Welcome to the RAE

Region 1 overview – TCPI/SIM LC | July 13, 2018

ROCKY MOUNTAIN
HEALTH PLANS®
We understand Colorado. We understand you.

The power of networks

Link
Station

CENTRALIZED
(A)

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DISTRIBUTED
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Paul Baran, “Godfather of the Internet, 1964

Region 1 Health Communities

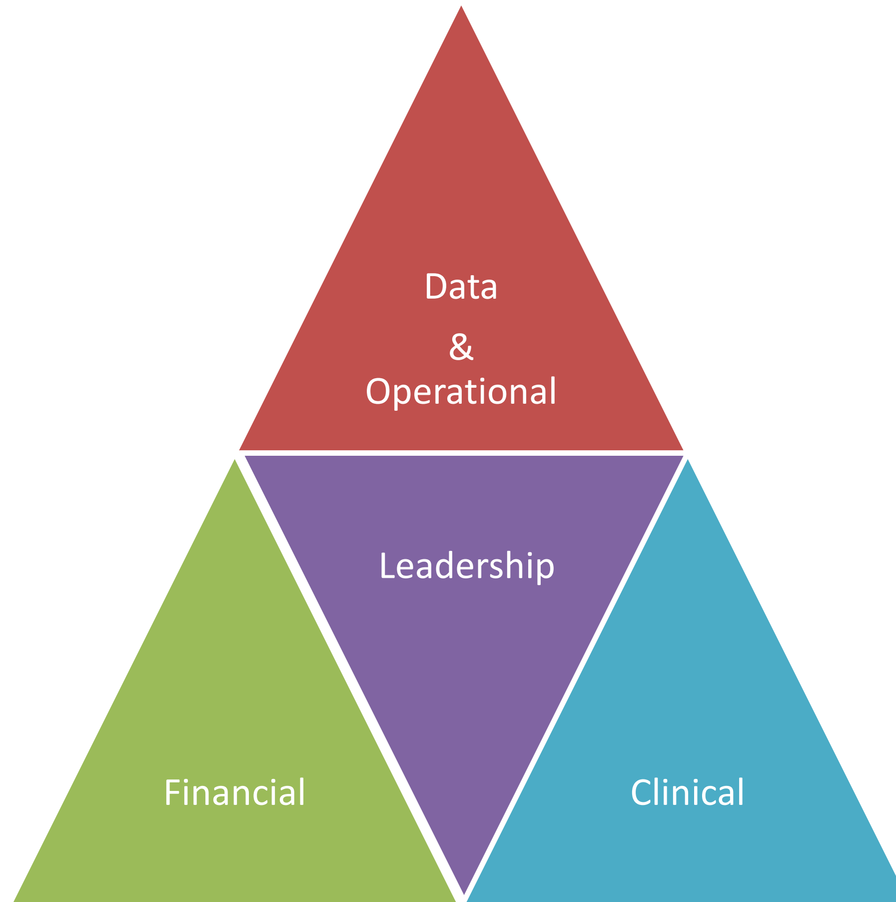
NORTHWEST COLORADO COMMUNITY
Moffat
Routt
Jackson
Rio Blanco
Grand
LARIMER COUNTY COMMUNITY
Garfield
Eagle
Summit
Pitkin
WESTERN MOUNTAIN COMMUNITY
MESA COUNTY COMMUNITY
Delta
Gunnison
MIDWESTERN COLORADO COMMUNITY
Montrose
Ouray
San Miguel
Hinsdale
Dolores
San Juan
Montezuma
La Plata
SOUTHWEST COLORADO COMMUNITY
Archuleta

- 6 distinct “Health Communities”
- Population
  - 140,000 “PCCM” Members
  - 182,000 BH Benefit Members
  - 36,500 “Prime” MCO Members
  - 11,500 CHP+ Kids
- Community-based oversight & health alliances partnerships
- Aligned initiatives – CPC+, AHCM, SIM

RMHP’s role

- To create an economic basis for whole person care.
- To maximize flexibility in public programs – not spending.
- To create a durable program founded on local leadership.
- To share data for transparent analysis and goal setting.
- To prioritize resources and focus on goals.
- To share burdens and benefits – equitably and timely.
- To improve community capacity and health trends.

