the eCQM. If the performance goals are met or partially met, then a higher point value will be given. Practice performance will be based upon the “Close the Gap” Calculation (see below).

Measure Reporting

• **Structural Measures**: Measure achievement and Patient Centered Medical Home (PCMH) status will be collected by the Regional Accountable Entities (RAEs) within the first quarter following the measurement year. These are pass/fail measures.

• **Claims Measures**: The Department automatically collects the baseline and performance year’s data from the Medicaid submitted claims. The practice performance will be based upon the “Close the Gap” Calculation (see below).

• **eCQMs**: Health Data Colorado (HDCo) will collect eCQMs from practices automatically via an interface from the EMR to HDCo for baseline and performance rate calculations. If a practice does not have an interface in which to send continuity of care documents (CCDs), then HDCo will help practices manually report their measures. HDCo is an entity that is comprised of three partners: Quality Health Network (QHN), Colorado Regional Health Information Organization (CORHIO), and Colorado Community Managed Care Network (CCMCN). Based upon your practice type, existing interfaces with these organizations and geographical location, one of the partners will be working with your practice.

The practice performance will be based upon the “Close the Gap” Calculation (see below). A practice can earn points several ways for eCQMs:

- **Earn full credit**: report data for both the baseline (2019) and performance (2020) and demonstrate “Close the Gap” improvement OR reporting data for the performance year (2020) and achieve the Department goal for the measure.

- **Earn partial credit**: If a practice can report baseline (2019) and performance (2020) and demonstrate “Close the Gap” improvement between 5 to 10 percent, then partial credit will be given.

- **Earn half credit**: If a practice cannot report two years’ worth of data and does not meet the Department’s goal for the measure, then half credit will be given for reporting.
Close the Gap Calculation

The Department has established goals for each claims and eCQM measure. To receive full points for the measure, PCMPs need to show improvement by “closing the gap” between their baseline and the Department’s goal by 10 percent. If the practice does not close the gap by 10 percent, partial credit will be given if at least 5 percent close the gap improvement is achieved. For a more detailed explanation of the “Close the Gap” calculation, see page 10 of the 2020 APM Guidebook.

APM Quality Score Calculation

The APM Quality Score is the sum of all points a practice has earned by demonstrating achievement on the practice’s selected APM measures. Each practice must earn an APM Quality Score of 200 points to receive the maximum payment rate available for the APM Code Set.

APM Quality Score and Impact on Payment

Practices that earn a Quality APM score of at least 200 points will receive the maximum payment rate. Practices that achieve less than 200 points will receive a reduced payment rate. This is a budget neutral APM, so statewide practice performance will ultimately impact the payment rate adjustments. The table below shows the APM Quality Score range in relation to the percent payment reduction in the APM Code Set for Non-FQHCs and cost-based reimbursement rates for physical and behavioral health services for FQHCs.

<table>
<thead>
<tr>
<th>APM Quality Score Range</th>
<th>Payment Reduction Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50</td>
<td>3% - 4%</td>
</tr>
<tr>
<td>51-100</td>
<td>2% - &lt;3%</td>
</tr>
<tr>
<td>101-150</td>
<td>1% - &lt;2%</td>
</tr>
<tr>
<td>151-200</td>
<td>0% - &lt;1%</td>
</tr>
</tbody>
</table>

Since this is a budget neutral program, practices that achieve an APM Quality Score of >200 points, may receive a slight payment increase through the APM. This is dependent on overall statewide performance. Note that FQHCs and Non-FQHCs have different funding pools for the APM and will not be evaluated together.

Payment changes will begin the beginning of the Fiscal Year (July 1st) following the end of the measurement year.

Non-FQHC PCMP Considerations

Eligibility

- Must be enrolled as an Accountable Care Collaborative (ACC) PCMP.
- PCMPs must have either 200 ACC enrollees or more than $30,000 in historical annual paid claims associated with services defined in the APM Code Set.
  - PCMPs that do not meet the eligibility criteria will not experience an increase or decrease in their rates.
  - If the PCMP is ineligible, they cannot opt into the APM.
- Comprehensive Primary Care Plus (CPC+) practices will earn full payment in the APM in 2020 because they will automatically earn 200 points. CPC+ practices will become eligible in 2021.
Measure Guidance

- Practices cannot earn more than 180 points from Structural Measures
- PCMPs can earn half of their points (100 out of 200) by having their PCMH recognition from any of the following organizations:
  - National Committee for Quality Assurance (NCQA)
  - Utilization Review Accreditation Commission (URAC)
  - Accreditation Association for Ambulatory Health Care (AAAHC)
  - The Joint Commission

PCMPs will need to select six more measures to earn the remaining 100 points. If choosing Structural Measures, only two of the measures can be selected: Accepting New Patients and Interdisciplinary Team. The remaining measures that can be selected must be Claims Measures and/or eCQMs.

Measure Selection

- Practices need to submit their measure selections via electronic survey by December 31, 2019. [Click here](#) to complete the electronic survey. If there is a hardship or reason why the practice cannot submit measures before December 31, 2019, the Department will accept a late measure selection submission if approved by the Department before December 31, 2019.
- If PCMPs do not select measures by January 31, 2020, the Department will select measures for the practices.

Measure Reporting

- **Structural Measures:** RMHP will be working with and collecting Structural Measure demonstration materials from practices.
- **eCQMs:** All practices will be working with HDCo for eCQM reporting. Each practice will be assigned an HDCo partner based upon existing interfaces or geographical location.

Impact on Payment

The APM Quality Score will determine the payment reduction percent on the APM Code Set.

FQHC PCMPs Considerations

Eligibility

- The APM applies to all FQHCs in Colorado.

Measure Guidance

- All FQHCs must choose at least one Claims Measure.
- FQHCs that earn PCMH credit (100 out of 200 points) cannot choose any Structural Measures to earn the remaining 100 points. FQHCs must choose six Claims Measures and/or eCQMs.

Measure Selection

- The Colorado Community Health Network (CCHN) board selects measures on behalf of all FQHCs. If the FQHC practice would like to select different measures, that should be communicated to CCHN by no later than January 15, 2020.
Measure Reporting

- **Structural Measures:** CCHN will be working with and collecting Structural Measure demonstration materials from practices.
- **eCQMs:** All practices will be working with HDCo for eCQM reporting. For FQHCs, this partner is CCMCN.

Impact on Payment

- The APM Quality Score will determine the payment reduction percent on the cost-based reimbursement rates for physical and behavioral health services.

RMHP HCPF APM Support

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

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

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

Questions? Email **practice.transformation3@rmhp.org**.

HCPF APM Resources

Department email: **HCPF_primarycarepaymentreform@hcpf.state.co.us**.

- Alternative Payment Model Website
- 2020 APM Guidebook
- 2020 APM FQHC Measure Selection Workbook
- 2020 APM Non-FQHC Measure Selection Workbook
- 2020 Alternative Payment Model Code Set
- Frequently Asked Questions (FAQs)
- Structural Measure Specifications
Get Involved

Statewide Program Improvement Advisory Committee (PIAC) and Subcommittees

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

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

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

Current PIAC Subcommittees are:

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

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

Regional RAE 1 PIAC

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

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

The RAE 1 PIAC currently meets quarterly with a Front Range and West Slope in-person location and the option to participate remotely by Zoom. The committee has a formal voting membership structure. All meetings open to the public. For additional information, including the charter and meeting materials, visit: www.rmhp.org/medicaid-chp-plus/get-involved

Additional resources are available via multiple methods:

- View Department provider webinars and additional information at colorado.gov/pacific/hcpf/accpahse2
- 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 Rhonda Blankenship at rhonda.blankenship@rmhp.org
- Email raesupport@rmhp.org
- Call RMHP Customer Service at 888-282-8801
Monthly Newsletters
Receive a monthly newsletter that has information about upcoming RAE events, KPI information, payment updates, etc. To receive these newsletters, email Mindy Patton at mindy.patton@rmhp.org.

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

- Registration Link: [https://zoom.us/meeting/register/43605906784eb34f7510d14dfea9e911](https://zoom.us/meeting/register/43605906784eb34f7510d14dfea9e911)
- January 21, 2020 – December 15, 2020
- Third Tuesday every month from 12:15-1:15PM

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

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

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

2020 RMHP Collaborative Learning Series

**The Science and Art of Improvement - March 6, 2020**
Explore how data-driven decision making can improve clinical processes, value-based care, work-flow efficiency, and business outcomes.
**Two Rivers Convention Center, Grand Junction**

**Hot Topics in Primary Care - April 3, 2020**
Apply concepts and tools of quality improvement to effectively implement change in clinical processes, leadership techniques, and operational aspects.
**Larimer County Conference Center, Loveland**

**Behavioral Health Skills Training - May 1, 2020**
Develop enhanced skills to more comprehensively address a wide variety of behavioral health needs that commonly impact patients' experiences in healthcare.
**Two Rivers Convention Center, Grand Junction**

**TBD - July 31, 2020**
**Two Rivers Convention Center, Grand Junction**

**Care Management Training - October 23, 2020**
Identify the skills and resources needed to improve patient care through enhanced care coordination and effectively managing health conditions.
**Two Rivers Convention Center, Grand Junction**

Registration links will be included in the monthly newsletters or email Mindy Patton at mindy.patton@rmhp.org.
Practice Transformation Resources

Need assistance with a workflow, behavioral health, data, EMRs, etc.? Contact the Practice Transformation team to get involved! The RMHP Practice Transformation Team has free resources and tools to help your practice succeed! Not only will the programs and services assist with advancing care delivery, but also support your success in the RAE. To learn more, email practice.transformation3@rmhp.org.

