A NORTHEAST HEALTH PARTNERS, LLC RESPONSE TO:

The Colorado Department of Health Care Policy and Financing Request for Proposals, Solicitation # 2017000265 Regional Accountable Entity for the Accountable Care Collaborative for Region 2

PROPOSAL SUBMISSION DEADLINE: July 28, 2017, 3:00 p.m. Mountain Time

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EXECUTIVE SUMMARY

Northeast Health Partners, LLC (NHP) is excited for this opportunity to provide our proposal to the Colorado Department of Health Care Policy and Financing (Department) to serve as the Regional Accountable Entity (RAE) for Region 2 of the Department's Accountable Care Collaborative.

The Department has expressed its intent to re-invent and innovate every aspect of Health First Colorado's physical, behavioral and long term services and supports programs to promote improved health for Members by delivering care in an increasingly seamless way. It is asking interested parties to propose a regional based RAE that achieves the following goals: (1) Expand access to comprehensive primary care; (2) Ensure access to a focal point of care (i.e., Medical Home) for all Members; (3) Ensure a positive Member and provider experience; and (4) Apply an unprecedented level of statewide data and analytics functionality. NHP is excited about the opportunity to respond to the Department's challenge with a proposal for a Region 2 RAE designed to achieve these goals and make it easier for Members and providers to navigate the system at the same time it makes smarter use of every dollar spent.

NHP's RAE proposal has the support of the Colorado Health Foundation and leading Region 2 provider groups

NHP is a joint partnership between two Federally Qualified Health Centers (FQHC), Sunrise Community Health (Sunrise) and Salud Family Health Centers (Salud), along with the Northeast Region's Community Mental Health Centers, Centennial Mental Health Center, Inc. (Centennial), and North Range Behavioral Health (North Range). The organizations that are forming NHP have deep roots providing health care services to the under-served and disadvantaged populations of Region 2 and have demonstrated their commitment to improving the lives of these individuals. The NHP partners also have demonstrated experience in servicing the current Regional Care Collaborative Organization (RCCO) and the Behavioral Health Organization (BHO) programs. To supplement this local knowledge and expertise, we will be supported by the national experience of Beacon Health Options (Beacon) who will provide administrative service support. Our four organizations have formed this partnership due to our strong belief that we will be able to operate the Region 2 RAE in a way that meets the "fundamental premise of the Program that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all Members."

LOCAL EXPERIENCE AND KNOWLEDGE OF REGION 2

NHP's partner organizations represent the largest medical and behavioral health care providers serving the Health First Colorado program in Region 2. Together, our partners represent over 30 physical and behavioral health care provider sites across Region 2. As the Department noted in its RFP, "A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to Members." As you will note in our response, NHP partnering organizations have a longstanding and successful history of collaborating with one another to provide a more coordinated delivery experience to the individuals living in Region 2. Combining our service delivery into one entity will allow us to build upon this collaboration and improve the Member experience by creating one point of contact and clear accountability for treating the whole person. Our deep roots in the counties that comprise Region 2 will ensure we can establish critical community linkages. This will include collaborating with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex Member needs that span multiple agencies and jurisdictions that the success of the RAE will be dependent upon.

NHP partners bring the following experience serving the Health First Colorado membership and the safety-net community. The vast majority of these Members reside in Region 2:

- Salud serves more than 4,000 uninsured local residents and more than 9,000 Medicaid Members each year
- North Range serves more than 3,000 uninsured local residents and more than 9,000 Medicaid Members each year
- Centennial serves more than 889 uninsured local residents and more than 2,500 Medicaid Members each year
- Sunrise serves more than 9,500 uninsured local residents and more than 21,000 Medicaid Members each year

The success of the Region 2 RAE to meet the goals of the program will be highly dependent upon its ability to serve Members in rural and frontier counties. Although Weld is the most populated county in the region, its 4,000 square mile footprint includes many rural areas. Five of the 10 counties included in Region 2 are classified as 100 percent rural. We are uniquely qualified to address this issue as we are intimately familiar with servicing a rural population with limited resources. To meet the needs of rural counties, the partners that comprise NHP have individually and collectively developed an extensive network of crisis and community-based alternative services, enabling people to be treated in their local communities, instead of depending upon services in the urban and metro areas that are sometimes hours from their homes.

EXPERIENCED LEADERSHIP AND PROVEN INFRASTRUCTURE

NHP can provide the Department with a high level of assurance that it will successfully implement and launch the Region 2 RAE and immediately begin focusing on key performance indicators. We can confidently provide this assurance based upon the experienced health care executives that are prepared to step into key RAE leadership positions and a proven IT infrastructure designed to meet the requirements of the Health First Colorado program.

The participating partners in NHP will build upon their previous experience of collaborating with each other to establish a management structure with clearly defined lines of responsibility and designed to facilitate interaction with the Department and Colorado's Region 2 Health First Colorado Members. In our review of the RAE's Scope of Work, we identified a need for a new type of partnership bringing together local, experienced organizations that serve the physical and behavioral health needs of Members through well designed care coordination, public health education, and provider transformation programs. Our Program Officer will be the main point of contact for the Department, with all other positions supporting the RAE reporting up to this individual. They will work out of an existing administrative office in Region 2, with all key personnel and the majority of the supporting staff located in one central location.

NHP will be a data-driven organization and, as such, will integrate a comprehensive set of information systems to meet the operational and strategic health information needs of Region 2 and the Department. The core systems that will be used by NHP are already operational and in use by our administrative agent, Beacon for the BHO and RCCO programs. These systems are also already fully integrated into the Colorado interChange, the Department's health information systems and the new Business Intelligence and Data Management (BIDM) system. NHP and Beacon have not only invested in data systems that integrate with the Department, but also systems and integrations for providers so that all of our Region 2 Provider, Health Neighborhood, and stakeholder partners can continue to perform their duties using the systems they have invested in or adopt our systems. This flexible approach accommodates the needs of the community we serve and will enhance our ability to successful connect the Region 2 network.

NHP's data and analytics strategy will be sophisticated, but also realistic. We will balance high-tech with high-reliability and create a system of people, process and technology that can meet any provider where they are to share actionable analytics in a meaningful and efficient manner. As a result of our experience we have learned that while health information standards exist, the most successful managed care organization provides multiple options to the provider community so that any provider can find a meaningful way to receive information and collaborate with the organization. We believe the RAE's role is to provide actionable and impactful information to providers that augments what they will leverage from other Department investments like BIDM.

REGION 2 SPECIFIC APPROACH TO MEET THE GOALS OF THE PROGRAM

The successful launch and operation of the Region 2 RAE cannot be achieved solely on the basis of having an experienced team and an operational IT infrastructure. To fully achieve the goals of the program, the RAE proposal must propose a Region 2 specific operational plan that will:

- Promote Members' physical and behavioral well-being by creating Health Neighborhoods consisting of a diverse network of health care providers and Community organizations providing services to residents within Region 2
- Demonstrate an understanding of the health disparities and inequities in Region 2 and develop plans with Providers, Members and Community Stakeholders to optimize the physical and behavioral health of its Members
- Understand that population health management requires a detailed understanding of the distribution of health conditions and health related behaviors, and is strengthened by the consideration of social determinants of health, such as income, culture, race, age, family status, housing status, and education level
- Ensure that Care Coordination is part of the Contractor's Population Health Management Plan

Our approach to building the Health Neighborhood is characterized by the following values:

1. Leveraging our long-established relationships across the spectrum of health and human services providers and organizations throughout the Region
2. Maximizing technology to support analytics, communication, coordination and innovation across the Health Neighborhood and among community partners
3. Participating actively as a good neighbor in local, regional and state collaborations, initiatives and policy-making consortia to develop meaningful solutions that improve health and well-being of Health First Colorado Members and their families

Through our own experiences and multiple collaborations, we have built an in-depth understanding of the health disparities and inequities in Region 2. Recognizing that the conditions in which Members live also impact their health and well-being, each NHP partnering organization has established relationships, independently and collaboratively, with economic, social, educational, justice, vocational, recreational and other relevant organizations to promote the health of local communities and populations. Although social determinants of health are not static and intersect on a multitude of fronts, we will initially focus on the following in Region 2:

- Across the region, close to 50 percent of school age children are enrolled in the Free and Reduced School Lunch program, reflecting their low-income level. Morgan County reports the highest rate at 63 percent and Phillips County reports the lowest at 39 percent
- Another indicator of well-being is the percentage of children living in poverty. Depending on the county, a range of between 14 and 25 percent of children in a county are living in poverty
- Between 2002-2014, rural Colorado saw a 140 percent increase in opioid overdose deaths, compared to a 96 percent increase in urban areas during the same time frame. Washington County saw the biggest increase in the state, with a 400 percent increase in opioid overdose deaths between '02-'14
- Although all counties in the region have behavioral health access through Centennial and North Range, additional network providers are not prevalent in the most remote counties and tele-psychiatry and tele-health are critical initiatives to assure access for all Members.

- Cheyenne County does not have a dentist or a physician[1]

We have developed a Region 2 specific population health plan based upon a comprehensive analysis of the needs of the community and their congruence with local, state and national health priorities. Initially, we assessed the priorities that have been identified by each of the public health departments in our region to find consistent issues. Subsequently, we analyzed State level priorities and evidence-based interventions from the Colorado Opportunity Project and Colorado's 10 Winnable Battles. Finally, we reviewed priorities and requirements that impact FQHCs and primary care providers (UDS and national quality targets through HEDIS and to a lesser extent MACRA). Our goals in developing the Population Health Management Plan are to focus on high priority areas and to reduce duplication of effort for Primary Care Medical Providers wherever possible. The initial specific major interventions NHP will implement include the following:

- Care Coordination/Case Management
- Wellness Technology: Text4Health
- Reduce incidence of smoking through a text solution and QuitLine
- Suicide prevention—use Zero Suicide Teams
- Reduce Emergency Department Visits for Ambulatory Sensitive Conditions
- Improve number of children with at least 90 days of continuous program enrollment that have had a well-child visit within a rolling 12-month period
- Improve prenatal care rates for pregnant women

NHP will continue the successful Care Coordination approach that is currently in place in Region 2 that combines best practices of delegated community-based Care Coordination with a strong central resource for specialized services, transitions of care, program management, training and evaluation. Our care coordination program includes a range of activities to organize and facilitate the appropriate delivery of health and social services that support our population health plan and Member health and well-being.