We must drive all facets of integration



"Joint Operating Agreement" – JOA

Regional Accountable Entity for the Accountable Care Collaborative

Technical Proposal Solicitation # 2017000265

Colorado Department of Health Care Policy and Financing

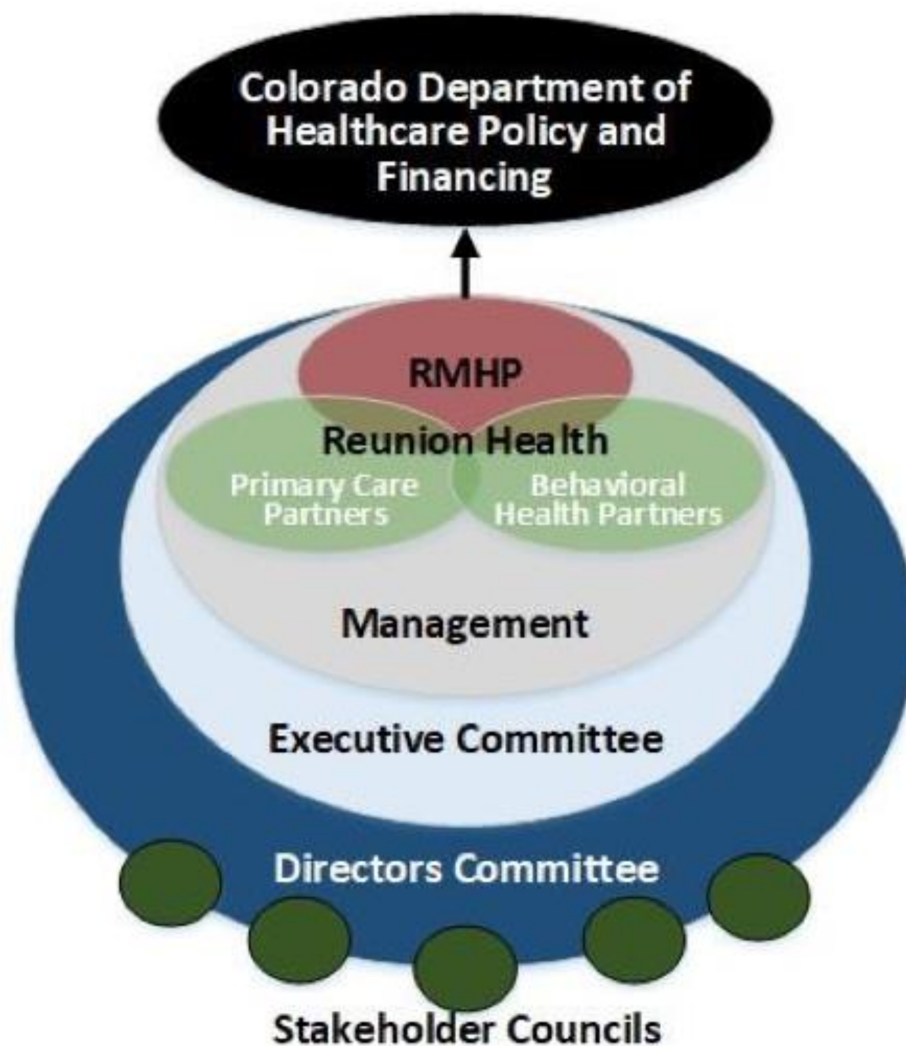
Reunion Health

July 28, 2017

Reunion Health in Partnership with Rocky Mountain Health Plans

- MH providers get a pathway out of carve out, opportunity to participate in health system design and savings;
- 10 FQHCS + 3 Mental Health Centers form "Reunion Health, LLC" to navigate program changet;
- Contractual agreement w. 'first principles': **"It's not who you are, it's what you do"**....plus, transparency + responsibility for community;
- **Checks & balances**: RMHP a minority "vote" on care model design and related issues – but can act unilaterally when necessary to manage risk;
- Independent providers, health and human services stakeholders get both **"a voice and a vote".**
- Explicit commitment **to practice transformation and network tiering for PH and BH.**