Supplemental Resources for Patient Care

CareNow: Virtual Care Platform

RMHP is committed to working with our valued providers to help our Members get the care they need, when they need it. CareNow is a virtual care program on the EasyCare Colorado platform that allows eligible RMHP Members to connect to a doctor or therapist through their computer or mobile device. Members can message, share photos, or video chat. Doctors are available on CareNow every day from 9:00 a.m. to 9:00 p.m. MDT. Therapists are available Monday-Friday from 9:00 a.m. to 5:00 p.m.

CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members. Members may be referred back to you, allowing for high-quality and informed care.

CareNow is designed to complement the care provided within the medical home setting and help reduce unnecessary emergency room visits.

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

You may also view a CareNow demo from the May 2019 RAE Value Based Contracting Office Hours webinar, which includes participant Q&A.

See Exhibit B for a flyer that can be shared with your patients.

Rural Interpreting Services Project (RISP): Free American Sign Language (ASL) Interpreting Services

The Rural Interpreting Services Project (RISP) Pilot provides qualified American Sign Language interpreters for individuals who are deaf, hard of hearing, or deafblind in rural areas of Colorado at no cost to consumers or service providers. Areas outside of the Front Range – all of RAE Region 1 except for Larimer County – are included in RISP.

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

A request can be submitted in any of the following ways:

- Online through RISP website colorisp.com. Select Request Form tab
- On paper (interpreter request form) via email, fax, or mail
- Call CCDHHDB office at 720-457-3679
- It is best to make requests at least 72 business hours in advance (2 weeks is ideal).
- For additional information, visit the RISP website at colorisp.com

See Exhibit C for a flyer that can be shared with your patients.
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.
RMHP RAE ATTESTATION PROCESS AND ONGOING TIER DEMONSTRATION
**RAE Attestation Directions & Ongoing Tier Demonstration**

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

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

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

- Openness to Health First Colorado Members
- eCQM submission to RMHP quarterly and meeting benchmark thresholds annually
- Care compacts
- By Quarter 1 2020, perform satisfactorily (80%) on RMHP Tier Assessment and passes all 'MUST PASS' elements.
- Participation and performance on the Department’s Alternative Payment Model (APM)
- Other demonstration criteria based upon tier

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

With the movement from volume-based payments to value-based payments, RMHP remains dedicated to strengthening primary care and rewarding high-quality, high-value care and to reimburse through a payment structure designed to achieve better care, more efficient spending and healthier communities. The Value Based Contracting Review Committee (VBCRC) will provide the venue for a consistent process through which to evaluate practice performance in any of the value-based contracting relationships of CPC+, RAE, and Prime.

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

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

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

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

Changing EMRs may impact performance on meeting the RAE Tier Ongoing Demonstration Criteria. RMHP will evaluate how the change in EMRs may impact the practice’s performance in the RAE on a practice by practice basis dependent on old and new EMR capabilities. **In order to begin this process, email your RMHP Clinical Informaticist OR practice.transformation3@rmhp.org at least 60 days prior of the go-live date for your new EMR.**
New RAE PCMP Attestation
If you are a newly contracted RAE PCMP, utilize the information below to complete the RMHP RAE Tier Attestation process by the date agreed upon with RMHP Provider Relations. Contact your local RMHP provider representative, Susan Hall at susan.hall@rmhp.org or Rhonda Blankenship at rhonda.blankenship@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: 2020 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: 2020 Timeline**
## Tier 1 – Comprehensive RMHP Population Health Partner

### Profile

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

#### Demonstration

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

#### Reimbursement Enhancement

- RMHP RAE Medical Home Payment = $3.50 PMPM
- RAE Geographic Attribution Payments: $2.00 PMPM
- Potential FFS enhancement on the APM Code Set per the Medicaid APM
- Eligible for RMHP Community Integration Agreement to fund behavioral health, SDoH and related services

#### Incentive Eligibility

- Eligible for KPI Pool distributions – relative to tier

#### Resource Supplementation

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

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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-attrition 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-attrition 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
- Medicaid APM/ FQHC APM Score = (at least) 51 – 75%

### Reimbursement Enhancement

- RMHP RAE Medical Home Payment = $3 PMPM
- RAE Geographic Attribution Payments = $2.00 PMPM
- Potential FFS enhancement on the APM Code Set per the Medicaid APM

### Incentive Eligibility

- Eligible for KPI Pool distributions – relative to tier

### Resource Supplementation

- Attribution and Feedback reports
- Eligible for Practice Transformation resources for NCQA PCMH recognition with application fee reimbursement
- Eligible for Consultative Practice Transformation resources
- Eligible for RMHP designated applications with technical assistance
## 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
- RAE Geographic Attribution Payments = $2.00 PMPM
- Potential FFS enhancement on the APM Code Set per the Medicaid APM

### Incentive Eligibility

- Eligible for KPI Pool distributions — relative to tier

### Resource Supplementation

- Attribution 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
- Potential FFS enhancement on the APM Code Set per the Medicaid APM

### Incentive Eligibility

- Eligible for KPI Pool distributions – relative to tier

### Resource Supplementation

- Attributions reports
- Feedback reports upon request
- Practice Transformation resources with $10K incentive for Foundations program participation
<table>
<thead>
<tr>
<th><strong>PCMP Tiering Appendix C: Practice Information Form</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Submit if New RAE PCMP</strong></td>
</tr>
<tr>
<td><strong>Practice Name</strong> ________________________________</td>
</tr>
<tr>
<td><strong>Type of Practice:</strong></td>
</tr>
<tr>
<td>Family Practice Pediatrics  Internal Medicine  FQHC</td>
</tr>
<tr>
<td><strong>Mailing Address</strong> _____________________________</td>
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<td><strong>Physical Address</strong> _____________________________</td>
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<tr>
<td>If you have multiple locations, please list other addresses. Use another sheet if necessary ______________________</td>
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<tr>
<td><strong>Main Phone</strong> _____________________________</td>
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<tr>
<td><strong>Office</strong> _____________________________</td>
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<tr>
<td><strong>Manager</strong> _____________________________</td>
</tr>
<tr>
<td><strong>Main Contact</strong> _____________________________</td>
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<tr>
<td><strong>Email/Phone</strong> _____________________________</td>
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<tr>
<td><strong>Best way to get in touch with you:</strong> Email  Phone  Email</td>
</tr>
<tr>
<td><strong>Number of providers</strong> ________  <strong>Number of staff</strong> ________  <strong>Total number of patients</strong> ________</td>
</tr>
<tr>
<td><strong>Do you use paper charts?</strong>  Yes  No  <strong>EMR system:</strong> ________  PM System: ________</td>
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<tr>
<td><strong>Length of time on EMR</strong> __________________________</td>
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<tr>
<td><strong>EMR version</strong> ___________________________</td>
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<tr>
<td><strong>If you are an FQHC, does your practice use Azara?</strong>  Yes  No</td>
</tr>
<tr>
<td>On Health Information Exchange (HIE)?  Yes  No  <strong>If yes, which one?</strong> QHN  CORHIO</td>
</tr>
<tr>
<td><strong>Participating in MIPS or an Advanced APM?</strong> Yes  No  <strong>If yes, which one?</strong> ________</td>
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<thead>
<tr>
<th><strong>Printed Name of Practice Representative</strong></th>
<th><strong>Signature of Practice Representative</strong></th>
<th><strong>Date</strong></th>
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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

- Has the practice graduated any practice transformation programs (i.e. SIM, RMHP programs, PCMH recognition, CPC)? **YES / NO**
- Is the practice able to report at least 6 electronic Clinical Quality Measures (eCQMs) of the RMHP eCQM suite from a certified EMR dashboard? **YES / NO**
- Is the practice open to Medicaid patients? **YES / NO**
- Is the practice willing to undergo regular (quarterly/semi-annually) reviews/reporting with RMHP? **YES / NO**

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

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

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

- **YES**
- **NO**

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).

- **YES**
- **NO**
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**

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

1. **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**

2. **CPC Classic Graduate or Current CPC+ Track 1**
   e. **YES to all (Initial:_____)**

3. **CPC+ Track 2 or PCMH Level 3 / PCMH 2017 Recognized**
   a. 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). **YES / NO**
   b. **NO to any (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 $\geq 80\%$ on appropriate assessment and pass all ‘MUST PASS’ elements
  - Tier 4 Assessment – none
  - Tier 3 Assessment – semi-annually
  - Tier 2 Assessment – quarterly
  - Tier 1 Assessment – quarterly
- Achieve Medicaid APM scoring thresholds
  - Tier 4 – Medicaid APM score of 0–25%
  - Tier 3 – Medicaid APM score of 26–50%
  - Tier 2 – Medicaid APM score of 51–75%
  - Tier 1 – Medicaid APM score of 76–100%
- Submit six CQMs quarterly and annually meet or exceed the RAE benchmarks
  - Tier 4 – none
  - Tier 3 – 2/6 eCQMs must meet or exceed the RAE benchmarks
  - Tier 2 – 4/6 eCQMs must meet or exceed the RAE benchmarks
  - Tier 1 – 6/6 eCQMs must meet or exceed the RAE benchmarks
- Be open to Health First Colorado Members
  - Tier 4 – Not open to new Health First Colorado Members
  - Tier 3 – Limited, intermittent availability for new Health First Colorado Members
  - Tier 2 – Open to Health First Colorado Members with equitable panel management across all RMHP lines of business. All policies, procedures, patient applications, etc. will be subject to RMHP review
  - Tier 1 – Fully open to new Health First Colorado Members (RAE and RAE-PRIME Members)

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

By signing below, I attest, to the best of my knowledge, that this practice is Tier _____________.
My practice wishes to participate at Tier ________. I understand that RMHP will conduct a verification process of the tier by December 1, 2020. 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. PCMH practices that receive auto-credits will still be responsible for submitting documentation for MUST PASS elements.