SUMMARY

NHP is uniquely prepared to deliver immediate value to the Department in its effort to launch the RAE program. It is important to note that Region 2 is the only region we are submitting a proposal for. An award to NHP for the Region 2 RAE will not represent a "consolation award", but fulfill our strong desire to provide a higher level of health care services to the community we serve and live in. Our approach was designed specifically to meet the region's unique needs. We know that the successful launch of the next iteration of the Accountable Care Collaborative program will require engaging an Offeror who will bring the Department a combination of deep and broad experience transforming state Medicaid programs, as well as local knowledge and experience working with Colorado providers in Region 2. As evidenced by the letters of support that accompany our proposal as **Attachment 1**, NHP has a broad range of support from providers and other key entities within Region 2. We also have received encouragement from Colorado Health Foundation. Upon award, the Foundation is prepared to invite NHP to apply for financial support infrastructure start-up costs and program Related Investment Support for Risk-Based Capital.

PROPOSAL CONTACT PERSON

Name: Larry Pottorff
Phone Number: 970.347.2120
Email Address: larry.pottorff@northrange.org

CORE VSS NUMBER

Northeast Health Partner's CORE VSS number is: VS50000000026813.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

See Specific Instructions on page 2. Print or type

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Northeast Health Partners LLC

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ P

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
1300 N 17th Ave

Requester's name and address (optional)

6 City, state, and ZIP code
Greeley, CO 80631

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
8 2 – 2 0 7 8 9 0 6

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 7/18/17

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

OFFEROR'S RESPONSE 1

Provide documentation demonstrating how the Offeror meets all mandatory qualification requirements including, at a minimum, the following information:

a. Offeror's legal name and address, number of years in business under this legal name, total number of employees, including contracted staff, and the organization's location(s), including any in Colorado.
b. Documentation of the Offeror's licensure required to perform the Work and verification that the licensure is not suspended, revoked, denied renewal or found to be noncompliant by the Colorado Division of Insurance. If the Offeror is not licensed as required by the Colorado Division of Insurance at the time the proposal is submitted, the Offeror shall attest that the appropriate licensure shall be obtained prior to executing a Contract with the Department.
c. Attestation that the Offeror meets the requirements of a PCCM Entity and a PIHP.

A. OFFEROR'S INFORMATION

Northeast Health Partners, LLC (NHP) is new legal entity created specifically to serve the Department and Colorado's Medicaid Members as the Region 2 Regional Accountable Entity (RAE). NHP is a partnership composed of four provider organizations with a long-established relationship serving economically disadvantaged individuals in Region 2. In our review of the Department's RFP, we identified a need for a new type of partnership bringing together local, experienced organizations currently serving the physical and behavioral health needs of Members operating well established care coordination, education, transformation, and administration programs and processes. By combining the resources and knowledge of Plan de Salud del Valle, Inc. (Salud Family Health Centers or Salud), North Range Behavioral Health (North Range), Centennial Mental Health Center (Centennial), Sunrise Community Health (Sunrise), and Beacon Health Options, Inc. (Beacon), this new partnership brings experienced Medicaid provider and service organizations together with equal stakes in the success of the RAE, and shared risk in the management of the capitated behavioral health benefits.

As the Offeror, NHP provides the required information in the table below. As you will note, our new organization leverages the complimentary experience and expertise of our partner organizations and blends the best attributes of local, regional, and national organizations to better serve Colorado's Medicaid Members in Region 2. This innovative collaboration offers the Department the best of local organizations (Salud, Sunrise, North Range, and Centennial) with deep roots in the counties that Region 2 is composed supported by a nationally recognized managed care organization (Beacon).

Required Information	Response
Legal Name	NHP Partners, LLC (NHP)
Address	1300 N 17th Ave. Greeley, CO
Number of years in business under this legal name	NHP is a newly formed organization created specifically to deliver integrated health care services for RAE Region 2.
Total number of employees, including contracted staff	NHP is composed of four partner organizations that collectively employs approximately 1,500 individuals. Details of our staffing plan are provided below in response to Offeror's Response 5.
Organization's location(s)	1300 N. 17th Avenue Greeley, CO 80631

NHP's partner organization represent the largest medical and behavioral health care providers in Region 2. Together, our partners represent over 30 physical and behavioral health care provider

sites across Region 2. In addition, our subcontractor partner Beacon has administered behavioral health benefits for Colorado's Medicaid programs since 1995 in the South/West Service Area under various organizational structures, in the Metro West Service Area since 2009, and served the Northeast Service Area from 2009 to 2014. Beacon has been a national managed behavioral health care organization for 30 years, and NHP's provider partners each have more than 35 years serving the needs of the residents of Region 2.

In the following tables, we provide the legal name and address; number of years in business under the legal name; total number of employees, including contracted staff; and locations for each of our partner organizations.

Required Information	Response
Legal Name	Plan de Salud del Valle, Inc. dba Salud Family Health Centers
Address	203 South Rollie Avenue Fort Lupton, Colorado 80621
Number of years in business under this legal name	47 years
Total number of employees, including contracted staff	661
Organization's location(s)	**Administrative and Training Center** 203 S. Rollie Avenue Fort Lupton, CO 80621 **Clinic Locations** 1860 Egbert Street Brighton, CO 80601 30 S. 20th Avenue Brighton, CO 80601 6255 Quebec Parkway Commerce City, CO 80022 4371 E. 72nd Avenue Commerce City, CO 80022 1950 Red Tail Hawk Drive Estes Park, CO 80517 1635 Blue Spruce Drive Fort Collins, CO 80524 1830 Laporte Avenue Ft. Collins, CO 80521 1115 Second Street Fort Lupton, CO 80621 729 E. Railroad Avenue Fort Morgan, CO 80701 5995 Iris Parkway Frederick, CO 80530 220 E. Rogers Road Longmont, CO 80501 1410 S. 7th Avenue Sterling, CO 80751

Required Information	Response
Legal Name	North Range Behavioral Health (North Range)
Address	1300 N. 17th Ave, Greeley, CO 80631
Number of years in business under this legal name	20 years as North Range Behavioral Health, 26 years prior as Weld Mental Health Center
Total number of employees, including contracted staff	487
Organization's location(s)	All offices are in Weld County. Colorado. North Range has behavioral health consultants integrated within all of the Weld County Sunrise and Salud practices and within the North Colorado Family Medicine practice.

Required Information	Response
Legal Name	Centennial Mental Health Center (Centennial)
Address	211 Main Street, Sterling, CO 80751
Number of years in business under this legal name	38 years
Total number of employees, including contracted staff	192
Organization's location(s)	With a Corporate office in Sterling, Colorado, Centennial operates and establishes offices in each of the following local markets served. 871 E 1st Street, Akron, CO 80720 1291 Circle Drive, Burlington, CO 80807 80 E. 1st, Suite 2, Cheyenne Wells, CO 80810 650 E. Walnut, Elizabeth, CO 80107 (RAE Region 3) 821 E. Railroad Avenue, Fort Morgan, CO 80701 115 N. Campbell, Holyoke, CO 80734 118 W. 3rd Avenue, Julesburg, CO 80737 606 Main Street, Limon, CO 80828 211 W. Main Street, Sterling, CO 80751 1112 N. Fourth Street, Sterling, CO 80751 (supported housing and crisis residential respite) 365 W. 2nd Street, Wray, CO 80758 215 S. Ash, Yuma, CO 80759 Centennial has behavioral health consultants integrated within: Salud: 1410 S. 7th Avenue Sterling, CO 80751 Salud: 729 E. Railroad Avenue Fort Morgan, CO 80701 Peak Vista: 820 1st Street, Limon, CO, 80828

Required Information	Response
Legal Name	Sunrise Community Health (Sunrise)
Address	2930 11th Avenue, Evans, CO 80620
Number of years in business under this legal name	44
Total number of employees, including contracted staff	415
Organization's location(s)	Kid's Care Clinic. 1400 37th Street, Evans, CO 80620 Loveland Community Health Center, 302 3rd Street SE Loveland, CO 80537 Monfort Children's Clinic, 100 N 11th Avenue, Greeley, CO 80631 Monfort Family Clinic, 2930 11th Avenue, Evans, CO 80620 Sunrise Adelante Clinic, 1010 A Street, Greeley, CO 80631 Sunrise Family Dental, 1006 A Street, Greeley, CO 80631 Sunrise North Range Clinic (hosted at North Range Behavioral Health), 1300 N 17th Avenue, Greeley, CO 80631 Sunrise SummitStone Clinic (hosted at SummitStone Health Partners), 1250 N Wilson, Loveland, CO 80537

Required Information	Response
	970-494-9789 Weld County Prenatal Clinic (hosted at Weld County Health Dept), 1555 N 17th Avenue, Greeley, CO 80631 Sunrise Outreach Services – mobile health van delivering care throughout Weld and Larimer counties; based at 2930 11th Avenue, Evans, CO 80620

Required Information	Response
Legal Name	Beacon Health Options, Inc. (Beacon)
Address	200 State St., Suite 302, Boston, MA 02109
Number of years in business under this legal name	Beacon has operated under the name Beacon Health Options, Inc. for one and one-half years. On December 9, 2015, Beacon changed their name from ValueOptions, Inc. to Beacon Health Options, Inc. Prior to the name change, Beacon operated as ValueOptions, Inc. for 30 years.
Total number of employees, including contracted staff	5,115
Organization's location(s)	Headquartered in Boston, Massachusetts, Beacon operates and establishes offices in each of the local markets they serve. Beacon has over 70 offices across the US and the UK, including the following locations that will support the RAE contract for Region 2: • 9925 Federal Dr., Suite 100, Colorado Springs, CO 80921 • 7979 East Tufts Ave., Suite 820, Denver, CO 80237 • 4 British American Blvd., Bldg. 4, Latham, NY 12110

b. OFFEROR'S LICENSURE

Salud, North Range, Centennial, and Sunrise have joined to form NHP. NHP will have all necessary licenses, certifications, approvals, insurance, and permits required to perform the services described in this RFP and proposed in our response, including a Certificate of Authority by July 1, 2018.

NHP has already met with the Colorado Department of Insurance to discuss the organization and to obtain guidance on licensing procedures. There were no barriers identified and, as required, NHP is moving forward with a Limited Service Licensed Provider Network (LSLPN) as required in *Section 4.1* in the RFP, and will have it in place prior to July 1, 2018.

c. PIHP AND PCCM ENTITY ATTESTATION

NHP certifies that we meet the federal requirements of a Primary Care Case Management Entity (PCCM Entity) set forth in 42 C.F.R. § 438.2, and as a Prepaid Inpatient Health Plan (PIHP). NHP is a Limited Service Licensed Provider Network (LSLPN), as defined by 3 CCR 702-2, Colorado Insurance Regulation 2-1-9. This will qualify us to meet the requirements of a PCCM Entity. Also, as defined in 42 CFR § 438.2, by virtue of engaging Beacon as our administrative agent we are able to attest to meeting this requirement as detailed below.