Transparent program oversight

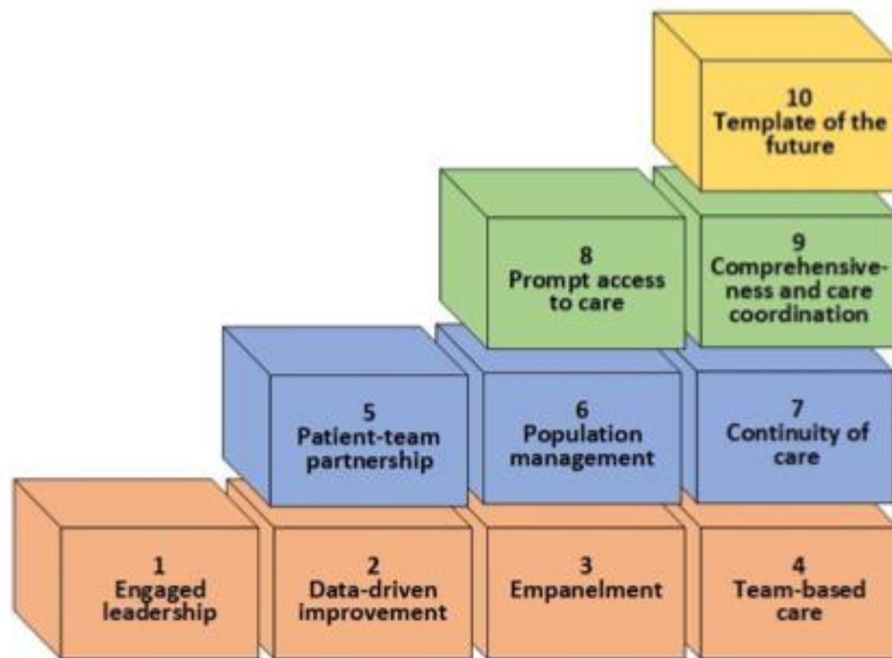


Key Committees – Thus far

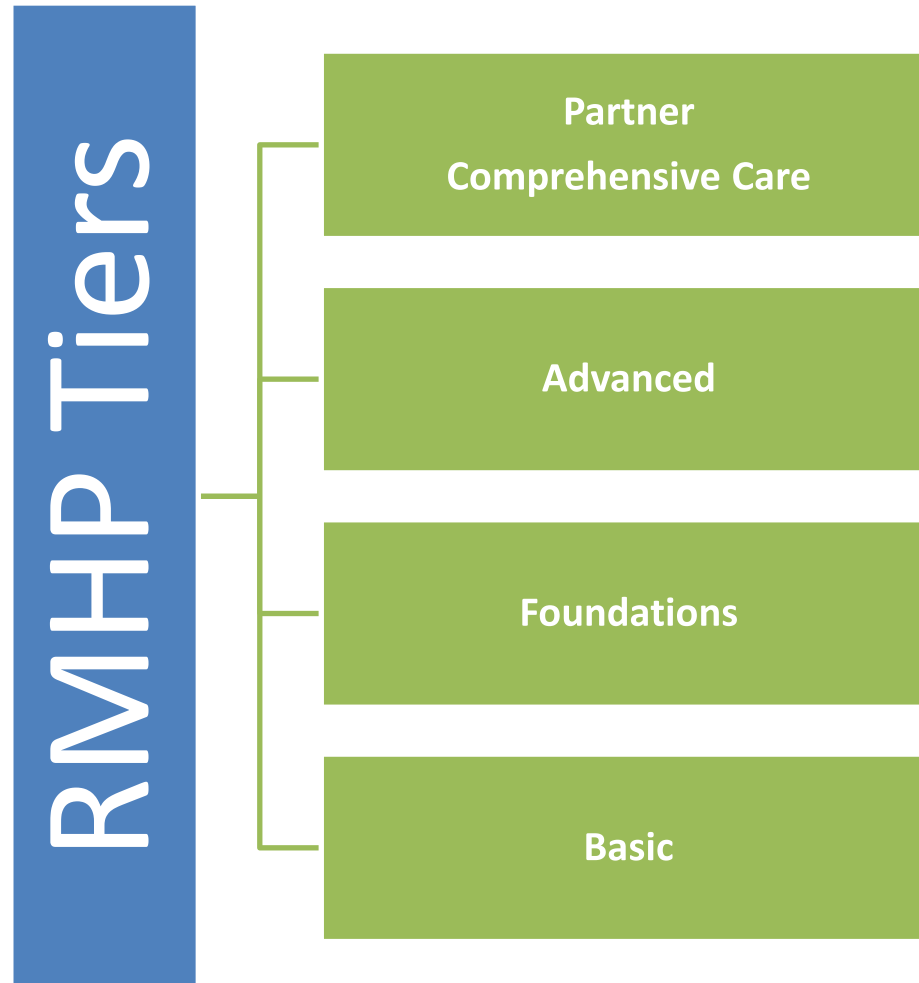
- **Clinical** policy and utilization management
- **Quality** improvement & key performance indicators
- **Data** sharing & business intelligence
- **Compliance** & BH network quality assurance
- **Financial** performance
- **Community Leads:** Health alliances, SDoH, public health