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

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

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

### Access and Continuity

- (2020 MUST PASS) Practice is fully open to Health First Colorado Members and maintains at least 95% empanelment to practitioner and/or care teams
- (PCMH Auto-Credit) Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR
- (PCMH Auto-Credit) Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice

- 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

- (PCMH Auto-Credit) 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
- (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
- (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
- (PCMH Auto-Credit) Provide short-term (episodic) care management, including medication reconciliation to patients following hospital admission/discharge/transfer,* and, as appropriate, following an ED discharge
- (2020 MUST PASS) Ensure patients with ED visits receive a follow-up interaction within one week of discharge
- (2020 MUST PASS) Contact at least 75% of patients who were hospitalized in target hospital(s),* within two business days

### Comprehensiveness and Care Coordination

- (2020 MUST PASS) Using data review (gap analysis) the timeliness of notification and information transfer from hospitals and EDs responsible for the majority of patients’ hospitalizations and ED visits
- (2020 MUST PASS) Enact collaborative care agreements with at least three groups of high volume/critical specialists that meet minimum requirements for RAE KPI
- (2020 MUST PASS) Establish at least one collaborative care agreement with a community behavioral health entity that supports and meets patients’ psychosocial needs
## Tier 1 – Comprehensive Participation
### Assessment Elements

### Comprehensiveness and Care Coordination

(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*

(2020 MUST PASS) Routinely assess patients’ psychosocial needs (AHCM, as an example)

Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs

(PCMH Auto-Credit) 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

Convene a PFAC at least quarterly, and integrate recommendations into care and quality improvement

Implement self-management support (such as PAM) for at least three high-risk conditions

(PCMH Auto-Credit) Identify and engage a subpopulation of patients and caregivers in advance care planning (peds exception)

### Quality Improvement

(2020 MUST PASS) Practice reviews data on at least two utilization measures at the practice level to set goals to improve population health management

Practice reviews data on at least six CQM measures derived from the certified EHR on practice and provider level to set goals to improve performance

(PCMH Auto-Credit) Conduct Quality Improvement team meetings at least monthly to review practice- and panel-level data for internal monitoring; use this data to guide testing of tactics to improve care and achieve practice goals

## Tier 2 – Advanced Participation
### Assessment Elements

### Ongoing Demonstration 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%
### Tier 2 – Advanced Participation

#### Assessment Elements

<table>
<thead>
<tr>
<th>Care Management</th>
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<tbody>
<tr>
<td><strong>Care Management</strong></td>
</tr>
<tr>
<td><em>(2020 MUST PASS)</em> Practice has equitable panel management processes and an empanelment rate at or above 90%</td>
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<tr>
<td><em>(PCMH Auto-Credit)</em> Practice measures continuity of care and has set a continuity of care target</td>
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<tr>
<td><em>(2020 MUST PASS)</em> Practice has developed and deployed a risk stratification workflow (includes process for reassessing patients’ risk scores and assessing risk of new patients). 80% of active patients have an assigned risk score.</td>
</tr>
<tr>
<td><em>(2020 MUST PASS)</em> Practice has documented and deployed a care management workflow (includes who on the team manages high risk patients and which patients receive care management services)</td>
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<tr>
<td><em>(2020 MUST PASS)</em> Practice uses a patient needs assessment tool (assess at minimum the 9 Domains of Need) to develop care plans for high risk patients</td>
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<tr>
<td><em>(2020 MUST PASS)</em> Practice creates care plans for its high risk patients</td>
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<tr>
<td><em>(PCMH Auto-Credit)</em> Practice has completed a Team-based Care Assessment and has implemented a strategy to address gaps (i.e. huddles, standing orders, etc.)</td>
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<tr>
<td>Practice has evaluated progress on their Care Management Plan and developed a strategy to address gaps (i.e. monitoring patient outcomes, penetration rate, operational metrics, etc.)</td>
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<tr>
<td>Practice has implemented Self-Management Support for at least one high-risk condition</td>
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<tr>
<td>The practice assesses patient activation levels and/or readiness to change</td>
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<tr>
<td>The practice uses Coaching for Activation or Motivational Interviewing Techniques</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Comprehensiveness and Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(PCMH Auto-Credit)</em> Practice has defined timely fashion follow up for ED and hospital discharge workflows and has reviewed necessary improvements or changes to the process</td>
</tr>
<tr>
<td><em>(2020 MUST PASS)</em> Practice follows up with at least 70% of their patients seen at the ED within their definition of timely fashion (must report numerator and denominator)</td>
</tr>
<tr>
<td><em>(2020 MUST PASS)</em> Practice follows up with at least 70% of patients discharged from hospital within their definition of timely fashion (must report numerator and denominator)</td>
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<tr>
<td><em>(2020 MUST PASS)</em> Practice has established a Care Compact with at least one high volume specialist that meets the minimum requirements of the RAE KPI</td>
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<thead>
<tr>
<th>Patient and Caregiver Engagement</th>
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</thead>
<tbody>
<tr>
<td><em>(PCMH Auto-Credit)</em> The practice has completed at least two rounds of patient surveys OR has established a Patient Feedback and Advisory Council (PFAC) that has met at least twice. The practice uses the survey or meeting to obtain feedback from their patient population for purposes of informing their QI work.</td>
</tr>
<tr>
<td><em>(PCMH Auto-Credit)</em> The practice has completed at least two QI projects with data collected from either patient surveys or PFAC.</td>
</tr>
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</table>

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<tr>
<th>Sustainability and Spread</th>
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<tbody>
<tr>
<td>Practice has plan for sustainability and spread</td>
</tr>
<tr>
<td>Practice has an internal and external communication plan to inform practice and patients of QI work</td>
</tr>
</tbody>
</table>
## Tier 2 – Advanced Participation
### Assessment Elements

### Quality Improvement

- **(PCMH Auto-Credit)** Practice has multidisciplinary QI team that meets regularly
- **(2020 MUST PASS)** Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement
- **(PCMH Auto-Credit)** Practice has completed at least a single PDSA cycle for each of the identified CQMs.

## Tier 3 – Foundations Participation
### Assessment Elements

### Ongoing Demonstration 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%

### Quality Improvement

- **(PCMH Auto-Credit)** Practice Identified multidisciplinary staff members for QI team
- **(PCMH Auto-Credit)** Practice has assigned QI team members specific duties
- **(2020 MUST PASS)** Practice uses agendas and minutes in QI team meetings
  - Practice evaluates patient flow for identification of gaps and opportunities for improvement in efficiency (i.e., cycle times study, patient access evaluation, etc.)
- **(PCMH Auto-Credit)** Practice implemented a QI project supporting an area of improvement impacting patient flow and/or office efficiency
- **(2020 MUST PASS)** Practice has identified clinical quality measures and targets for each of the measures for purposes of performance improvement
- **(PCMH Auto-Credit)** Practice has completed at least a single PDSA cycle for each of the CQMs (minimum of two CQMs)

### Comprehensiveness and Care Coordination

- **(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

### Access and Continuity

- **(2020 MUST PASS)** Practice has a defined panel management process and an empanelment rate at or above 60%
  - Practice has set a continuity of care target
- **(PCMH Auto-Credit)** Practice has completed a Team-based Care Assessment and has implemented a strategy to address gaps (i.e., huddles, standing orders, etc.)