PCCM Entity Attestation

> *Primary Care Case Management Entity (PCCM Entity) – An organization that provides any of the following functions, in addition to PCCM services, for the state: provision of intensive telephonic or face-to-face case management; development of enrollee care plans; execution of contracts with and/or oversight responsibilities for the activities of fee-for-service providers in the Fee-for-Service program; provision of payments to Fee-for-Service providers on behalf of the state; provision of enrollee outreach and education activities; operation of a customer service call center; review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; coordination with behavioral health systems/providers; coordination with long-term services and supports systems/providers as defined in 42 C.F.R. § 438.2.*

As a current Behavioral Health Organization (BHO) member for the South/West and Metro West Service Area, and the administrative services organization for Integrated Community Health Partners, LLC (ICHP), the current Regional Care Collaborative Organization (RCCO) for Region 4, Beacon provides the following functions for the state:

- Provision of intensive telephonic, face-to-face and Skyping/videoconferencing case management
- Development of Member care plans
- Execution of contracts with and/or oversight responsibilities for the activities of fee-for-service (FFS) providers
- Provision of payments to FFS providers on behalf of the state
- Provision of Member outreach and education activities
- Operation of a customer service call center
- Review of provider claims, utilization, and practice patterns to conduct provider profiling and practice improvement
- Implementation of quality improvement activities including administering Member satisfaction surveys or collecting data necessary for performance measurement of providers
- Coordination with behavioral health systems/providers

PIHP Attestation

NHP certifies that we meet the federal requirements of a Primary Care Case Management Entity (PCCM Entity) set forth in 42 C.F.R. § 438.2, and as a Prepaid Inpatient Health Plan (PIHP). NHP is a Limited Service Licensed Provider Network (LSLPN), as defined by 3 CCR 702-2, Colorado Insurance Regulation 2-1-9. This will qualify us to meet the requirements of a PIHP Entity.

OFFEROR'S RESPONSE 2

Provide a detailed description of Offeror's organizational experience and skills, including specific years of experience, pertaining to each of the following:

a. Managing projects of similar size and scope.
b. Serving Medicaid covered populations.
c. Administering managed care.
d. Managing financial risk for covered services.

For Regions 1, 2, and 4, ensure the response addresses specific experience and skills working in Rural and Frontier areas.

As the Department noted in its RFP, "A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to Members." As you will note below, Northeast Health Partners, LLC (NHP) and our partnering organizations have a longstanding and successful history of collaborating with one another to provide a more coordinated delivery experience to the individuals living in Region 2. Combining our service delivery into one entity will allow us to build upon this collaboration and improve the Member experience by creating one point of contact and clear accountability for treating the whole person. Our deep roots in the counties that comprise Region 2 will ensure we can establish the linkages to collaborate with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex Member needs that span multiple agencies and jurisdictions that the success of the Regional Accountable Entity (RAE) will be dependent upon.

The organizational experience and skills detailed in the following paragraphs, demonstrates that the combined experience of NHP's partnering organization and its administrative agent meets or exceeds the requirements of *Section 4.2* of the RFP, including:

- Managing projects of similar size and scope
- Delivering and coordinating comprehensive physical and behavioral health care services spanning the continuum of care of outpatient and inpatient services in the last 15 years
- Delivering community behavioral health care for Members with serious and persistent mental illness (SPMI) and serious emotional disturbance (SED)
- Delivering and coordinating physical health care services as an administrative services organization or Primary Care Case Management entity (PCCM Entity) in the past five years
- Serving Medicaid covered populations, including children, adults, older adults, Medicare and Medicaid Members, individuals with disabilities, and individuals with multiple chronic, co-morbid conditions in the last five years
- Administering managed care with the infrastructure necessary to improve access to care, build and manage a provider network, pay claims, monitor and evaluate provider and system performance, and implement quality improvement initiatives in the last 10 years
- Managing financial risk for covered services within the last 10 years
- Delivering and coordinating health services in rural and frontier counties in the last five years that is a requirement for the Region 2 RAE
- The NHP Partners serve 100 percent of the Regions Behavioral Health Medicaid Members and are currently attributed 30 percent of the Physical Health Medicaid Members.

Even though NHP is a new entity, we bring together experience, experts, and an intimate knowledge of the both Members' needs, the region's health care infrastructure, the relationships between health care providers across the region and the Accountable Care Organization (ACO) and Behavioral Health Organization (BHO) models of care in the Northeast Service Area and Region 2. Our Region

2 RAE will build upon a broad foundation of management expertise and knowledge of the Region that we demonstrate through descriptions of several projects that are similar in size and scope to the RAE Region 2 project. These include:

- Centennial's 38 years as the primary, comprehensive mental health and substance use disorder (behavioral health) treatment provider across the 63 rugged rural and frontier communities of Northeastern Colorado.
- Salud's extensive experience as a Primary Care Medical Provider (PCMP) in four of seven Accountable Care Collaborative (ACC) regions with formal care management delegation or community integration agreements with the Regional Care Collaborative Organizations (RCCO) s serving four separate regions. Salud is an active participant in RCCO state-wide committees.
- North Range and Centennial have part-ownership in the entity that manages the Crisis System contract for Northeastern Colorado as well as ownership in Northeast Behavioral Health (NBH), along with the Community Mental Health Center serving Larimer County, SummitStone Health Partners.
- Sunrise's experience as the first PCMP in Colorado's ACC and its current experience as a PCMP in two of the seven regions with formal care management delegation or community integration agreements with two of the current RCCOs and North Colorado Health Alliance (Alliance).
- North Range and Sunrise's unique integrated care delivery model which embeds North Range behavioral health staff in Sunrise medical clinics and embeds Sunrise primary care clinicians in North Range's behavioral health clinics, providing seamless access to medical and behavioral health services across the spectrum of the Federally Qualified Health Center (FQHC) and mental health center programs.
- North Range and Sunrise's leadership role in founding the Alliance and subsequent community care management program in response to the RCCO goals and funding.

The combination of our individual and shared experiences and lessons learned throughout the years will ensure our ability to strengthen the coordination of services and advancing Team-based Care and Health Neighborhoods.

EXPERIENCE IN RURAL AND FRONTIER AREAS

With more than 40 years serving the population of Region 2, NHP's partners have delivered high quality behavioral and physical health services to residents of some of the most rural areas in Colorado. To meet the needs of rural counties, the partners that comprise NHP have individually and collectively developed an extensive network of crisis and community-based alternative services, enabling people to be treated in their local communities, instead of depending upon services in the urban and metro areas that are sometimes hours from their homes. Community and School-based services, in-home, crisis support and homeless outreach services all improve access for persons most at risk. Centennial and the BHO has a long history of ensuring that every county has a local behavioral health office so that services are available locally. Additionally, extensive telehealth networks for specialty services including psychiatry and other types of behavioral health treatment have been implemented. Salud operates a family medicine clinic in Fort Morgan and Sterling, bringing affordable primary health care to those in need in the rural parts of the region.

Section 4.2.2.7

Delivering and coordinating health services within rural and frontier counties in the last five years.

Although Weld is the most populated county in the region, its 4,000 square mile footprint includes many rural areas. Both Salud and Sunrise have robust migrant and seasonal farmworker programs which deliver affordable access to primary care via (mobile health vans) to those in need in some of the most rural areas in the county.

North Range's Experience Serving Rural and Frontier Populations:

While the area served by North Range, Weld County, has some highly populated areas, the majority of the county is rural and composed of small communities and scattered farming and ranching operations. North Range provides a number of resources to the rural and frontier areas of Region 2. It operates three intensive residential programs that service the entire region, the Acute Treatment Unit (ATU), the Withdrawal Management Unit (Detox) and the SUD Residential program, True North. These programs operate within North Range, but serve all of the counties within Region 2 as well as Larimer and Elbert County residents. North Range has also managed a 24/7/365 crisis line for the region since 1998. While this has evolved since implementation of the state-wide crisis line, North Range still acts as dispatch to the entire region and manages regional crisis transportation services. Through implementing these rural based services and the experiences we have gained through operating them will allow North Range to contribute to the ability of our Region 2 RAE to establish knowledgeable and sensitive approaches to the Members in the region's frontier and rural communities. It is important to note that some of the rural areas of Region 2 are experiencing rapid population growth and the Region 2 RAE will have to adjust its service delivery system to accommodate this growth. An example of this is three years ago, North Range identified that one of the fastest growing areas in Weld County was the "tri-town" area (Erie, Frederick, Dacono). While North Range operated clinics in the Fort Lupton area for almost 20 years, the "tri-town" area is culturally and socioeconomically different and required additional resources. North Range adjusted to this demand and opened a satellite clinic in Frederick. The success of the Region 2 RAE will require similar adjusting and enhancing of the supply of available health care service as the population continues to grow, decline or migrate.

Centennial's Experience Serving Rural and Frontier Populations

Centennial delivers services in rural communities of Fort Morgan and Sterling. In serving these two communities, we also serve the population of the surrounding more remote communities.

Known first as Northeast Colorado Mental Health Clinic, Centennial's history reflects devotion to developing and implementing outpatient services to meet the behavioral health needs of the residents of Northeast Colorado since 1956. Starting in Logan County, services were expanded over the following years to include Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties. In 1979, Northeast Colorado Mental Health Clinic combined with East Central Colorado Mental Health Clinic, which had served Elbert, Lincoln, Kit Carson and Cheyenne Counties for over 10 years, to form Centennial Mental Health Center, Inc., a private, non-profit 501(c)(3). Fast forward to 2017, Centennial is celebrating its 38th year as the primary, comprehensive mental health and substance use disorder (behavioral health) treatment provider across the 63 rugged rural and frontier communities of Northeastern Colorado. Within the last few years, Elbert County (part of Region 3 for purposes of this RAE bid) shifted into an "urban" designation based on population and proximity to Metro Denver. Of the nine counties in Region 2 that Centennial serves, two are considered rural, and the rest are frontier, with no signs of any significant change in population in the future. Despite the additional challenges, Centennial offers a robust continuum of services from prevention/early intervention, mental health and substance use disorder (SUD) outpatient treatment to crisis residential respite. Continuous improvement over the years in expanded collaborative cross-system integration, service delivery, client population growth, telehealth and co-located treatment (e.g. jails, schools and primary care), has resulted in a highly efficient model able to serve a vast rural geographic area and increase access to behavioral health services.