RMHP Practice Tiering Program

Basic to Comprehensive Care

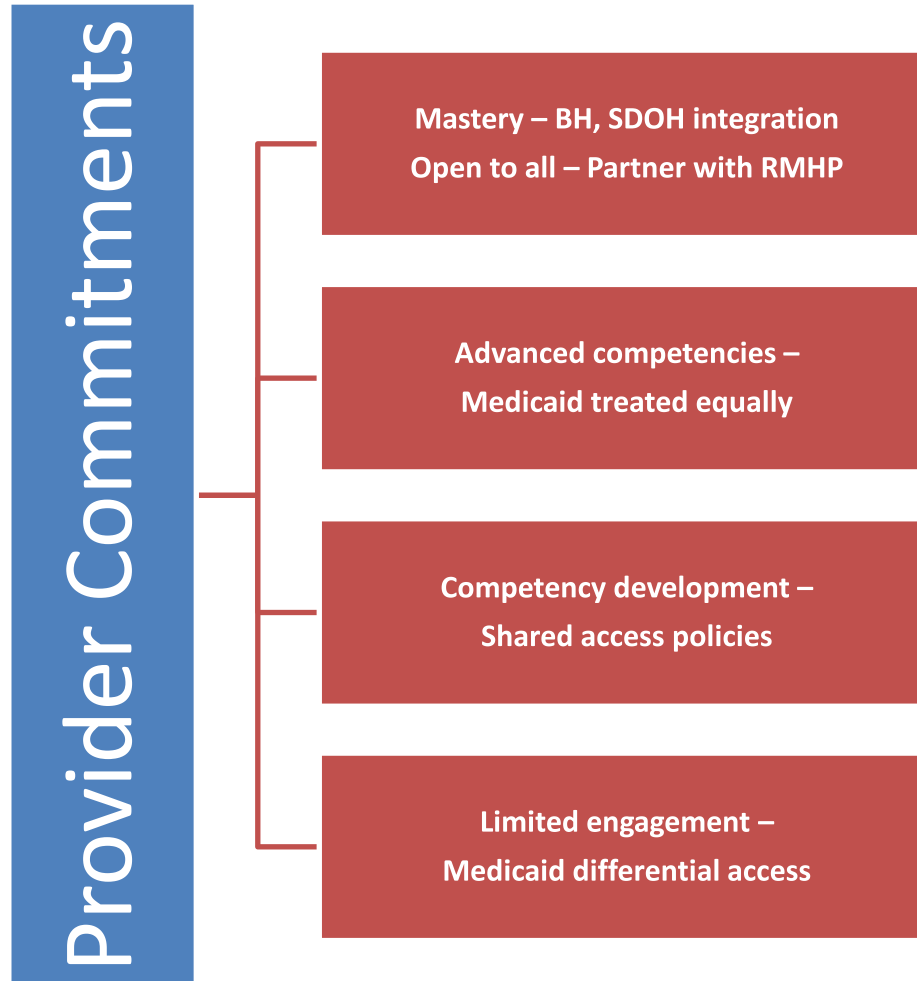


It's not who you are – it's what you do.



*See pages 21-23 of RMHP *Orientation Guide* for detail

It’s not who you are – it’s what you do.



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Measurement Evolution

Five key measures of value

Avoided Costs / Prometheus	• SUD • Chronic Conditions
Patient Engagement	• Patient Activation (PAM™) • Timely MH Access
Practice Measure Alignment	• Depression mgt • Diabetes mgt