### Sustainability and Spread

- Practice has plan for sustainability and spread
- Practice has an internal and external communication plan to inform practice and patients of QI work
<table>
<thead>
<tr>
<th>NQF#</th>
<th>CMS#</th>
<th>Measure Type</th>
<th>Description</th>
<th>Denominator</th>
<th>Numerator</th>
<th>EHR 70th percentile</th>
<th>Benchmark Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>137v7</td>
<td>Process / complex care</td>
<td>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.</td>
<td>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. **</td>
<td>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.</td>
<td>2.24%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>18</td>
<td>165v7</td>
<td>Outcome</td>
<td>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 (&lt;140/90mmHg) during the measurement period.</td>
<td>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. **</td>
<td>Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt;140 mmHg and diastolic blood pressure &lt;90 mmHg) during the measurement period.</td>
<td>72.01%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>22</td>
<td>156v7</td>
<td>Process / complex care</td>
<td>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.</td>
<td>Patients 66 years and older who had a visit during the measurement period.</td>
<td>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.</td>
<td>0.04%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>28</td>
<td>138v7</td>
<td>Process</td>
<td>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.</td>
<td>All patients aged 18 years and older seen for at least two visits or at least one preventative visit during the measurement period. **</td>
<td>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.</td>
<td>94.64%</td>
<td>QPP - MIPS</td>
</tr>
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<tr>
<td>32</td>
<td>124v7</td>
<td>Process</td>
<td><strong>CERVICAL CANCER SCREENING:</strong> 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.</td>
<td>Women 23-64 years of age with a visit during the measurement period. **</td>
<td>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.</td>
<td>48.31%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>34</td>
<td>130v7</td>
<td>Process</td>
<td><strong>COLORECTAL CANCER SCREENING:</strong> Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.</td>
<td>Patients 50-75 years of age with a visit during the measurement period. **</td>
<td>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 sigmoidoscopy during the measurement period or the 4 years prior; 3) Colonoscopy during the measurement period or the 9 years prior.</td>
<td>64.01%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>41</td>
<td>147v8</td>
<td>Process</td>
<td><strong>INFLUENZA IMMUNIZATION:</strong> Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>Equals Initial Population and seen for a visit between October 1 and March 31</td>
<td>Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>56.02%</td>
<td>QPP - MIPS</td>
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<td>0421</td>
<td>69v7</td>
<td>Process</td>
<td><strong>ADULT BMI:</strong> 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 &lt; 30; 18-64 ≥ 18.5 and &lt;25.*</td>
<td>All patients 18 and older won the date of the encounter with at least one eligible encounter during the measurement period.*</td>
<td>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.*</td>
<td>60.31%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>55</td>
<td>131v7</td>
<td>Process</td>
<td><strong>DIABETES - EYE EXAM:</strong> 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.</td>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period.</td>
<td>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.</td>
<td>95.65%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>59</td>
<td>122v7</td>
<td>Outcome</td>
<td><strong>DIABETES HEMOGLOBIN A1C (HbA1c) POOR CONTROL:</strong> Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period.</td>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period.</td>
<td>Patients whose most recent HbA1c level (performed during the measurement period) is &gt; 9.0%.</td>
<td>25.87%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>62</td>
<td>134v7</td>
<td>Process</td>
<td><strong>DIABETES: MEDICAL ATTENTION FOR NEPHROPATHY:</strong> 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.</td>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period**</td>
<td>Patients with a screening for nephropathy or evidence of nephropathy during the measurement period</td>
<td>91.11%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>101</td>
<td>139v7</td>
<td>Process / complex care</td>
<td><strong>FALLS - SCREENING FOR FUTURE FALL RISK:</strong> Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.</td>
<td>Patients aged 65 years and older with a visit during the measurement period.**</td>
<td>Patients who were screened for future fall risk at least once within the measurement period.</td>
<td>78.60%</td>
<td>QPP - MIPS</td>
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<tr>
<td>418</td>
<td>2v8</td>
<td>Process</td>
<td>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.</td>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period**</td>
<td>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</td>
<td>56.83%</td>
<td>QPP - MIPS</td>
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<tr>
<td>712</td>
<td>160v7</td>
<td>Process</td>
<td>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.</td>
<td>Patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during the four month period**</td>
<td>Patients who have a PHQ-9 tool administered at least once during the four-month period</td>
<td>22.09%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>2372</td>
<td>125v7</td>
<td>Process</td>
<td>BREAST CANCER SCREENING: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.</td>
<td>Women 51-74 years of age with a visit during the measurement period.**</td>
<td>Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period.</td>
<td>65.68%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>N/A</td>
<td>127v6</td>
<td>Process</td>
<td>PNEUMOCOCCAL VACCINATION STATUS FOR OLDER ADULTS: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
<td>Patients 65 years of age and older with a visit during the measurement period**</td>
<td>Patients who have ever received a pneumococcal vaccination</td>
<td>71.82%</td>
<td>QPP - MIPS</td>
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<tr>
<td>N/A</td>
<td>347v2</td>
<td>Process</td>
<td>STATIN THERAPY 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 &gt;= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR *Adults aged &gt;= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level &gt;= 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</td>
<td>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 &gt;= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis 2) Patients aged &gt;= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C &gt;=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**</td>
<td>Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period</td>
<td>77.22% QPP - MIPS</td>
<td></td>
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<tr>
<td>N/A</td>
<td>149v7</td>
<td>Process / complex care</td>
<td>DEMENTIA - COGNITIVE ASSESSMENT: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.</td>
<td>All patients, regardless of age, with a diagnosis of dementia. **</td>
<td>Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.</td>
<td>73.33% QPP - MIPS</td>
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<td>N/A</td>
<td>50v7</td>
<td>Process</td>
<td>CLOSING THE REFERRAL LOOP - RECEIPT OF SPECIALIST REPORT: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.</td>
<td>Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.</td>
<td>Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.</td>
<td>60.25%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>0033</td>
<td>153v7</td>
<td>Process</td>
<td>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.</td>
<td>Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.</td>
<td>Women with at least one chlamydia test during the measurement period.</td>
<td>44.78%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>formerly 0036</td>
<td>126v5</td>
<td>Process</td>
<td>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.*</td>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement year.*</td>
<td>Patients who were ordered at least one prescription for a preferred therapy during the measurement period.*</td>
<td>83.87%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>2908</td>
<td>144v7</td>
<td>Process</td>
<td>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.*</td>
<td>All patients ages 18 and older with a diagnosis of heart failure with a current or prior LVEF &lt; 40%.*</td>
<td>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.*</td>
<td>89.74%</td>
<td>QPP - MIPS</td>
</tr>
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<td>NQF#</td>
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<tr>
<td>0419</td>
<td>68v8</td>
<td>Process</td>
<td><strong>MEDICATION RECONCILIATION.</strong> 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, herbal, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration.*</td>
<td>All visits occurring during the 12 month reporting period for patients ages 18 years and older before the start of the measurement period. *</td>
<td>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, herbal, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosages, frequency and route of administration.*</td>
<td>99.58%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>1799</td>
<td>N/A</td>
<td>Process</td>
<td><strong>ASTHMA -</strong> The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.</td>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement period</td>
<td>The number of patients who achieved a proportion of days (PDC) of at least 75% for their asthma controller medications during the measurement year</td>
<td>35.00%</td>
<td>HCPF APM</td>
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<tr>
<td>0710</td>
<td>159v7</td>
<td>Outcome</td>
<td><strong>DEPRESSION REMISSION AT 12 MONTHS -</strong> The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.</td>
<td>Adolescent patients 12 to 17 years of age and adult patients 18 years of age or older who reached remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five</td>
<td>Adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event</td>
<td>7.14%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>formerly 0036</td>
<td>126v5</td>
<td>Process</td>
<td><strong>ASTHMA -</strong> Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.*</td>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement period.*</td>
<td>Patients who were ordered at least one prescription for a preferred therapy during the measurement period.*</td>
<td>35.00%</td>
<td>HCPF APM</td>
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</tbody>
</table>