Salud's Experience Serving Rural and Frontier Populations

Salud has a longstanding commitment to rural and frontier communities and was founded in 1970 in response to the critical health needs of migrant farm workers in northeastern Colorado. In 1969, a large migrant labor camp located in Fort Lupton was closed by the Colorado Department of health

due to severe environmental health risks. This housing displacement, coupled with a time of social unrest in north central Colorado compounded significant health care access needs among the farmworker population and led to a proposal to establish a migrant health program in Weld County. A proposal was submitted to the U.S. Public Health Service by a Denver-based non-profit organization, the Foundation for Urban Neighborhood Development (FUND), with support from the University of Colorado School of Medicine. The proposal was funded under the Migrant Health Act and was selected because it sought to depart from traditional approaches to health care delivery and offered a comprehensive, cross-disciplinary and culturally sensitive model of care to farmworker population that uniquely combined health care delivery with attention to social determinants of health. On July 1, 1970, Salud opened for business in a small apartment in Fort Lupton. A former onion warehouse across the street was later purchased and converted into a small medical and dental facility, which was Salud's home for over a decade. In 1979, Salud acquired its first mobile unit affectionately known as "the bus," the mobile unit brought health care to the many farmworkers in Salud's growing rural service area. In the 47 years that followed, Salud has established 12 clinics in nine communities and is the health care home to 76,754 Members. Salud's integrated model offers comprehensive integrated primary care services including dental, behavioral health, pharmacy, and care coordination services. Salud maintains a strong commitment to rural communities and continues to deploy the mobile unit to provide care to farmworkers and other isolated populations. The apartment and former onion warehouse still stand in Fort Lupton and provide a reminder of the compassion that drives the mission to provide a quality integrated health care home to the communities it serves.

Sunrise's Experience Serving Rural and Frontier Populations

Sunrise has extensive experience serving migrant and immigrant populations that populate Region's 2 rural and frontier areas. We began in 1973 as a migrant health clinic focusing on providing preventive and acute health care services to these hard to reach, vulnerable, and under-served populations. Since then, Sunrise has been the health care home for migrants and immigrants from Central and South America. Recently, we have become the health care home for many of the area's newest refugees from east Africa and southeast Asia.

Sunrise has always recognized that the primary impediment to accessing health care in rural areas is lack of transportation. From the beginning, our staff delivered care from the trunk of their cars and by transporting people and their families to Sunrise clinics. In 2004 Sunrise added a mobile health unit (a large RV) to our tool kit. This mobile van has an exam room, refrigeration for medications and immunizations, and adequate space to provide care to individuals on site—in their work space, at low-income housing, and locations where other hard-to-reach populations gather and live.

From the beginning our program has also focused on providing needed primary care to migrant/seasonal farmworkers in agriculture. Despite the national decline in migrant/seasonal farmworkers, we continue our programming and staffing to reach this underserved population. We have adapted as our migrant members have adapted—we seek them out not only in the fields, but also those working in dairies, the homeless, those living in low-income housing areas, and those supporting agencies such as food banks.

Weld County is a large county—over 4000 square miles - with both urban and rural areas. Sunrise designs its operations with an understanding of the challenges faced by those living in the rural areas. For example, we recognize trips to the clinics in Greeley and Evans are not easily made for those from the rural areas so delivering as much care as possible in one visit is always the goal as well as keeping an eye on length of prescriptions, same day scheduling for tests, etc.

NORTH RANGE

a. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

North Range has partnered in several managed care endeavors in the last twenty years. North Range was part owner of Northeast Behavioral Health and later Northeast Behavioral Health Partnership (NBHP); the Mental Health Assessment and Service Agency (MHASA), later called the Behavioral Health Organization (BHO) for Northeast Colorado from 1995 to 2014.

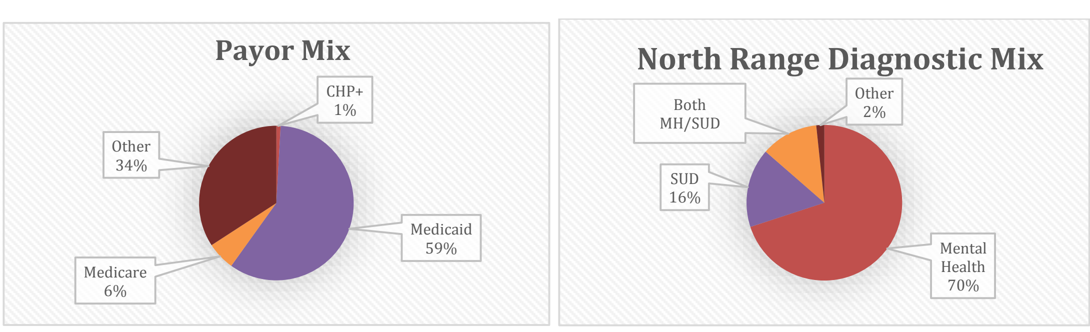
On the Substance Use Disorder side, Island Grove Regional Treatment Center which merged with North Range in 2008, was a one-third owner and the managing partner of Compass Behavioral Health Systems, LLC. Compass was the first entity in Northeast Colorado to function as a Managed Service Organization. When Signal won the contract fully in 2001, Island Grove became part owner of Signal. During the merger between Island Grove and North Range, North Range obtained that partial ownership. Signal is the largest Managed Service Organization (MSO) in Colorado.

North Range is one-third owner of the entity that manages the Crisis System contract for Northeastern Colorado as well, NBH. Northeast Behavioral Health is an Administrative Service Organization serving North Range as well as the Community Mental Health Center serving Larimer County, SummitStone Health Partners.

b. SERVING MEDICAID COVERED POPULATIONS

North Range is a behavioral health provider with more than 450 employees, serving more than 15,000 people annually, over 50 percent of these individuals—nearly 9,000 were Colorado Health First recipients in 2015-16. North Range has an annual budget of $30,000,000 and offers one of the broadest continuum of services in the state from prevention/early intervention, treatment to acute SUD and Mental Health Treatment.

Payor and Diagnostic Percentages



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Services include traditional outpatient mental health and SUD and integrated mental health and SUD. Services are offered in group, individual and family modalities at the office, in the home and in schools and other community locations. Services also include afore-mentioned ATU, Detox, Residential SUD intensive services: We also provide Intensive Outpatient services for adult SUD and adolescents. We also specialize in early childhood mental health service. Staff often collaborates with other community organizations to share insight and expertise to better serve individuals: over 45 percent of our staff work in the community, helping people “where they are” to help them achieve health.

c. ADMINISTERING MANAGED CARE

As a part owner of NBH, NBHP, Compass and Signal, North Range has successfully assumed risk in several managed care contracts and had various levels of involvement in day to day operations. NBH is the ASO for SummitStone and NRBH and manages the financial and administrative functions. In the early years, before the contract required more formal separation, many North Range staff held key roles in the management of these entities including executive director, finance director, quality assurance director and utilization manager. These roles have since become exclusive to employees of the entities and our staff no longer hold such positions. However, the institutional knowledge and understanding has allowed us to effectively participate as owners while allowing the entities to function independently.

d. MANAGING FINANCIAL RISK FOR COVERED SERVICES

North Range holds full risk contracts both on the Medicaid side with the current and past BHOs and the MSO side with Signal. This has been accomplished through collaborative work with the managing entity, creative development of community-based alternative services, and strong communication with the broader provider network to ensure the right services at the right time for Members.

CENTENNIAL

a. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

As noted above, since 2017 Centennial is celebrating its 38th year as the primary, comprehensive mental health and substance use disorder (behavioral health) treatment provider across the 63 rugged rural and frontier communities of Northeastern Colorado. Centennial offers a robust continuum of services from prevention/early intervention mental health and SUD outpatient treatment to crisis residential respite. Continuous improvement over the years in expanded collaborative cross-system integration, service delivery, client population growth, telehealth, and co-located treatment (e.g. jails, schools and primary care), has resulted in a highly efficient model able to serve a vast rural geographic area and increase access to behavioral health services.

Centennial, an equal opportunity employer with administrative offices in Sterling, now provides behavioral health services to individuals in Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. Services include a variety of behavioral health service programs: outpatient therapy, community support programs, crisis intervention, emergency response, substance use disorder, prevention and child, adult, and family counseling. Services are offered at the Centennial office in each county as well as other community locations such as private homes, schools, nursing homes, jails and hospitals.

Centennial is a one-third owner of NBH, the entity that manages the at risk contract for Colorado Crisis Services in Northeastern Colorado. NBH is an administrative service organization serving Centennial, North Range Behavioral Health as well as the Community Mental Health Center serving Larimer County, SummitStone Health Partners.

b. SERVING MEDICAID COVERED POPULATIONS

Centennial has served Medicaid covered lives since 1982, when mental health services were incorporated into the Medicaid program. With more than 180 employees, Centennial delivered 101,979 services to over 2,500 Medicaid members across the life span during Fiscal Year 2015-2016.

c. ADMINISTERING MANAGED CARE

Centennial served as Managing Partner of Compass Behavioral Health Systems, LLC (Centennial and Hope Counseling Centers, Inc.). Compass worked from 1997-2005 with a network of subcontractors to provide to the public an ADAD-defined continuum of substance treatment and related services. Compass contracted independently with providers to furnish services in locations throughout the twelve counties. In addition, Compass successfully contracted with out of area providers for services not available.

d. MANAGING FINANCIAL RISK FOR COVERED SERVICES

Centennial, as a partner of NBH, is a full risk bearing entity for the Colorado Crisis Services.

SALUD

a. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

Salud has been an active participant in ACC since the program begin in 2011. Salud is a PCMP in four of the seven ACC regions and has formal care management delegation or community integration agreements with Rocky Mountain Health Plans (RCCO 1), Colorado Access (RCCO 2 and 3) and Colorado Community Health Alliance (RCCO 6). These agreements allow Salud to offer a high level of comprehensive care coordination services to close to 40,000 RCCO Members.

One of the primary project requirements of the RAE is to understand population health management and ensure that care coordination is interventions available to Members, The Salud Care Management project begin in response to the vision of the ACC and is committed to improving health and reducing health care costs by offering comprehensive, individualized care management that empowers high-risk Members with the ability to make healthy choices and improve health. Care Managers reach out to high risk Members based on risk stratification of claims data, hospital transitions or referrals from Members of the interdisciplinary team at the point of care. Once a Member has been identified for care management, a comprehensive health needs assessment is completed to identify Member driven areas of focus for an ongoing care plan. Salud believes that a care plan must be Member centered and outline goals and actions as defined by the Member. Because Salud Care Managers are integrated in the Member centered medical home, Members have immediate access to clinical pharmacists, behavioral health providers, dental providers, enrollment specialists, health educators and the primary care provider team.