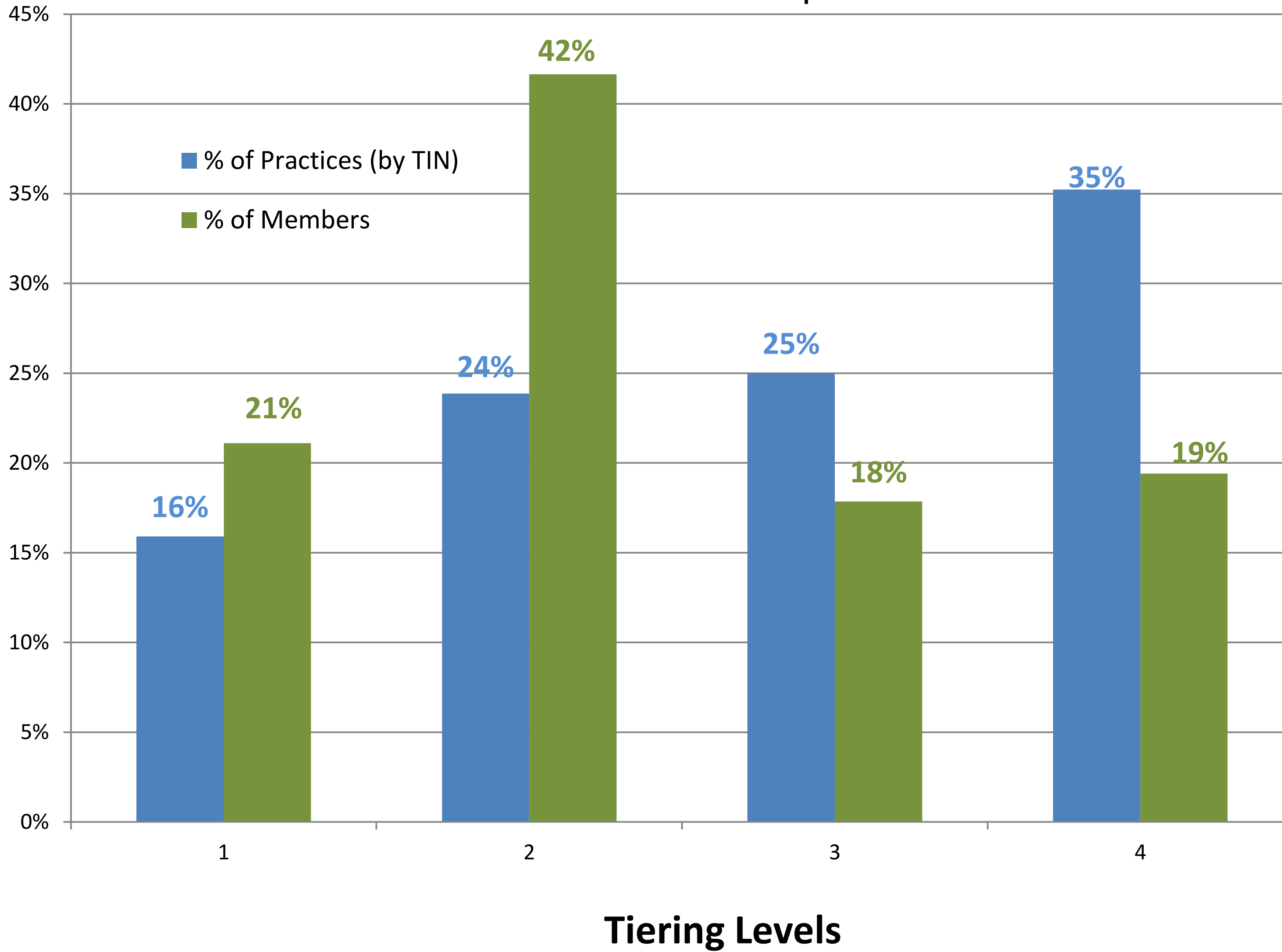
Objective, regular assessment

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

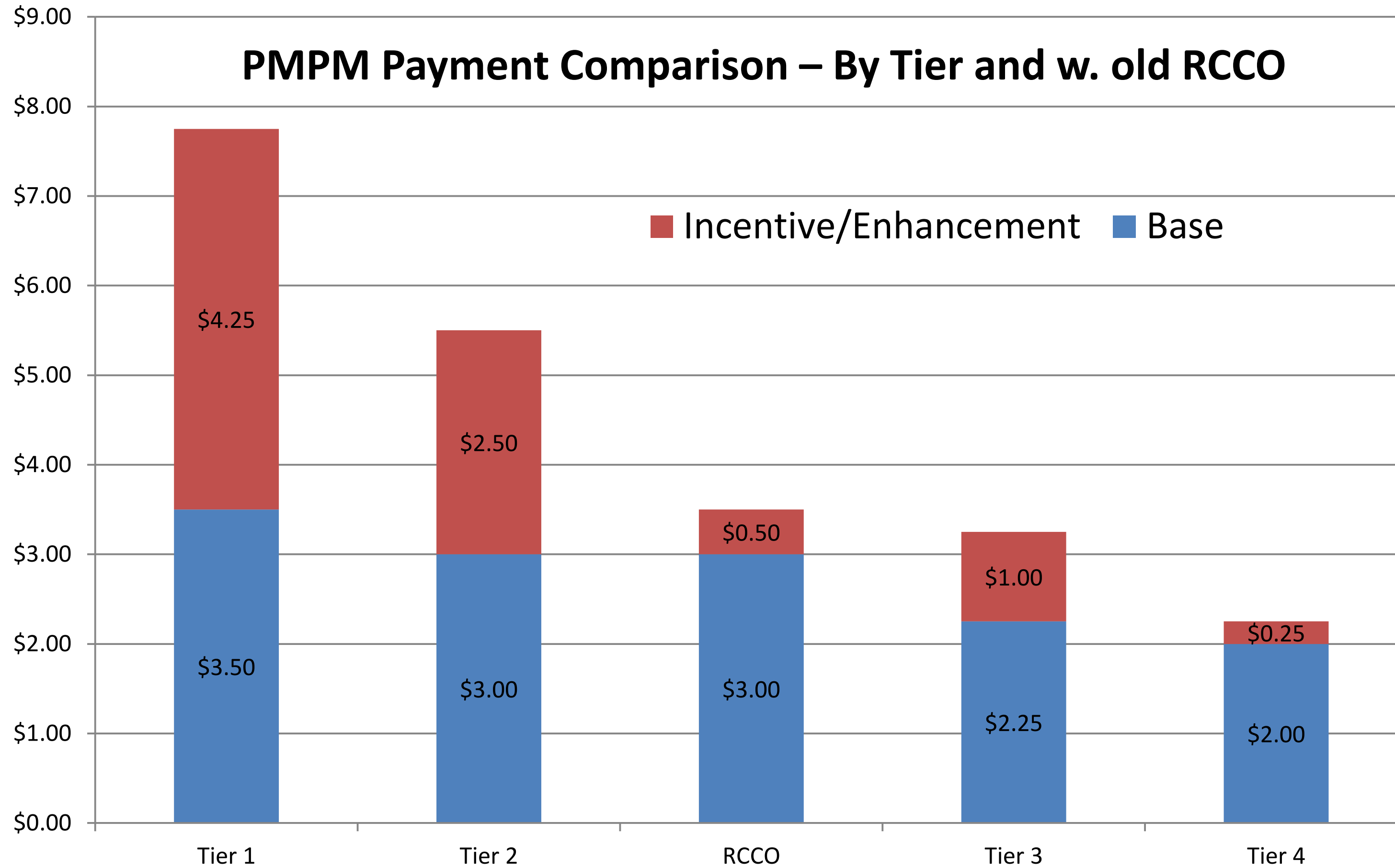
- Achieve ≥80% on appropriate assessment
  - Tier 4 Assessment – none
  - Tier 3 Assessment – semi-annually
  - Tier 2 Assessment – quarterly
  - Tier 1 Assessment – quarterly
- Achieve Medicaid APM scoring thresholds
  - Tier 4 – Medicaid APM score of 0-25%
  - Tier 3 – Medicaid APM score of 26-50%
  - Tier 2 – Medicaid APM score of 51-75%
  - Tier 1 – Medicaid APM score of 76-100%
- Submit 6 CQMs quarterly AND annually meet or exceed the 70th percentile CMS benchmarks
  - Tier 4 – none
  - Tier 3 – 2/6 eCQMs must meet or exceed the 70th percentile of the current CMS benchmarks
  - Tier 2 – 4/6 eCQMs must meet or exceed the 70th percentile of the current CMS benchmarks
  - Tier 1 – 6/6 eCQMs must meet or exceed the 70th percentile of the current CMS benchmarks
- Be open to Medicaid
  - Tier 4 – Not open to new Medicaid.
  - Tier 3 – Limited, intermittent availability for new Medicaid patients
  - Tier 2 – Open with equitable panel management processes and tools applied in order to maintain current Medicaid attribution numbers (at a minimum). Attach processes and tools.
  - Tier 1 – Open to new Medicaid