**EXCLUSIONS APPLY**
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<thead>
<tr>
<th>NQF#</th>
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<tbody>
<tr>
<td>4</td>
<td>137v7</td>
<td>Process / complex care</td>
<td>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT:</td>
<td>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.</td>
<td>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.**</td>
<td>2.24%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>41</td>
<td>147v8</td>
<td>Process</td>
<td>INFLUENZA IMMUNIZATION: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>Equals Initial Population and seen for a visit between October 1 and March 31</td>
<td>Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>56.02%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>418</td>
<td>2v8</td>
<td>Process</td>
<td>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</td>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period **</td>
<td>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</td>
<td>56.83%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>N/A</td>
<td>50v7</td>
<td>Process</td>
<td>CLOSING THE REFERRAL LOOP - RECEIPT OF SPECIALIST REPORT: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.</td>
<td>Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.</td>
<td>Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.</td>
<td>60.25%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>formerly 0002</td>
<td>146v7</td>
<td>Process</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>87.63%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
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<tr>
<td>0024</td>
<td>155v7</td>
<td>Process</td>
<td><strong>CHILDHOOD BMI/NUTRITION/PHYSICAL ACTIVITY:</strong> 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.*</td>
<td>Patients 3-17 years of age with at least one outpatient visit with a primary care physician or OB/GYN during the measurement period.*</td>
<td>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 occurred during the measurement period. Numerator 3: Patients who had counseling for physical activity during a visit that occurred during the measurement period.*</td>
<td>38.73%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>0033</td>
<td>153v7</td>
<td>Process</td>
<td><strong>CHLAMYDIA SCREENING FOR WOMEN</strong> - Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.</td>
<td>Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.</td>
<td>Women with at least one chlamydia test during the measurement period.</td>
<td>44.78%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>1799</td>
<td>N/A</td>
<td>Process</td>
<td><strong>ASTHMA</strong> - The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period</td>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement period.</td>
<td>The number of patients who achieved a proportion of days (PDC) of at least 75% for their asthma controller medications during the measurement year</td>
<td>35.00%</td>
<td>HCPF APM</td>
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<tr>
<td>0038</td>
<td>117v7</td>
<td>Process</td>
<td><strong>CHILDHOOD IMMUNIZATIONS:</strong> 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.</td>
<td>Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.</td>
<td>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.</td>
<td>37.23%</td>
<td>QPP - MIPS</td>
</tr>
<tr>
<td>0069</td>
<td>154v7</td>
<td>Process</td>
<td><strong>UPPER RESPIRATORY TREATMENT IN CHILDREN</strong> - (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.</td>
<td>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.</td>
<td>Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.</td>
<td>96.88%</td>
<td>QPP - MIPS</td>
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<td>0108</td>
<td>136v8</td>
<td>Process</td>
<td><strong>FOLLOW UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION</strong> - 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. · Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. · 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.</td>
<td>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.</td>
<td>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.</td>
<td>49.80%</td>
<td>NCQA</td>
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<tr>
<td>0576</td>
<td>N/A</td>
<td>Process</td>
<td><strong>HOSPITAL FOLLOW UP MENTAL ILLNESS</strong> - 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: · The percentage of discharges for which the patient received follow-up within 30 days of discharge · The percentage of discharges for which the patient received follow-up within 7 days of discharge.</td>
<td>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).</td>
<td>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.</td>
<td>47.50%</td>
<td>NCQA</td>
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<td>1346</td>
<td>N/A</td>
<td>Outcome</td>
<td><strong>SECONDHAND SMOKE EXPOSURE TO CHILDREN</strong> - Determines the percentage of children who live with a smoker and if that smoker smokes inside the child’s house</td>
<td>Children age 0-17 years</td>
<td>Percentage of children who live in a household with someone who smokes and smoking occurs inside home</td>
<td>28.00%</td>
<td>CDPHE</td>
</tr>
<tr>
<td>1365</td>
<td>177v7</td>
<td>Process</td>
<td><strong>CHILD AND ADOLESCENT SUICIDE RISK</strong> - Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.</td>
<td>All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder.</td>
<td>Patient visits with an assessment for suicide risk.</td>
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<tr>
<td>1392</td>
<td>N/A</td>
<td>Process</td>
<td><strong>WELL CHILD VISITS IN THE FIRST 15 MONTHS</strong> - 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.</td>
<td>Children 15 months old during the measurement year.</td>
<td>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</td>
<td>56.00%</td>
<td>HCPF APM</td>
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<tr>
<td>formerly NQF 1401</td>
<td>82v6</td>
<td>Process</td>
<td><strong>MATERNAL DEPRESSION SCREENING</strong> - The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child’s first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.</td>
<td>Children with a visit who turned 6 months of age in the measurement period.</td>
<td>Children with documentation of maternal screening or treatment for postpartum depression for the mother.</td>
<td>63.00%</td>
<td>HCPF APM</td>
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<tr>
<td>1448</td>
<td>N/A</td>
<td>Process</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>54.00%</td>
<td>CDPHE</td>
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<tr>
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<tr>
<td>1516</td>
<td>N/A</td>
<td>Process</td>
<td>Adolescent Well Care Visits (Ages 12-21): adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.</td>
<td>Adolescents and young adults 12-21 years of age in the measurement year.</td>
<td>Adolescents and young adults who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.</td>
<td>56.00%</td>
<td>HCPF APM</td>
</tr>
<tr>
<td>1516</td>
<td>N/A</td>
<td>Process</td>
<td>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.</td>
<td>Children 3-6 years of age during the measurement year.</td>
<td>Children who received at least one well-child visit with a PCP during the measurement year.</td>
<td>56.00%</td>
<td>HCPF APM</td>
</tr>
<tr>
<td>formerly 0036</td>
<td>126v5</td>
<td>Process</td>
<td>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.*</td>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement year.*</td>
<td>Patients who were ordered at least one prescription for a preferred therapy during the measurement period.*</td>
<td>35.00%</td>
<td>HCPF APM</td>
</tr>
</tbody>
</table>

**EXCLUSIONS APPLY**

Some eCQMs were retired from the RAE eCQM measure suite in 2020 due to loss of measure endorsement.
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

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, autism spectrum disorder services, non-emergent medical transportation, and hospice care. More information about these wrap-around services is available in RMHP’s provider manual.

For Questions about Submitting Claims

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

Electronic Eligibility Verification

Providers will want to confirm eligibility of RAE Members before providing services. Determination of eligibility and enrollment in the Accountable Care Collaborative program is based on the State of Colorado eligibility standards developed and applied by the Department of Health Care Policy and Financing. Health First Colorado eligibility should be verified by using the system available through the State of Colorado, the Colorado interChange.

The Department’s interChange is updated in “real time” and serves as the most accurate method for determining eligibility. Documentation relating to eligibility verification for Members enrolled in the Medicaid Accountable Care Collaborative, including RAE Members and RAE Members also enrolled in RMHP Prime, should be retained by the RMHP network provider, as these documents will be required to support a provider appeal if a claim is denied due to patient eligibility and enrollment status. If the Department retroactively adjusts eligibility, claims payment may be retracted if you are unable to demonstrate eligibility was verified at the time of service.

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

**Care Coordination for RAE and PRIME Members**

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

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

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

**Pre-Authorization Requirements**

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Process</th>
<th>RAE</th>
<th>RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandatory/Passive Enrollment</strong></td>
<td>Enrollment is mandatory. All Health First Colorado Members must enroll. No opt out.</td>
<td>RMHP Prime is passive enrollment. Members can opt-out to receive physical health benefits through Health First Colorado FFS.</td>
</tr>
<tr>
<td><strong>Enrollment Effective Date</strong></td>
<td>Enrollment begins upon Member’s Health First Colorado eligibility determination.</td>
<td>Enrollment begins upon Member’s Health First Colorado eligibility determination.</td>
</tr>
<tr>
<td><strong>Member Enrollment Region</strong></td>
<td>Member enrollment in the RAE is based on the physical location of the Member’s attributed PCMP site, not the Member’s residence.</td>
<td>Member enrollment in RMHP Prime is based on county of residence and Health First Colorado eligibility.</td>
</tr>
<tr>
<td><strong>Member Attribution</strong></td>
<td>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.</td>
<td>Member attribution follows RMHP’s attribution methodology, using claims and Patient Choice.</td>
</tr>
<tr>
<td><strong>Member Re-Attribution</strong></td>
<td>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.</td>
<td>RMHP determines attribution each month</td>
</tr>
<tr>
<td><strong>PCMP Agreement</strong></td>
<td>Each PCMP site has an agreement, either directly or via their IPA participation, with the RAE in that site’s region.</td>
<td>RMHP Prime participating provider agreement</td>
</tr>
<tr>
<td><strong>PCMP Payments</strong></td>
<td>RAE pays at least $2 PMPM to PCMPs for attributed RAE Members. Additionally, incentive payments for higher performing practices are available.</td>
<td>Payment per terms of RMHP Prime participating agreement</td>
</tr>
<tr>
<td><strong>Physical Health Reimbursement</strong></td>
<td>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.</td>
<td>PCMPs and physical health claims paid by RMHP.</td>
</tr>
<tr>
<td><strong>Six Behavioral Health Sessions at PCMP Practice</strong></td>
<td>Allows primary care practices to bill up to six sessions behavioral health sessions to the Department, not to the RAE.</td>
<td>For RMHP Prime Members, these six primary care behavioral health sessions are billed to RMHP.</td>
</tr>
</tbody>
</table>
### For RMHP Prime PCMPs: RMHP RAE Members without RMHP Prime & RMHP RAE Members with RMHP Prime

<table>
<thead>
<tr>
<th></th>
<th>RMHP RAE Members <strong>without</strong> RMHP Prime</th>
<th>RMHP RAE Members <strong>with</strong> RMHP Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>RMHP RAE Members <strong>without</strong> RMHP Prime include:</td>
<td>RMHP RAE Members <strong>with</strong> RMHP Prime include:</td>
</tr>
<tr>
<td></td>
<td>- All Region 1 RAE Members who do <strong>not</strong> reside in an RMHP Prime county (Garfield, Gunnison, Mesa, Montrose, Rio Blanco, Pitkin) and Most children who reside in an RMHP Prime County.</td>
<td>- 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)</td>
</tr>
<tr>
<td><strong>Enrollment Process</strong></td>
<td>Mandatory RAE enrollment by Department based on the site of the Member’s attributed PCMP</td>
<td>Passive enrollment by Department based on Member’s county of record and eligibility category.</td>
</tr>
<tr>
<td></td>
<td>- RAE Members attributed to a PCMP practice site within Region 1 are enrolled with RMHP as the RAE.</td>
<td></td>
</tr>
<tr>
<td><strong>Attribution</strong></td>
<td>Department calculates attribution for RAE Members following Department’s methodology</td>
<td>RMHP calculates attribution following RMHP’s methodology for RMHP Prime Members.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department calculates attribution for RAE Members following Department’s methodology</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>RMHP contracts with PCMPs</td>
<td>RMHP contracts with PCMPs</td>
</tr>
<tr>
<td></td>
<td>- RMHP pays at least $2 PMPM for attributed RAE Members</td>
<td>- RMHP pays global monthly PMPM for attributed RMHP Prime Members</td>
</tr>
<tr>
<td></td>
<td>- RMHP provides practice transformation activities</td>
<td>- RMHP provides practice transformation activities</td>
</tr>
<tr>
<td><strong>Behavioral Health Benefits</strong></td>
<td>RMHP as RAE is responsible for administering covered services under the Capitated Behavioral Health Benefit (RMHP pays claims)</td>
<td>RMHP as RAE is responsible for administering covered behavioral health services (RMHP pays claims)</td>
</tr>
<tr>
<td><strong>Physical Health Benefits</strong></td>
<td>Department continues to pay for pharmacy and physical health care services following Health First Colorado FFS schedule.</td>
<td>RMHP responsible for pharmacy and physical health care services (RMHP pays claims)</td>
</tr>
<tr>
<td><strong>Social Determinants of Health</strong></td>
<td>Additional activities to screen, refer, and connect Members to community-based services</td>
<td>Additional activities to screen, refer, and connect Members to community-based services</td>
</tr>
</tbody>
</table>
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.
RMHP RAE KEY CONTACT INFORMATION
RMHP RAE Key Contact Information