In addition to activity within the health care home, Saluds' RCCO Care Managers are active within the health neighborhood and leverage relationships with key community partners like hospitals, community mental health centers, county services, food banks, specialty providers and health departments. These relationships help assist Health First Colorado Members in accessing the right care, at the right time in the right setting.

Salud is committed to the ACC and is involved on multiple RCCO advisory boards and ACC advisory committees including the Department of Health Care Policy and Financing's Program Improvement Advisory Committee (PIAC). Salud is committed to Phase II of the ACC and believes continued regional collaboration is essential to the future of health care delivery and payment reform in Colorado.

b. SERVING MEDICAID COVERED POPULATIONS

Salud is a FQHC with 12 clinics in nine communities in northeastern Colorado. For over 47 years, Salud has maintained a strong commitment to Colorado's Medicaid program. In 2015 Salud was the

health care home to 76,754 Members, 40,806 were Health First Colorado recipients. Salud's mission is to provide a quality, integrated health care home to the communities they serve and provides the full scope of integrated medical, dental, and behavioral health care. Salud collaborates with area hospitals, specialty physician groups, specialty mental health agencies, and public health agencies to ensure a comprehensive referral network and Member access to a variety of services for Health First Colorado Members. Salud has always accepted new Medicaid Members and will continue to do so in ACC Phase II and beyond.

c. ADMINISTERING MANAGED CARE

When the state Medicaid payment methodology was in a managed care environment Salud and other FQHCs in Colorado participated in a risk based payment model. In 1994, participating FQHCs formed the Colorado Community Managed Care Network (CCMCN) which was founded as a non-profit organization to respond proactively to the advent of Medicaid managed care in Colorado. Under this model FQHCs shared downside risk with each other to assure no FQHC was paid less than their FQHC rate. The FQHCs under this model did a very good job in managing the risk pool dollars and providing increased health care access to our Members.

d. MANAGING FINANCIAL RISK FOR COVERED SERVICES

Salud does not currently hold any financial risk contracts.

SUNRISE

a. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

Sunrise was the first PCMP in Colorado's ACC; the program began in 2011. Today, Sunrise is a PCMP in two of the seven regions and has formal care management delegation or community integration agreements with Rocky Mountain Health Plans (RCCO 1), Colorado Access (RCCO 2 and 3) and the Alliance. These agreements enable Sunrise to offer a high level of comprehensive care coordination services to over 20,000 Medicaid Members.

The Department is requiring all RAEs to provide a person- and family-centered approach to care management that facilitates the appropriate delivery of physical health, behavioral health, and other health care services. From the beginning, Sunrise chose to align their RCCO care management work with the Alliance Community Model of Care Management. This model aligns with the Department's approach by placing the Member at the center of care in his/her health care neighborhood. The model is agnostic to location of care or agency since it is focused on the Member needs. Members have choice and transition between multiple locations and agencies of care. The agnostic community model of care management developed and used by Alliance assists the Members in activating and strengthening their engagement with their primary location of care, be that physical, behavioral, or oral health and helps them navigate between other necessary or desired care and services including into their home. The model allows the care manager to connect with the Member beyond the traditional limiting boundaries created by alignment with a single provider organization.

Alliance has worked for two RCCOs since the beginning of Phase I of Colorado's Accountable Care model. Alliance works through our partners, under delegation agreements, with Colorado Access and Rocky Mountain Health Plans. As the PCMP serving the largest percentage of RCCO Members in R2, Sunrise delegating its care management functions to Alliance provided the needed base for Alliance to offer its agnostic care management program to other PCMPs in the region.

The model includes community health workers, registered nurse care managers, and behavioral health specialists in Regions 1 and 2, including rural communities like Yuma. Care management services include face-to-face assessment, coordination, and navigation activities with clients and families, (including in their homes and inpatient care locations), care planning with clinical care teams (physical, behavioral, and oral health), telephonic engagement of Members, inter-organizational care planning via community hotspotting, and non-medical determinant work as necessary to ensure transportation to needed health care services. Alliance interfaces its community care management model with other programs such as First Steps (prenatal), Healthy Communities, Health Care Program for Children with Special Needs, Nurse Home Visitor Program, Title X Family Planning, Opioid Oversight, and substance use disorder services to enhance the outcomes for Health First Colorado beneficiaries. In addition, at the request of Human Services organizations, Alliance expanded its care management model via special contracts to address the needs of other high-risk populations not covered by Health First Colorado. Alliance uses the care management software of both Colorado Access and Rocky Mountain Health Plans to document its work. In addition, Alliance dedicates its own data team to ensure caseloads, activities, and outcomes are analyzed and used to improve processes focused on key performance indicators. Alliance does not provide direct clinical services and therefore is not in conflict with itself. Alliance, by representing the full spectrum of community providers, is fully collaborative and integrative by design and function.

b. SERVING MEDICAID COVERED POPULATIONS

Sunrise Community Health (Sunrise) opened its doors in 1973 as a migrant health clinic. In 2016, Sunrise supported the health of over 38,297 Members via 157,000 primary care visits. 84 percent lived at or below 200 percent of the Federal Poverty Level (FPL); 58 percent lived at or below 100 percent of FPL. 57 percent were covered by Medicaid; 23 percent were uninsured; nine percent had private insurance; eight percent had Medicare; and three percent had CHP. 40 percent spoke a different language than English as their primary language. 59 percent were Latino/Hispanic; three percent were from East Africa and Southeast Asia.

c. ADMINISTERING MANAGED CARE

Sunrise manages a $34M budget dependent upon effective utilization of services including direct medical and dental care, pharmacy, lab, and x-ray costs. In addition, Sunrise participates in the following state-wide efforts in accountable care: 1) Community Health Provider Alliance (CHPA)—an IPA which contracts with payors and focuses on care delivery improvements; 2) Colorado Community Health Network—a CHC association supporting CHCs in policy, payment reform, and clinical improvement activities; and 3) the CCMCN—a CHC association focusing on clinical quality improvement and data integration.

d. MANAGING FINANCIAL RISK FOR COVERED SERVICES

Sunrise does not currently hold any financial risk contracts.

BEACON HEALTH OPTIONS – NHB’s Administrative Agent

a. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

Beacon Health Options’ (Beacon) experience includes Medicaid, state general funds, state block grants, federal block grants, and county and city government financing streams. Beacon operates Medicaid and other publicly funded programs in 26 states and the District of Columbia, serving approximately 14 million members through direct contracts with state or local governments and more than 60 health plan partners. They have developed an established information technology infrastructure, mature quality and compliance programs, efficient credentialing systems, and

comprehensive expertise in all aspects of managed care. Their systems and processes have been designed with public behavioral health services in mind. They have created highly customized Medicaid managed care systems and solutions for localities across the country. Below we list Beacon's experience managing projects of similar size and scope in Colorado.

Colorado Health Partnerships, LLC (CHP)

CHP, a Managed BHO, provides Colorado residents with advanced behavioral health services through a unique and innovative partnership between Beacon and eight Community Mental Health Centers (CMHCs). This partnership includes NHP's CMHC provider partners (i.e., Health Solutions, San Luis Valley Behavioral Health, Solvista Health, and Southeast Health Group), as well as Pikes Peak Medicaid LLC and West Slope Casa, LLC. These organizations encompass the eight CMHCs with responsibility for behavioral health services in the 43 counties in the South/West Service Area. CHP and their predecessor organizations have operated since 1995 to provide services to Medicaid Members in the rural and frontier areas of southern and western Colorado.

Project Description

CHP, formerly known as Colorado Health Networks, was among the first examples nationally of a successful partnership between community-based, non-profit provider organizations and a national managed care company. The results of this partnership were remarkable in terms of the impact on community-based mental health services, which constitute the safety net for psychiatrically disabled and impoverished adults, children, and families. By creating robust, intensive community-based services customized to the needs of the populations served in each sub-region of the South/West Service Area, CHP has been able to achieve key service objectives, including:

- Integrating mental health and SUD treatment broadly across the Service Area
- Integrating behavioral health with primary care in some of the earliest successful efforts in the State
- Reducing wait lists for access to routine services from months to days
- Providing face-to-face crisis assessments in less than two hours for rural and frontier residents
- Providing in-home services to families throughout the entire Service Area
- Engaging adults, the families of children, and youth as active participants in every aspect of service planning
- Implementing a treatment culture that fosters independence and recovery for all people with serious and persistent mental health conditions
- Giving Members a choice of providers who are qualified to meet their needs
- Reducing reliance on institutional care that inhibits recovery in adults and resiliency in children and their families

CHP's efforts have resulted in a significant and meaningful shift of financial resources from institutions to community-based services. Prior to the implementation of the Colorado Medicaid program, more than 60 percent of Medicaid mental health funding in the South/West Service Area went to institutional care, with most services being delivered far from the homes where Members lived. ***Today, more than 90 percent of program funding goes to some form of community-based services.*** Members are able to access services that support their safety and wellness in or close to their homes in spite of the sparseness of population densities across the Service Area. This demonstrates that CHP:

- Delivers on their core value that Members have the right to expect access to safe and effective services in their own homes and communities
- Manages financial risk by implementing effective early intervention and diversionary services to manage utilization and reduce clinical acuity before it reaches catastrophic levels for the Member

- Leads in the system transformation that is called for today as we drive toward a more integrated system of care that is highly adaptable to changing conditions and ideas
- Applies a data-rich continuous quality improvement process to the challenge of rapidly evolving treatment technologies that are highly responsive to the needs of local populations and are sensitive to the capacity of local resources

Children, adults, and families are offered trauma-informed, evidence-based psychotherapies and best practice programs that foster resiliency and preserve families. Geographic access to both routine and specialized services has improved. Telehealth brings child psychiatric expertise into two dozen small communities that are several hours driving time from the Front Range population centers where nearly all of the State's sparse number of child psychiatry practices are located, which has improved Member and family satisfaction.

Recovery and resiliency principles and programs remain the cornerstones of CHP's treatment planning. First implemented by Colorado Health Networks beginning in early 1996, some of CHP's Member-run drop-in centers are among the oldest and most successful in the State. CHP's recovery services continue to evolve—now focused on the development of a variety of peer-run services and in the development of a curriculum and employment opportunities for peer integration specialists who work with a variety of medically and behaviorally complex Members.