Our commitment – data production & transparency

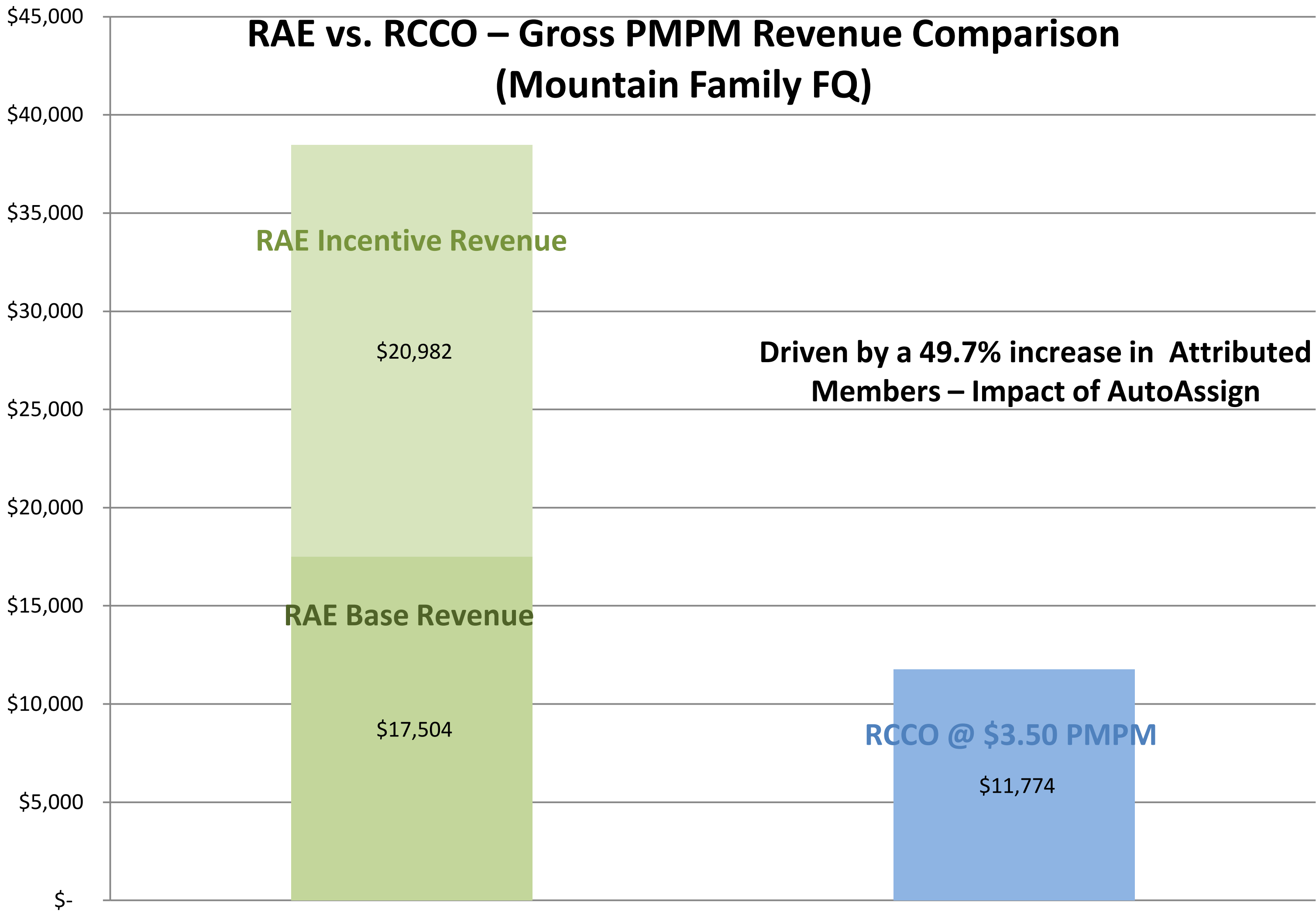
- **Quarterly:** Plan financial performance – BCR, COS, Incentives;
- **Quarterly:** Key performance Indicators, aggregate & provider-specific provider quality and utilization against risk-adjusted targets;
- **Monthly:** Attribution, risk-adjustment, "assigned but not attributed" (leakage);
- **Monthly:** Raw data – eligibility/COA, COS, cpt, dx, Rx, allowed amounts.