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

Meg Taylor, RAE Program Officer
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Dale Renzi, Senior Director, Provider Network Management
dale.renzi@rmhp.org

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

Kim Brown, Director, Clinical Program Development and Evaluation
kimberly.brown@rmhp.org

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

RMHP RAE Support
raesupport@rmhp.org

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

Practice Transformation
practice.transformation3@rmhp.org

RMHP Care Coordinators
888-282-8801 (TTY: 711), press Option 5, then Option 1
EXHIBIT A: KPI MEASURES
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Behavioral Health Engagement.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Behavioral Health Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of unique ACC members who received at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit within the 12-month evaluation period</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of unique members in the denominator who have received at least one behavioral health service billed within the rolling 12-month evaluation period</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of unique members enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period</td>
</tr>
<tr>
<td>Notes</td>
<td>Multiple behavioral health visits (“numerator events”) in the evaluation period for one unique member will only be counted once. All diagnosis codes on the claim will be considered, not just the primary diagnosis. This measure will be manually calculated by the Department until systems can correctly adapt and calculate behavioral health encounters. Only the fee-for-service (FFS) portion of the measure will be displayed in the data analytics portal.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. Value code sets can be found here under the “Performance measurement” section.</td>
</tr>
<tr>
<td>Resources</td>
<td>Short-Term BH Services Fact Sheet</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td>SFY 17-18 regional penetration rate: 0.829%</td>
<td></td>
</tr>
<tr>
<td>Level 1 Target:</td>
<td>1% -5% increase above baseline receives 75% of payment</td>
</tr>
<tr>
<td>Level 2 Target:</td>
<td>&gt;5% increase above baseline receives 100% of payment</td>
</tr>
<tr>
<td>Data Source</td>
<td>RAE Behavioral Health claims &amp; State claims—calculated by IBM Watson for a rolling 12 months (90 days claims run out); some claims will come from BH capitated payment, some will come from six visits in primary care practices and behavioral health delivery in Federally Qualified Health Center settings</td>
</tr>
<tr>
<td>Practice Interventions for Improvement</td>
<td>• Screen all patients for behavioral health (BH) conditions, using evidence-based screening tools (PHQ9, GAD-7, AUDIT, etc.) to determine appropriate behavioral health services to be offered within primary care or elsewhere in the community</td>
</tr>
<tr>
<td></td>
<td>• Engage with BH providers to develop care compacts for optimal care coordination and collaboration</td>
</tr>
<tr>
<td></td>
<td>• Develop talking points to discuss the importance of a signed release of information for primary care and BH providers to close referral loops &amp; discuss treatment progress</td>
</tr>
<tr>
<td></td>
<td>• Track referrals to ensure patient followed through on the referral to a behavioral health provider; reach out to patients to identify barriers preventing follow-through with the BH service</td>
</tr>
<tr>
<td></td>
<td>• Code the behavioral health visits properly to ensure accurate data capture for this measure in the data analytics tool</td>
</tr>
<tr>
<td>Tips for Using Data</td>
<td>• Using data from your EMR on positive screens, track referrals to integrated behavioral health or external behavioral health providers to monitor patient visit attendance (i.e. close the referral loop)</td>
</tr>
<tr>
<td></td>
<td>• Using the IBM Watson Data Analytics Portal dashboard for this measure, identify patients in the “not served” list who either have been referred to behavioral health and did not complete the visit, or who could benefit from a behavioral health service</td>
</tr>
<tr>
<td></td>
<td>• Using the IBM Watson Data Analytics Portal dashboard for ER visits, identify patients with frequent ER visits to determine whether the ER visits are related to an unmet BH need and how to craft an intervention tailored to this patient</td>
</tr>
</tbody>
</table>
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Dental Visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Dental Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of members who received professional dental services, including services from both medical and dental claims</td>
</tr>
<tr>
<td>Numerator</td>
<td>Distinct count of members who received at least one dental service within the 12-month evaluation period</td>
</tr>
<tr>
<td>Denominator</td>
<td>Distinct count of members enrolled in the ACC on the last day of the last month of the 12-month evaluation period</td>
</tr>
<tr>
<td>Notes</td>
<td>Dental visits counted in the numerator are included in CDT codes (D0000 to D9999)</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Population exclusion: Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. The Dental code value sets can be found <a href="#">here</a> under the “Performance measurement” section. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td>Resources</td>
<td>Coding for Dental Services, Cavity Free at Three Training (free), Smiles For Life Training (free), RAE Dental Benefits (DentaQuest), Dental Resources</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline SFY 17-18 performance for members with full Medicaid residing in each RAE Region: 33.384%</td>
</tr>
<tr>
<td></td>
<td>Level 1 Target: 1%-5% increase above baseline receives 75% of payment</td>
</tr>
<tr>
<td></td>
<td>Level 2 Target: &gt;5% increase above baseline receives 100% of payment</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated monthly by IBM Watson using fee-for-service claims; data is reported monthly for a rolling 12-month period (90 days claims run out)</td>
</tr>
<tr>
<td>Practice Interventions for Improvement</td>
<td>- Educate patients on importance of dental care</td>
</tr>
<tr>
<td></td>
<td>- Educate staff and providers on the link between oral health and physical health</td>
</tr>
<tr>
<td></td>
<td>- Complete the dental training programs for primary care providers, enabling the provision of oral screenings, oral exams, fluoride, etc. in the primary care setting</td>
</tr>
<tr>
<td></td>
<td>- Develop a referral loop workflow for patients referred out to dental service; review list of patients not obtaining dental services and seek to identify and address barriers for patients not obtaining appropriate dental care</td>
</tr>
<tr>
<td></td>
<td>- Develop a resource list for the practice including dental providers, types insurances accepted, clinic hours, emergency dental services, etc.</td>
</tr>
<tr>
<td>Tips for Using Data</td>
<td>- Using the IBM Watson Data Analytics Portal for this measure, identify patients on the “not served” list to identify patients who have not had a dental service during the evaluation period</td>
</tr>
<tr>
<td></td>
<td>- Use a referral tracking mechanism in your practice to close the loop, address no-shows, etc., if referring out for dental services</td>
</tr>
</tbody>
</table>

Revised November 2019
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Well Visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Well Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of distinct members who received a well visit within the 12-month evaluation period</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of members in the denominators who had at least one well visit during the 12 month evaluation period</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of members enrolled in the ACC as of the last month of the rolling 12 month evaluation period</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>Multiple numerator events in an evaluation period for a unique member will only be counted once. All diagnosis codes on the claim will be considered, not just the primary diagnosis. Paid claims and encounters will be considered as part of the numerator/denominator/exclusion criteria. Only claims submitted through the MMIS (interchange) will be used for this measure.</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period are excluded from the denominator</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>Please refer to the Department of Health Care Policy and Financing’s <a href="#">KPI Methodology</a> document for the full measure specifications. Value code sets can be found <a href="#">here</a> under the &quot;Performance measurement&quot; section. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>Patient Education Materials</td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td><strong>Level 1 Target</strong></td>
<td>1%-5% increase above baseline receives 75% of payment</td>
</tr>
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<td><strong>Level 2 Target</strong></td>
<td>&gt;5% increase above baseline receives 100% of payment</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Calculated monthly by IBM Watson using fee-for-service data for a rolling 12 month period (90 days claims run out)</td>
</tr>
<tr>
<td><strong>Practice Interventions for Improvement</strong></td>
<td>Evaluate your organization’s current guideline and/or workflow to support standardizing well visits</td>
</tr>
<tr>
<td></td>
<td>Identify gaps in care specific to this measure and reach out to patients who have not had a well visit during the evaluation period</td>
</tr>
<tr>
<td></td>
<td>Identify patients who have engaged with the practice recently, versus those who have not; strategies for well visit reminders may differ based on level of patient engagement</td>
</tr>
<tr>
<td></td>
<td>Review the patient schedule in advance to identify patients who are coming in for another type of visit, but have not had a well visit recently; consider changing the visit type to incorporate a well visit while the patient is in the office</td>
</tr>
<tr>
<td></td>
<td>Educate patients on differences between types of visits and the importance of each (e.g. sports physicals are not well visits)</td>
</tr>
<tr>
<td></td>
<td>Identify barriers to completing well visits and make accommodations where feasible (e.g. open clinic outside of regular work hours)</td>
</tr>
<tr>
<td><strong>Tips for Using Data</strong></td>
<td>Use the IBM Watson Data Analytics Portal for this measure to identify patients who have not had a well visit during the evaluation period</td>
</tr>
<tr>
<td></td>
<td>Build an internal registry or tracking system to support well visits, including a flagging system</td>
</tr>
<tr>
<td></td>
<td>Review patient history of engagement with the practice in your EMR to inform reminder strategy (e.g. review active patient list, analyze patient visit types for individual patients)</td>
</tr>
<tr>
<td></td>
<td>Gather quantitative/qualitative data from patients on potential barriers to completing well visits (e.g. surveys, PFAC)</td>
</tr>
</tbody>
</table>