CHP has never adopted the disarticulation of mental health from SUD treatment services. Mental health and SUD treatment have been continuously integrated in the majority of CMHC treatment sites since before the inception of the Community Behavioral Health Services Program in 1995. This integration had occurred in 100 percent of CHP's CMHCs treatment sites by 2004.

Integrated Community Health Partners, LLC (ICHP)

ICHP, the RCCO for Region 4, serves Colorado residents by improving the health outcomes of Members by ensuring right services at the right time and improving total cost of care. This involves a unique and innovative integrated relationship between Beacon, the CCMCN, CMHCs, and FQHCs. ICHP comprises nine different organizations with complimentary abilities, which allows ICHP to blend the knowledge of longstanding, time-tested agencies with the entrepreneurship and creativity of new enterprises. The primary partnership includes NHP's partners: Valley-Wide Health System, Inc. (Valley-Wide), Health Solutions, Beacon, San Luis Valley Behavioral Health Group (San Luis Valley Behavioral Health), Solvista Health, and Southeast Health Group, as well as High Plains Community Health Center and Pueblo Community Health Center.

Region 4 was one of the first partnerships to implement the ACC Program. By working and growing expertise with the Department, the partnership has demonstrated the knowledge in building integrated health care projects involving data and the needs of Members to improve outcomes of Members, building a whole-person care network, and strengthening community relationships. Over the past six years, ICHP has moved the ACC from a concept to a fully functional health care delivery model with demonstrable outcomes. Since the inception of the contract, membership has steadily increased. In 2013, there were 45,122 Members enrolled in the RCCO. As of the most recent enrollment data, there are 119,277 Members enrolled, with 81.8 percent attributed—the highest attribution rate in the state.

ICHP's provider partners are the basis for success in Region 4, as they are integrated into all aspects of regional operations through representation on all regional committees and workgroups and participation in quality-driven projects and initiatives. At the inception of the first ACC contract, the initial provider network development focus included only FQHCs in Pueblo and Fremont counties. The network grew to include pediatricians in the Pueblo area, as they represented the most needed and important specialty providers for the population at the time. As the network developed, provider outreach encompassed all FQHCs, providers identified through claims systems

as already serving Medicaid Members, providers specifically requested by Members, and providers in areas with little to no participation. Today, the ICHP network covers all 19 counties and includes 48 PCMPs with 108 sites, and more than 300 rendering providers. By partnering with the FQHCs and CMHCs, which were already well-established in the region's communities, Beacon has built a strong infrastructure for delivering quality physical and behavioral health care based on data driven population health management and evidence-based care coordination interventions.

In addition to building and supporting a robust provider network, Beacon brings extensive experience in designing and implementing quality programs, projects, and initiatives. The Quality Improvement Program structure incorporates Beacon's considerable experience operating both PCCM and Prepaid Inpatient Health Plan (PIHP) programs. Beacon's Quality Department simultaneously conducts multiple performance improvement projects in addition to integrated projects and other quality initiatives that have positively impacted Member outcomes and improved integration across systems. For example, Beacon has developed a population health management program that takes into account a multitude of medical and social determinants of health for identifying Members who could benefit from targeted care coordination interventions. The ability to identify and stratify Members based on social determinants of health and life transitions in addition to medical claims information is crucial to providing adequate support for care coordinators tasked with Member outreach.

b. SERVING MEDICAID COVERED POPULATIONS

Beacon is a current owner/partner in two Colorado BHOs and the Region 4 RCCO, all of which currently serve Colorado Medicaid Members. Through the BHOs, Beacon manages Medicaid-funded behavioral health services in 48 of Colorado's 64 counties for more than 614,000 Members. Each BHO, CHP and Foothills Behavioral Health Partners (FBHP), are community provider-driven partnership between local CMHCs and Beacon.

The BHOs are based on a unique managed care model first pioneered by Colorado in 1995. Under the State's original Medicaid Behavioral Health Capitation Program, Beacon partnered with three separate provider-driven companies together called Colorado Health Network to operate Mental Health Assessment and Service Agencies. The managed care system was renowned for its implementation of recovery-based services and represents some of the earliest and best examples of integrated health homes for behavioral and physical health.

Both BHOs are built on an integrated care coordination philosophy and have dedicated resources to ensure integration at the administrative and clinical levels. Beacon's assessment of network provider's move toward integrated practice showed that the majority of providers practicing along the integration continuum are working in integrated settings, and that most integrated settings are at a co-located stage. Less integrated practices tend to have fewer providers and/or providers spread across multiple clinical sites. Based on this assessment, Beacon developed a plan designed to assist providers move towards higher levels of integration.

Below, we describe several innovations and programs that Beacon has developed and implemented in Colorado to promote the delivery of integrated, coordinated care.

Assisting Providers Move along the Integration Continuum

The BHOs are organized into a formal committee structure whose mission to develop and promote best practices for integration throughout the BHO service areas. Beacon uses two web-based provider-facing instruments that were co-developed in partnership with other agencies and academic institutions to measure movement along the integration continuum. Data is routinely analyzed to assess the effectiveness of Beacon's integration strategies for each level of integration.

Colorado–Psychiatric Access and Consultation for Kids (C-PACK)

C-PACK replicates the evidenced-based Massachusetts Child Psychiatry Access Project to create a system of child psychiatry consultation and training for the primary care providers to achieve the following program outcomes:

- Promote systematic, evidence-based behavioral health screening
- Increase the capacity of primary care providers to deliver mental health care independently and team with local specialists when needed
- Improve access to treatment for behavioral health issues
- Ensure that scarce specialty psychiatric resources are directed toward the most complex and high-risk children
- Develop well-functioning primary care/specialist relationships among primary care providers and child psychiatrists

Provider training is offered by the nationally recognized REACH Institute and includes mini-fellowships in Primary Pediatric Psychopharmacology as well as the Child & Adolescent Training in Evidence-Based Psychotherapies.

Integrated Community Health Partners, LLC (ICHP)

Beacon also supports integration through partial ownership of ICHP, the Region 4 RCCO. In partnership with FQHCs, CMHCs, and the Colorado Community Managed Care Network, ICHP's integrated approach has led to the development of innovative care coordination solutions to targeted high-risk Members. Integration projects include:

- Pain management for Members receiving opioid prescriptions from numerous providers and/or numerous pharmacies
- Improving care coordination for adults with diabetes
- Ensuring Diabetes Society recommendations are met for all diabetic children within the service area
- Providing training on depression screening and treatment for primary care providers

Beacon has also developed several technical innovations to support ICHP:

- **I Can Help People Software System:** This web-based system allows medical and behavioral health care coordinators and case managers to alert other care providers if they have seen a shared Member.
- **Care Coordination Dashboard:** The dashboard displays medical, behavioral and pharmacy data with trend and drill-down functionality that is updated monthly.
- **Risk Stratification:** The Business Intelligence team uses claims data and enrollment data to determine care coordination tiers. Tiers are assigned based on a summary score developed from the combination of total cost, emergency room visits and inpatient visits. Once the Member tiers are determined, the stratified list is sent to the assigned care coordinators for review and action. The program has achieved success by reducing emergency room visits, high-cost imaging, and recidivism rates for acute care hospitals.

Today in Colorado, Beacon and their provider partners bring together the advanced information and managed care strengths of a national company with the full array of high quality local service providers who practice throughout Colorado.

As previous described, in Colorado, Beacon is an owner and partner in two BHOs, CHP and FBHP, as well as ICHP, the current RCCO for Region 4. CHP is an established partnership between

Beacon and three Colorado-based service delivery organizations. These three organizations and Beacon have administered the Community Behavioral Health Services Program in the South/West Service Area of Colorado for the past 22 years under various organizational structures that now form CHP. FBHP has successfully managed the Behavioral Health Services Program in the Metro West Service Area since 2009. FBHP comprises four members: Jefferson Center for Mental Health, the Mental Health Center of Boulder County (d/b/a Mental Health Partners), the Foothills Behavioral Health Partners Stakeholder's Council, and Beacon. Under these contracts, Beacon is responsible for improving access to care, building and managing the behavioral health provider network, processing and paying claims, monitoring and evaluating provider and system performance, and implementing quality improvement initiatives.

Nationally, Beacon is the largest provider of behavioral health managed care services to Medicaid Members in the United States. They manage behavioral health services for 50 million individuals through contracts with public and private employers, health plans, and state and local agencies in all 50 states, the District of Columbia, and the UK. Specifically, they manage behavioral health care services for 14 million Medicaid Members in 26 states, including services and supports for individuals with SPMI and SED, children, adults, older adults, Medicare and Medicaid Members, individuals with disabilities, and individuals with multiple chronic, co-morbid conditions.

Beacon's management of services focuses on ensuring adherence to the treatment plan, while improving Members' quality of life and functional status and achieving recovery and resilience. Management of services also span community behavioral health care through utilization management of social and alternative services, such as intensive case management, housing support, and medication management that wraparound an individual to support them living in the community.

Additionally, ICHP is a partnership between Beacon, the Colorado Community Managed Care Network, three medical care providers and four behavioral health providers.

c. ADMINISTERING MANAGED CARE

As previous described, in Colorado, Beacon is an owner and partner in two BHOs, CHP and FBHP, as well as ICHP, the current RCCO for Region 4. CHP is an established partnership between Beacon and eight CMHCs, including NHP's CHMC partners. Together, they have administered the Community Behavioral Health Services Program in the South/West Service Area of Colorado for the past 22 years under various organizational structures that now form CHP. FBHP has successfully managed the Community Behavioral Health Services Program in the Metro West Service Area since 2009. FBHP comprises four members: Jefferson Center for Mental Health, the Mental Health Center of Boulder County (d/b/a Mental Health Partners), the Foothills Behavioral Health Partners Stakeholder's Council, and Beacon. Under these contracts, Beacon is responsible for improving access to care, building and managing the behavioral health provider network, processing and paying claims, monitoring and evaluating provider and system performance, and implementing quality improvement initiatives.

Additionally, ICHP is a partnership between Beacon, the Colorado Community Managed Care Network, three medical care providers, and four behavioral health providers. NHP's provider partners: Valley-Wide, Health Solutions, San Luis Valley Behavioral Health, Solvista Health, and Southeast Health Group are part of ICHP's organizational structure.

