PRIME PROJECT SUMMARY

PRIME is a Medicaid payment model being tested in Colorado for primary care. The program is sponsored in partnership with Rocky Mountain Health Plans, the state's Health Care Policy and Financing who oversees Medicaid, multiple primary care practices, and Mind Springs Health/Whole Health. The program aims to pay providers differently with a goal of reducing ER visits, improving quality, and lowering costs. The savings are shared between all of the partners and therefore much are reinvested back to the community. It started as a pilot in 2014 and involved six (6) counties in western Colorado, and now has moved beyond pilot stage to ongoing. There is a hope to expand in the future to other communities.

The PRIME concept began in 2011 with discussions between Mind Springs Health and Rocky Mountain Health Plans. The state payment environment was one that paid for behavioral health separately, or carved out, from physical health. Mind Springs, as a community mental health center (CMHC) was paid a per member per month (PMPM) sub capitation and was in a full risk based contract with its Behavioral Health Organization. Rocky Mountain was planning to bid on the state's new model Regional Accountable Care Organization (RCCO) request for proposal (RFP), released in 2012, that would pay insurance companies $3 PMPM to help with care coordination starting in July 20013. Additionally, the state payment environment was starting discussion about carve in and integrated care as well as future testing a payment reform model. Mind Springs and Rocky Mountain saw opportunity and began conversation.

The conversation led to the design of a conceptual model based on paid claims. Paid claims were reviewed for the past three (3) years for both behavioral health and physical health. As the paid claims came from two separate contracts held by two separate insurance companies, actuaries helped with the translation and the modeling of a "whole person" spend for over 30 different categories. We looked at the spend in the ER, inpatient psychiatric and inpatient primary care, labs, prescription, outpatient visits, specialty care, etc. A logic model was developed that argued the case of spending additional funding for behavioral health and paying primary care differently, physical health care costs would decrease. We estimated savings of approximately $13 PMPM over a three-year period.

The model was submitted to the state in 2013 in response to a payment RFP and was selected to be implemented in six (6) counties. Initially, there were about 29,000 covered lives; today there are about 38,000 covered lives and the test period began July 2014. It has been in effect FY 2015, 2016, and 2017. The model included hiring Community Health Workers (CHW) to help address high ER use, paid PCPs on a sub capitation PMPM rate for managing a patient population (this

allowed the PCP office to hire care coordinators and care managers), and paid for behavioral health clinicians embedded in primary care.

In its first year, it had documented savings of about $15 PMPM. The quality metrics include completion of the PHQ 2 and then moved to the HEIDIS measurement of number of people who renew antidepressants, BMI, A1C measures, and screening and follow-up on the Patient Activation Measure (PAM™). Mutual interdependence was hard baked, in that unless all measures hit the mark the shared savings pool was significantly less. The second year also yielded similar success and the third year resulted in the depression measure not being achieved (due primarily to data collection issues regarding a hybrid HEDIS measure), so the shared savings is much less. In the subsequent year, the state agreed to base depression management performance directly on CMS-recognized clinical quality measures (eCQM) collected from primary care electronic health records.

For the future, there is hope to expand beyond the original six (6) counties and to continue to use data to reevaluate both quality and cost. Additional changes may entail a shift from a retrospective, "shared savings" model to prospective incentive arrangements, and to a tiered network based upon assessed practice transformation, integration and performance.