Revised November 2019
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Prenatal Engagement.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Prenatal Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of members who received a prenatal visit during pregnancy</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of deliveries where the member had at least one prenatal visit prior to delivery. In the event that a delivery claim contains bundled services, the prenatal visits will be counted in the numerator as long as prenatal falls within the 40 weeks prior to the delivery date, including the delivery date.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Unduplicated number of deliveries for members who are enrolled in the ACC as of the last month of the evaluation period and have gender code = F. Members can have multiple deliveries within an evaluation period, but only one within a 60-day period. Delivery logic will incorporate the earlier delivery date if two claims fall within 60 days of each other.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Excludes pregnancies not ending with a live birth; excludes members who were enrolled in any physical health managed care plan for more than 3 months any time during the evaluation period.</td>
</tr>
<tr>
<td>Notes</td>
<td>All diagnosis codes on the claim will be considered, not just the primary diagnosis. Paid claims and encounters will be considered part of the numerator/denominator/exclusion criteria. Only claims submitted through the MMIS (interchange) will be used for this measure.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. Value code sets can be found here under the “Performance measurement” section. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td>Resources</td>
<td><a href="#">Prenatal Care Statistics</a></td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline SFY 17-18 performance for members with full Medicaid residing in RAE Region: 60.194%</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated monthly by IBM Watson using fee-for-service claims for a rolling 12 month period (90 days claims run out)</td>
</tr>
</tbody>
</table>

**Practice Interventions for Improvement**
- For women of child-bearing age in your practice, provide education on the importance of prenatal care
- Coordinate with your county’s community health services, such as the Healthy Communities program, B-4 Babies, RMHP Care Managers, etc. to identify pregnant women for potential outreach to receive prenatal care
- If referring patients to a specialty clinic for prenatal care, track the referrals to ensure the loop is closed
- Ensure the prenatal services that you are providing in your practice are coded appropriately

**Tips for Using Data**
- Using a registry or referral tracking mechanism, track referrals to women's health clinics to ensure the loop was closed
- On a regular basis, run reports from the EMR for positive HcG tests to ensure a follow-up appointment is scheduled with the patient

Revised November 2019
### KPI: Emergency Department Visits

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

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Emergency Department Visits per Thousand Member Months per Year (PKPY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Number of emergency department visits per thousand Members per year (PKPY), risk adjusted</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of actual ED visits PKPY (# of ED visits/# Member months * 12,000)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Members will be counted in the denominator if they are enrolled in the ACC any month in the rolling 12 month evaluation period; to normalize this measure the denominator is measured in terms of Member months (PKPY). The PKPY is then risk adjusted using a RAE risk weight.</td>
</tr>
<tr>
<td>Notes</td>
<td>An ED visit will be counted in the numerator if it does not result in an inpatient admission. The per-thousand member months per-year rate is risk adjusted using Vercend’s Diagnostic Cost Group software, which calculates a raw cost risk score and an aggregated diagnostic cost grouper per Member. Raw cost risk scores are then converted into an ED visit risk weight by RAE region.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td>Resources</td>
<td>Return Visits to the ED</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated by IBM Watson using fee-for-service claims; data is reported monthly for a rolling 12-month period</td>
</tr>
</tbody>
</table>

### Practice Interventions for Improvement

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

### Tips for Using Data

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

Revised November 2019
KPI: HEALTH NEIGHBORHOOD PART 1

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

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of RAE PCMPs with new/renewed care compacts in effect with specialty care providers, that adhere to the Colorado Medical Society’s Primary Care Compacts criteria.</td>
</tr>
<tr>
<td>Numerator</td>
<td>PCMPs in the denominator who have at least one primary care/specialty care compacts in place within the 12 month rolling evaluation period</td>
</tr>
<tr>
<td>Denominator</td>
<td>PCMPs that are contracted with a RAE during the last month of the 12-month evaluation period</td>
</tr>
<tr>
<td>Notes</td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 1 accounts for 25% of the performance rate for this KPI. This component is calculated manually by the State and is paid out annually. Due to manual calculation, this component will not be displayed in the Data Analytics Portal. Note that the denominator for FY Quarter 4 expands to require at least two care compacts in effect, one being with behavioral health.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td>Resources</td>
<td>CO Medical Society Care Compact Guidelines</td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>Quarter 1: 50%+ of PCMP network has 2+ executed care compacts in place - 1 must be with behavioral health (Eval. Period: July 1, 2019-Sept. 30, 2019) Region final submission: 56.2%</td>
</tr>
<tr>
<td></td>
<td>Quarter 2: 50%+ of PCMP network has 2+ executed care compacts in place - 1 must be with behavioral health (Eval. period: Oct. 1, 2019-Dec.31, 2019) Region Final Submission: TBD</td>
</tr>
<tr>
<td>Data Source</td>
<td>RAEs will submit to the State a detailed list that includes the number of new/renewed compacts, PCMP and specialist names, and the signed date of the compacts.</td>
</tr>
<tr>
<td>Practice Interventions for Improvement</td>
<td>1. Identify high volume/high cost specialists with which to engage in care compact development. 2. Collaborate with the specialty practice when creating care compacts, ensuring that both parties’ needs are represented in the agreement and that the document promotes meaningful care coordination. 3. Ensure that the care compacts adhere to the criteria required by the State, using guidelines from the Colorado Medical Society. 4. Establish a mechanism for renewing care compacts at least annually, revising as needed.</td>
</tr>
<tr>
<td>Tips for Using Data</td>
<td>Using payer data (e.g. specialty visits in the IBM Watson Data Analytics Portal) identify high volume or high cost specialists that your practice refers patients to, in order to select specialty practices to engage with in care compact discussions. Track referrals using a registry or review care coordination process measures such as “closing the referral loop” to monitor referrals and the success of the care compact.</td>
</tr>
</tbody>
</table>

Revised November 2019
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Health Neighborhood.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Health Neighborhood Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of members who had an outpatient visit with a specialist who saw a PCMP within 60 days prior to the specialist visit and included a referring PCMP on the claim</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of specialty claims in the denominator with at least one PCMP visit within 60 days prior to the specialty visit and a referring PCMP listed on the claim</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of specialty claims for Members enrolled in the ACC as of the end of the rolling 12 month evaluation period (multiple specialist visits on a single date of service will be counted once in the denominator)</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Members who were enrolled in any physical health managed plan for more than 3 months anytime during the evaluation period are excluded from the denominator.</td>
</tr>
<tr>
<td>Notes</td>
<td>The Health Neighborhood is a composite measure made up of two parts. Part 2 accounts for 75% of the performance rate for this KPI. This portion of the Health Neighborhood KPI is calculated monthly and paid out quarterly.</td>
</tr>
<tr>
<td>Measure Specifications</td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. Value code sets can be found <a href="#">here</a> under the “Performance measurement” section. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td>Resources</td>
<td><a href="#">Detailed Coding Criteria</a> (page 26), <a href="#">Instructions for Referring Claim Submissions</a>, <a href="#">Improving Referral Management</a></td>
</tr>
<tr>
<td>KPI Baseline and Targets</td>
<td>RAE Region 1 Baseline SFY 17-18 performance for members with full Medicaid residing in each RAE Region: 2.098% Level 1 Target: 1% -5% decrease below baseline Level 2 Target: &gt; 5% decrease below baseline</td>
</tr>
<tr>
<td>Data Source</td>
<td>Calculated by IBM Watson Health using only claims submitted through the MMIS (interChange); data is available in the Data Analytics Portal</td>
</tr>
</tbody>
</table>

**Practice Interventions for Improvement**

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

**Tips for Using Data**

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

Revised November 2019
As the Regional Accountable Entity (RAE) for Region 1, Rocky Mountain Health Plans (RMHP) is committed to meeting specific key performance indicators (KPIs) to help improve our Members’ health.

**RAE Key Performance Indicators**

**Understanding Key Performance Indicators**

Key performance indicators, or KPIs, are designed to assess the functioning of the overall system to support population health. Each RAE has KPIs they strive to meet. KPIs are based upon paid claims and encounters and offer RAEs the opportunity to earn back withheld PMPM for reaching certain performance targets as a region. Those performance thresholds are set by the Colorado Department of Health Care Policy and Financing.

You can find the KPIs on the back of this flyer.

**How KPI Payments Work**

RAEs will have $4.00 withheld from their total administrative PMPM payment. They are then able to earn back some or all of that amount by meeting the performance thresholds. The withheld funds are spread equally among all KPIs for 2018-2019; no indicator is worth more than another. KPI performance is evaluated using twelve rolling months of data and will be paid to the RAE on a quarterly basis. Unused KPI funds will be placed into a pool of funds available for additional performance measures or for participation in state and federal initiatives that align with the goals of the Accountable Care Collaborative.

**Measuring KPI Performance**

KPI performance is measured using Truven (IBM Watson). Truven is a data analytics portal that contains population and performance information. To request access to Truven, please contact Nicole Konkoly at nicole.konkoly@rmhp.org.