Beacon's National Managed Care Administration

Nationally, Beacon is the largest provider of behavioral health managed care services to Medicaid Members in the United States. They manage behavioral health services for 50 million individuals through contracts with public and private employers, health plans, and state and local agencies in all 50 states, the District of Columbia, and the UK. Specifically, they manage behavioral health care services for 14 million Medicaid Members in 26 states, including services and supports for individuals with SPMI and SED, children, adults, older adults, Medicare-Medicaid Members, individuals with disabilities, and individuals with multiple chronic, co- morbid conditions.

Beacon's Scope of Service
• **50 million total members served annually** • **14 million Medicaid members** • **Medicaid services in 26 states** • **6 active duals pilots**

In addition, Beacon is a leader in managing benefits for dual eligible (Medicare-Medicaid) Members on a fully integrated basis. Beacon's manages behavioral health services for these members through 11 health plans, and through two programs that provide managed long-term care and services for dual-eligibles: Fully Integrated Duals Advantage (FIDA) Demonstrations and Programs of All-Inclusive Care for the Elderly (PACE). FIDA integrates physical and behavioral health care, Medicare Part D prescription drugs, and long-term supports and services for dual-eligibles who require more than 120 days of long-term support and services and who reside in one of five New York counties.

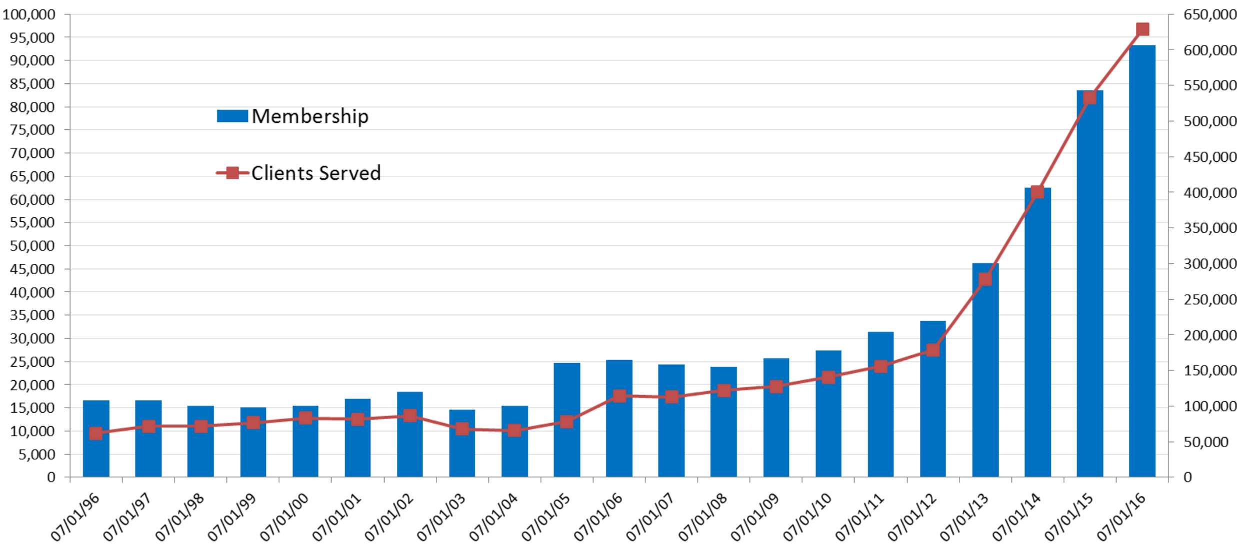
Beacon's management of services focuses on ensuring adherence to the treatment plan, while improving Members' quality of life and functional status and achieving recovery and resilience. Management of services also span community behavioral health care through utilization management of social and alternative services, such as intensive case management, housing support, and medication management that wraparound an individual to support them living in the community.

d. MANAGING FINANCIAL RISK FOR COVERED SERVICES

NHP's subcontractor, Beacon, has extensive experience managing behavioral health and SUD contracts on a capitated basis, in both full-risk and shared-risk contract arrangements, with a variety of Medicaid state partners. ***In fact, Beacon has managed more than $20 billion in risk-based contracts. Moreover, Beacon's BHO partnerships in Colorado have managed more than $2.2 billion in risk-based contracts since 1995.*** As such, NHP is prepared to meet all regulations and requirements including all solvency requirements if and when it is necessary to do so.

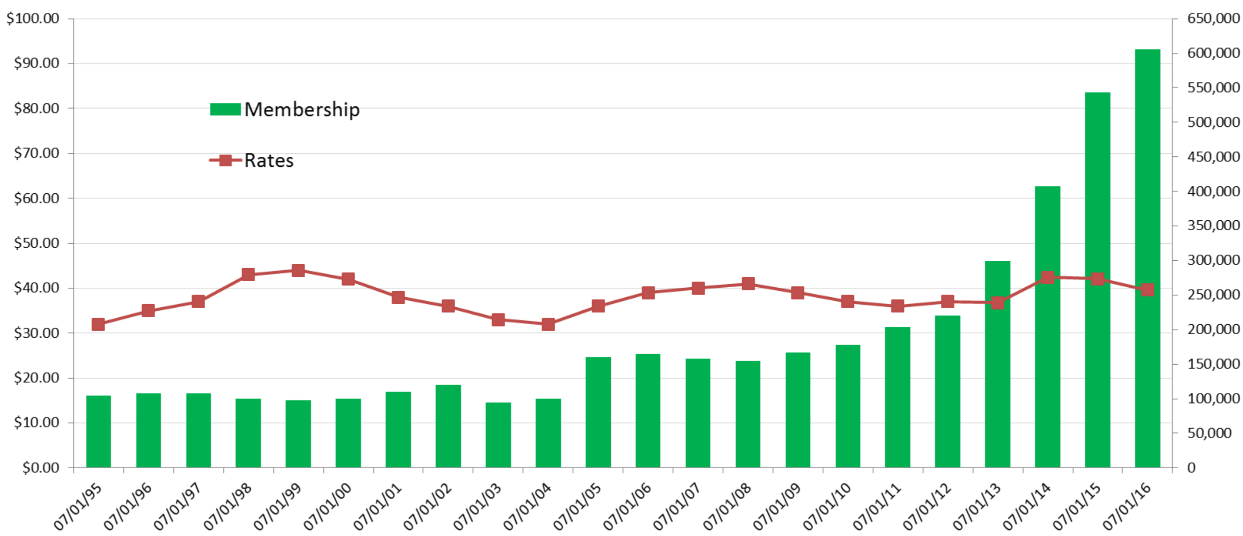
We are well-positioned and have a number of tools available to fund any potential losses to ensure continued compliance (e.g., reinsurance). One illustration of CHP's success comes from an analysis performed by the Altarum Institute, a non-profit systems research organization. Altarum demonstrated CHP's success at "bending the cost curve." As illustrated in the graphs below, while membership rose dramatically over the life the Community Behavioral Health Services Program, the capitated cost of care remained flat with only a slight upward trend. This was accomplished while service penetration rates actually increased instead of decreasing as one many have expected with population growth.

CHP Members Served



As shown in the graph below, the cost to the State of adding Medicaid Members, as occurred with the Medicaid expansion since 2011, can be reliably and accurately predicted by the Department due to CHP's superior ability to manage financial risks under the contract over time—through economic boom and bust, and across the largest and most challenging service area in the State.

CHP Rates and Membership



This demonstrates that Beacon's performance with managing risk and meeting and/or beating client expectations focuses on a Member's goals and needs, the total cost of individualized care, and collaboration with providers and State stakeholders to manage and support an integrated care plan model. Instead of contracting providers at low reimbursement rates and denial-driven utilization management that occurs in outdated clinical models and have hurt the community of essential providers, Beacon manages financial risk by collaborating, educating, and coaching the provider community. This strategy aligns with the Department's goal to enhance an individual's access to a

more complete, coordinated, and cost-effective system of community-based health care services and supports. It also adheres to our commitment to the Quadruple Aim, described in detail in our response to *Offerors Response 7*, of achieving better care for Members, improving the health of all populations, reducing the per capita cost of care, and improving the work life of health care providers, including clinicians and staff.

OFFEROR'S RESPONSE 3

Provide a detailed description of the Offeror's experience providing, arranging for, or otherwise being responsible for the delivery and coordination of comprehensive physical health, behavioral health, or both. Include for each project:

a. The name and location(s) of each project;
b. The population(s) served and number of covered lives;
c. Whether the population served was Medicaid, Non-Medicaid or a combination;
d. The primary health care services included in the project;
e. Level of managed care and financial risk;
f. Activities in Rural and Frontier areas, if appropriate;
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;
i. A Project Contract Manager with contact information

For behavioral health projects, the Offeror must describe their experience delivering community behavioral health care, as described in 4.2.2.2.1.

Northeast Health Partners, LLC (NHP) is a partnership between four deeply embedded Colorado health care organizations: Salud, North Range, Centennial, and Sunrise, and Beacon Health Options (Beacon), who has extensive experience delivering physical and behavioral health care services across Colorado and in Region 4 as a Regional Care Collaborative Organization (RCCO). This partnership leverages the complimentary experience and expertise of these organizations and blends the best attributes of local, regional, and national organizations to better serve Colorado's Medicaid Members. This local knowledge and experience will be crucial in establishing and strengthening relationships among it's the Region's provider community and supporting existing collaborations and facilitating the creation of new connections and improved processes to create the Health Neighborhood that is a RAE requirement.

In addition to each partner's individual experience, the partners of NHP bring a history of teaming up with each other on regional projects, grants and business arrangements that have strengthen our ability to work together and with key organizations and agencies within Region 2. The following examples of this collaboration will lend itself to successfully entering into our new proposed RAE new arrangement:

- Beacon, Centennial and North Range in Northeast Behavioral Health Partnership Behavioral Health Organization (BHO) 2009-2014
- Centennial and North Range in Northeast Behavioral Health BHO 1998-2008.
- Centennial and North Range in Compass Behavioral Health Systems, LLC a Managed Service Organization from 1997-2002
- Centennial and North Range in Northeast Behavioral Health Crisis Response Contract 2014-Present
- North Range and Sunrise in Behavioral and Physical Health Integration for nearly 15 years.
- North Range and Salud in Behavioral and Physical Health Integration for two years
- Centennial and Salud in Behavioral and Physical Health Integration for nearly 10 years.