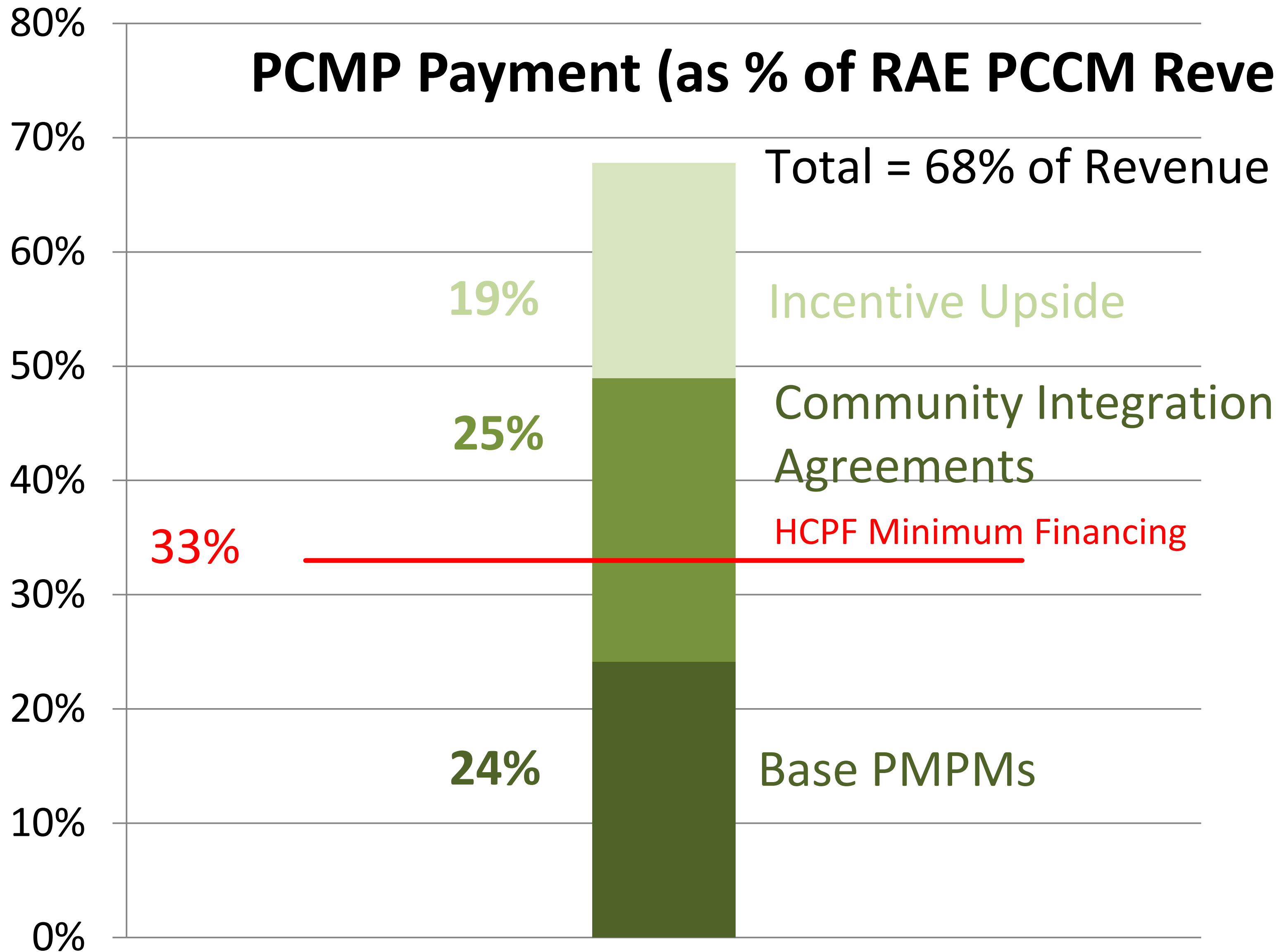
Distribution of Practices and Attributed PCMP Membership
% of Practices (by TIN)
% of Members
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
16%
21%
24%
42%
25%
18%
35%
19%
1
2
3
4
Tiering Levels