**How RMHP Can Help**

RMHP can support your practice by offering:

- Free consultative services (Business Acumen & Integrated Behavioral Health)
- Advanced practice conferences
- Practice Transformation programs
- PCMH recognition assistance

**RAE Glossary of Terms**

**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

**Primary Care Medical Provider (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

**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 (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

---

**RMHP is the RAE for Region 1**

- 22 counties with a population of 910,852
- 175,793 RAE Members (excluding ~39,000 RMHP Prime Members)
- 201 unique PCMP sites
### KPIs for FY 2018-2019

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description</th>
<th>Focus or Baseline</th>
<th>Tier 1 Payment</th>
<th>Tier 2 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Avoidable Costs (PAC)</td>
<td>Compares a standard cost of an episode of care to actual costs.</td>
<td>RMHP focus: Diabetes, SUD, Anxiety &amp; Depression</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>Number of ED visits, per 1,000 Members per year (PKPY) risk-adjusted.</td>
<td>Region 1 baseline: 597.431 (ER Risk Adjusted/Actual ER Visits PKPY)</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Behavioral Health Engagement</td>
<td>Percentage of Members that access BH services.</td>
<td>Region 1 baseline: .829%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Well Visits</td>
<td>Percent of Members who receive a well visit during 12-month evaluation period.</td>
<td>Region 1 baseline: 31.32%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Prenatal Engagement</td>
<td>Percent of deliveries where a woman received prenatal care during pregnancy.</td>
<td>Region 1 baseline: 60.19%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Dental Visit</td>
<td>Percent of Members who received professional dental services.</td>
<td>Region 1 baseline: 33.38%</td>
<td>$0.428 PMPM</td>
<td>$0.571 PMPM</td>
</tr>
<tr>
<td>Health Neighborhood</td>
<td><strong>Part 1: Care Compacts (25%)</strong> Percentage of PCMPs that have an effective care compact with a specialty provider within a 12-month rolling evaluation period.</td>
<td>N/A</td>
<td>$0.143 PMPM</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Part 2: PCMP-Specialty Referrals (75%)</strong> Percentage of Members who had an outpatient visit with a specialist who saw a PCMP within 60 days and obtained a referral for the specialty services</td>
<td>Region 1 baseline: 2.098%</td>
<td>$0.321 PMPM</td>
<td>$0.428 PMPM</td>
</tr>
</tbody>
</table>

- **Level 1 Performance Improvement:** 1% - 5% improvement from baseline (75% incentive payment)
- **Level 2 Performance Improvement:** > 5% improvement from baseline (100% incentive payment)

### References

EXHIBIT B: CARE NOW
Members of Rocky Mountain Health Plans (RMHP) can use CareNow from EasyCare Colorado to get the care you need, when you need it. Connect with a doctor or therapist from your computer or cell phone — at no cost to you.

Download the EasyCare Colorado app or visit EasyCareCO.com/CareNow to register for CareNow today!

- Connect to a doctor in <90 seconds
- Message, share photos, or video chat
- Skip a trip to the ER or urgent care
- Easy access from a computer or phone
- Speak to a therapist
- Ask questions at no cost to you

Members can connect with a:
- **Doctor** every day from 9:00 a.m. - 9:00 p.m. MDT.
- **Therapist** Monday - Friday from 9:00 a.m. - 5:00 p.m.

You can use CareNow if you are a Health First Colorado (Colorado’s Medicaid Program) Member belonging to RMHP’s regional organization, or if you are an RMHP Prime or CHP+ Member.
Sign up for CareNow

Once you register or log in, you can choose to receive care from a doctor or a therapist.

Get the EasyCare Colorado App

1. Download the free EasyCare Colorado App from the App Store or Google Play. You can find the app by searching for EasyCareCO.

2. Open the app, then choose Create Account under the Sign In box.
3. Enter your date of birth and Health First Colorado ID number, then select Continue.
4. Enter your email address, then choose Continue. You must use a different email for each Member you register.
5. Check your email for the invitation from CareNow, and select Accept Invitation.
6. Create and confirm a password, then check the box to agree to the Terms of Use.
7. You’re now ready to get care now!

Register From Your Computer

1. Visit EasyCareCO.com/CareNow.
2. Choose Register.
3. Enter your date of birth and Health First Colorado ID number, then select Continue.
4. Enter your email address, then choose Continue. You must use a different email for each Member you register.
5. Check your email for the invitation from CareNow, and select Accept Invitation.
6. Create and confirm a password, then check the box to agree to the Terms of Use.
7. You’re now ready to get care now!

Need help finding your Health First Colorado ID number?

Here’s how you can find this information:

- View your Health First Colorado ID card from the PEAKHealth mobile app or at colorado.gov/PEAK and look for your Member ID #.
- Find a letter from Health First Colorado about your benefits.
- Call or visit your county Department of Human Services.
- If you are enrolled in RMHP Prime or CHP+, you can also find your Health First Colorado ID number on your RMHP Member ID card. Look for the number called State ID Number.
Free American Sign Language (ASL) Interpreting Services

The RISP Pilot will provide qualified American Sign Language interpreters for individuals who are deaf, hard of hearing, or deafblind in rural areas of Colorado at no cost to consumers or service providers. Areas outside of the Front Range (including Grand Junction and Pueblo) are included in RISP.

Interpreting services are available for a variety of needs, including:

- Medical (doctors, dentists, mental health services)
- Legal (municipal court, attorney-client meetings, police, sheriff)
- Community (events, meetings, presentations, trainings, government)
- Employment-related (job site meetings, interviews, trainings), or other situations.

Note: school interpreting for Pre K-12th grade students or college/university students is not covered; however, parents will be covered for school meetings/events.

To Request an Interpreter:

- Fill out a form online at www.colorisp.com
- Contact the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind
  - E-Mail: ccdhhdb_risp@state.co.us
  - Video Phone: 720-457-3679
  - Voice: 303-866-4824
  - Fax: 303-866-4831
  - Address: 1575 Sherman Street, Garden Level, Denver, CO 80203

The RISP Pilot also provides opportunities for initial and advanced sign language interpreter training. Contact us for more information.
RMHP FILE TRANSFER PROCESS:
BOX TO ECG QUICK CONNECT FAQ
Why is RMHP Changing from Box to ECG Quick Connect?

Rocky Mountain Health Plans (RMHP) is changing the way we receive and send files with our partners utilizing an Electronic Communication Gateway (ECG) in order to more securely transfer data.

What Types of Data are Affected?

The type of data determines how you will send and receive information to and from RMHP. The below table provides a reference for the types of data.

<table>
<thead>
<tr>
<th>Sending and/or Recieving Information</th>
<th>Type of Data</th>
<th>Frequency</th>
<th>Quick Connect</th>
<th>Email</th>
<th>Department Sending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anything containing PHI</td>
<td>Ad hoc</td>
<td>X</td>
<td></td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>General communication not containing PHI</td>
<td>Ad hoc</td>
<td></td>
<td>X</td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>Large file sizes</td>
<td>Ad hoc</td>
<td>X</td>
<td></td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>Documents (RAE, PCMH, etc.)</td>
<td>Ad hoc</td>
<td></td>
<td>X</td>
<td>Practice Transformation</td>
</tr>
<tr>
<td></td>
<td>CQM reporting tool if your firewall blocks the email</td>
<td>Quarterly</td>
<td>X</td>
<td></td>
<td>Practice Transformation</td>
</tr>
<tr>
<td></td>
<td>CQM reporting tool if your firewall does not block it</td>
<td>Quarterly</td>
<td></td>
<td>X</td>
<td>Practice Transformation</td>
</tr>
</tbody>
</table>
|                                      | Attribution Reports (PRIME, CPC+, RAE, Masters)   | End of each month | X |       | Community Integration (RAE, CPC+, Prime)  
Practice Transformation (Masters) |
|                                      | Patient Lists (PAM, HEDIS projects, etc.)        | Ad hoc    | X             |       | Practice Transformation |
|                                      | Patient reports-QI (A1c Gaps and Breast Cancer Screening) | Annually | X             |       | Quality Improvement |

Please contact RMHP with questions about other types of data that may not be listed.

Facts About ECG Quick Connect

- This is not a data repository. After you receive notification that you have an item in your Quick Connect account, you must retrieve and download that item within 30 days. After 30 days, the item will expire.
- You will have to create an Optum ID. Save this username and password.
- You will receive an email notification for each item sent to you; however, when you log in to your Quick Connect account, you will see all documents sent to you.
- An RMHP employee must initiate a “relationship” with you in order for you to be able to send information to that specific RMHP employee via Quick Connect. For example, if you wanted to send RMHP a patient list, the RMHP employee must first send you a test email via Quick Connect to initiate the relationship. Once that is completed, you will be able to send that RMHP employee anything via Quick Connect.
- You may receive several emails stating that an RMHP employee has invited you to exchange documents. If you select the link within the email, it will take you to create an Optum ID account. Please note: you may receive this email several times from several different RMHP employees. Every time an RMHP employee adds you to the ECG Quick Connect as a contact, you will receive an email. Although you may receive several invitations, you will only create an Optum ID one time. All documents sent to you by RMHP via ECG Quick Connect will go to your one account.
RMHP is Here to Help

Community Integration

- Nicole Konkoly: nicole.konkoly@rmhp.org
- Kendra Peters: kendra.peters@rmhp.org
- Rhonda Hastings: rhonda.hastings@rmhp.org

Practice Transformation

- Chelsea Watkins: chelsea.watkins@rmhp.org
- Quality Improvement Advisor (QIA): assigned to each practice
- Clinical Informaticists (CI): assigned to each practice