PMPM Payment Comparison – By Tier and w. old RCCO
Incentive/Enhancement
Base
$9.00
$8.00
$7.00
$6.00
$5.00
$4.00
$3.00
$2.00
$1.00
$0.00
$4.25
$3.50
$2.50
$3.00
$0.50
$3.00
$1.00
$2.25
$0.25
$2.00
Tier 1
Tier 2
RCCO
Tier 3
Tier 4



RAE vs. RCCO – Gross PMPM Revenue Comparison
(Mountain Family FQ)
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-
RAE Incentive Revenue
$20,982
RAE Base Revenue
$17,504
Driven by a 49.7% increase in Attributed Members – Impact of AutoAssign
RCCO @ $3.50 PMPM
$11,774


PCMP Payment (as % of RAE PCCM Revenue)
80%
70%
60%
50%
40%
30%
20%
10%
0%
Total = 68% of Revenue
19%
Incentive Upside
25%
Community Integration Agreements
33%
HCPF Minimum Financing
24%
Base PMPMs

BH Integration Strategy

BH Integration Support

- **Community Integration Agreements:** Direct payments to top tier primary care for integrated behavioral health consultants. Defined budgets and FTE.
- **SDoH Investments:** Additional funding to support CHWs and transportation for defined patient cohorts.
- **Six visits:** State expansion of BH benefit to fund six visits of therapy. RMHP funds additional visits when necessary – subject to Measurement-Based Care requirements.
- **Value-based payments:** Primary care and mental health centers receive shared savings / performance incentives when provider and plan targets are hit.

The “Six Visit” Benefit Expansion

Provider Type: The Billing provider must be a contracted PCMP billing as one of the following primary care provider types: clinic (primary care); Federally Qualified Health Center (FQHC); Rural Health Center (RHC); Indian Health Center (IHC); or non-physician practitioner group. This excludes any primary care provider that is on the same site as a Medicaid enrolled community mental health center CMHC.

Rendering Provider: the rendering provider offering the service in the PCMP clinic must be a Medicaid enrolled, licensed behavioral health clinician which may include: Licensed clinical social worker; licensed marriage and family therapist; licensed professional counselor; licensed addition counselor; or licensed PhD psychologist. A rendering provider in a PCMP clinic does not need to be credentialed by the RAE and contracted as a behavioral health network provider unless the rendering provider wants to provide 7 or more short-term behavioral health visits within the state fiscal year.

90791	Diagnostic Evaluation without Medical Services
90792	Diagnostic Evaluation with Medical Services
90832	Psychotherapy – 30 minutes
90834	Psychotherapy – 45 minutes
90837	Psychotherapy – 60 minutes
90846	Family Psychotherapy (w/o patient)
90847	Family Psychotherapy (with/patient)

What has to work.

1. **Payment model –** Basic FFS, enhanced pmpms, risk-adjusted capitation, incentives & shared savings – designed and executed from the “ground-up”.

2. **Clinical transformation –** boots on the ground, human intelligence, regular quarterly meetings. eCQM, HIE and advanced measures collection and state reporting.

3. **Network & configuration –** Claims must pay accurately, encounter accurately and be reported to both the state and providers regularly and accurately.

4. **Shared care management –** external deployment of care mgt and stratification intelligence. Willingness to share (contractually) in design, oversight and decision-making.

5. **Authentic BH Integration –** Plan and partners run CM, UM, network, tiering, CHW, peer and community capacity development.