It is important to note that most of these joint projects involved enhanced coordination of the behavioral and physical health. We recognize that linkages between behavioral health and physical health care are of the utmost importance to a Member's overall well-being and recovery. The organizations that make up NHP are valued and proven community partners in Colorado, serving Region 2 for over 40 years. As members of the community and by serving those most at risk populations in RAE Region 2, we have gained an in-depth knowledge of our communities and the

resources available. We have developed strong relationships with behavioral health and substance use disorder (SUD) providers, primary care providers, hospitals, Member and family support organizations, nursing homes and assisted living facilities, the juvenile justice system, adult corrections, law enforcement, social services, developmental disability agencies, and other stakeholders. This deep network of community relationships has enabled us to design our administrative and clinical supports to ensure that Members receive assistance and advocacy while obtaining appropriate medical and behavioral health services from the right health care professional in the right setting.

We provide descriptions of NHP's collaborative and independent experience providing, arranging for, or otherwise being responsible for the delivery and coordination of comprehensive physical and/or behavioral health in Colorado below.

NORTH RANGE PROJECTS

Project Name: Northeast Behavioral Health

a. **Project Name and Location**: Colorado Department of Health Care Policy and Financing; Denver Colorado (Northeast Behavioral Health, LLC) 1300 N. 17th Ave. Greeley, CO 80631

North Range and Centennial were involved in one of the earliest provider-owned Behavioral Health Organization as Northeast Behavioral Health, LLC (NHP), along with SummitStone Health Partners, NHP was a successful partnership between community-based, non-profit provider organizations and a Managed Care organization. Later, the partners incorporated Beacon to bring the experience and resources of a national managed care company. The results of this partnership were significant in terms of the expansion of community-based mental health and SUD services, which constitute the safety net for psychiatrically disabled and impoverished adults, children, and families.

By creating expansive, intensive community-based services customized to the needs of the populations served in the Northeast Service Area, we achieved key service objectives that will be required by the RAE, including:

- Integrating mental health and SUD treatment broadly across the Service Area
- Integrating behavioral health with primary care in some of the earliest successful efforts in the State.
- Providing face-to-face crisis assessments in less than one hour for urban and two hours for rural and frontier residents.
- Providing in-home services to families including Multi-Systemic Family Therapy and Functional Family Therapy models.
- Engaging adults, the families of children, and youth as active participants in every aspect of service planning.
- Implementing a treatment culture that fosters independence and recovery for all people with serious and persistent mental health conditions.
- Giving Members a choice of providers who are qualified to meet their needs.
- Reducing reliance on institutional care that inhibits recovery in adults and resiliency in children and their families.
- Developing the first Nationally Certified Clubhouse in the state.
- Developing a continuum of prevention services for early childhood, suicide prevention, and substance use prevention in youth populations.

NHP was able to shift the focus of system delivery from an over-dependence on institutional care to community-based services. Prior to implementing the NHP processes, more than 60 percent of

Medicaid mental health funding in the Northeast area went to institutional care, with services being delivered far from the homes where Members lived. NHP ensured that all Members have ready access to services in their communities despite the sparseness of population densities across the Service Area. NHP believed:

- Members have the right to expect access to safe and effective services in their own homes and local communities.
- Financial risk is best managed by implementing effective early intervention and treatment services to address clinical needs in the most individualized, community-based manner possible—reducing clinical acuity before it reaches catastrophic levels for the Member.
- Innovative models of care and recovery including the first Acute Treatment Unit (ATU) in the state, as well as the first Clubhouse in the state.
- In operating via data driven management and decision-making.

The efforts of NHP have continued in recent years, ensuring that children, adults, and families are offered trauma-informed and evidence-based models of care that support recovery, foster resiliency and improve lives.

Northeast partner organization have been part of the RCCO's care delivery system since its inception. A unique approach of the Region 2 RCCO since the beginning, is a flexible policy of attempting to meet the local communities where they are. For example, Sunrise, Banner, and North Colorado Family Medicine chose to align RCCO care management activities at a community level while Salud preferred to do theirs by themselves. That flexibility enabled different approaches to be tested.

b. Population Served and Number of Covered Lives: Medicaid Members, including AFCD/BC adults and children FC, OAP and SSI adult, children and adolescents. The total number of lives covered was 55,575 Members.

c. **Population Served:** Medicaid

d. **Primary health care services included:** No

e. **Level of managed care and financial risk:** NHP is a full risk bearing entity that received a single capitated payment from the Department to manage all mental health services and supports for the Northeast BHO contract.

f. **Activities in Rural and Frontier Areas:** Northeast Behavioral Health offered care in twelve counties in Colorado. Two of those counties have large population centers, but they also have huge areas of rural farm and ranch land. The other ten counties are all considered rural and/or frontier. NHP ensured services were available in all twelve counties.

g. **Corrective Action Plans:** Corrective Action Plans involved the re-writing of policies and procedures and are provided by year in the table below:

Time Period	Policy and Procedure
2004-2005	• Subcontracts and Delegation • Member Rights and Responsibilities • Access and Availability • Quality Assessment and Performance Improvement • Grievance, Appeals, Fair Hearings • Credentialing / Re-credentialing

2005-2006	• Continuity of Care • Credentialing
2006-2007	• Delegation • Provider Issues • Credentialing
2007-2008	• No Corrective Action Plans
2008-2009	• Notice of Actions • Appeals

h. **Adverse Contract Actions or Project Litigation:** None

i. **Project Manager:** Marceil Case
Contract Manager
(303) 866-2992
marceil.case@state.co.us

Project Name: Integrated Behavioral Health

a. **Project Name and Location**: Colorado Department of Health Care Policy and Financing; Denver Colorado (Northeast Behavioral Health, LLC) 1300 N. 17th Ave. Greeley, CO 80631

b. **The population(s) served and number of covered lives:** Individuals receiving services at North Range, Sunrise and Salud. For more than 15 years, Sunrise and North Range have worked to integrate physical health and behavioral health in Weld County. 30,000 patients have access to integrated behavioral health services through Sunrise clinics in Weld County. Salud and North Range have been partnering for the past five years to provide North Range behavioral health staff within two Salud clinics (Frederick and Fort Lupton). Another 9,000 patients have access to integrated behavioral health services through Salud clinics in Weld County.

c. **Population served:** Primarily Medicaid and some Indigent

d. **Primary health care services included:** All Sunrise and Salud locations or facilities in Weld County provide primary health services as a Federally Qualified Health Center (FQHC). Sunrise staff are also embedded at North Range within their psychiatric clinic, literally next door to the psychiatric team. This clinic serves as a family practice clinic.

e. Level of managed care and financial risk: Primarily service provision with no financial risk

f. **Activities in Rural and Frontier Areas:** All of the locations of Salud in the region are in rural or immediate adjacent communities and Sunrise clinics in Evans and Greeley serve many of the communities rural Weld County.

g. **g. Corrective actions:** n/a

h. **Adverse Contract Actions or Project Litigation:** n/a

i. **Project Contract Manager:** Larry Pottorff, Executive Director

Project Name: Compass Behavioral Health System

a. **Project Name and location:** Alcohol and Drug Abuse Division (now Office of Behavioral Health) State of Colorado. 3824 West Princeton Circle, (Compass Behavioral Health Systems. LLC) Denver CO 80236. A Managed Service Organization (MSO) owned and operated by the three SUD providers in the region, Centennial, Island Grove (now merged with North Range) and Hope Counseling Center (later merged with Island Grove.

b. **The population(s) served and number of covered lives:** Individuals in 12 counties of Northeast Colorado with SUD diagnosis and needs.

c. **Population served:** All individuals with SUD needs in Northeast Colorado (SUD services were not covered by Medicaid at the time of this contract).

d. **d. Primary health care services included:** N/A

e. **Level of managed care and financial risk:** Full-risk contract in partnership with Signal Behavioral Health Network.

f. **Activities in Rural and Frontier Areas:** SUD services were offered in all of the 12 counties of the Compass network.

g. **g. Corrective actions:** None that we have record of.

h. **h. Adverse Contract Actions or Project Litigation:** None

i. **Project Contract Manager:** Program no longer operational

Project Name: Signal Behavioral Health Network

a. **Project Name and location:** Office of Behavioral Health; MSO for Regions 1, 2 and 4 Signal Behavioral Health Network MSO, Denver, CO a member-owned LLC. North Range is a 1/6th owner.

b. **The population(s) served and number of covered lives:** Individuals with Substance Use Disorders in Northeast Colorado, Metro Denver and Southern Colorado.

   Services include:

- Adult and Youth Outpatient SUD Treatment
- Adult and Youth Intensive Outpatient
- Transitional Residential Treatment
- Gender Specific Treatment Programs
- Methadone Maintenance Treatment
- DUI education and treatment
- Withdrawal Management (Detox)
- Intensive Residential Treatment
- Medication Assisted Treatment

c. **Population served:** Indigent SUD

d. **Primary health care services included:** None

e. **Level of managed care and financial risk:** Signal is an MSO tasked with managing the SUD delivery system in its three regions. Signal is responsible for quality review, maintaining an

adequate provider network, contracting with all Departments of Human Services for Core and Additional Family Services funding.

f. **Activities in Rural and Frontier Areas:** Signal is responsible for the full continuum of SUD services for 35 Rural and Frontier counties in its three regions.

g. **Corrective actions:** No corrective actions

h. **Adverse Contract Actions or Project Litigation:** None

i. **Project Contract Manager:**
Karen Mooney
Office of Behavioral Health
3824 West Princeton Circle
Denver CO 80236

CENNTENIAL PROJECTS

a. The name and location(s) of each project; Salud Family Health Centers (Salud) and Centennial Mental Health Center, Inc. (Centennial) integrated care services

b. The population(s) served and number of covered lives: Population served encompasses Medicaid Members including AFCD/BC adults and children FC, OAP and SSI adult/older adults, children and adolescents. The number of average covered lives per month was 12,624 Members in fiscal year 2015-2016 in Morgan and Logan Counties. Additionally, behavioral health services were available patients regardless of payer source or county of residence. Psychiatric consultations are available to Salud physicians across the State of Colorado.

c. Whether the population served was Medicaid, Non-Medicaid or a combination: The population served is a combination of both Medicaid and Non-Medicaid.

d. The primary health care services included in the project; Salud provided physical health care and Centennial provided behavioral health services and psychiatric consultations to supplement part-time support from Salud's behavioral health team.

Historically, Centennial has provided systematic levels of Collaboration/Integration of providing behavioral health services in primary care settings in all ten counties. Building upon an existing relationship with Salud (Sterling and Fort Morgan) to develop and implement a Primary Care Practice Medical Home (PCPMH), Centennial expanded on the concepts of consultation to Salud physicians, transitional care, collaboration, cross referrals, care coordination and co-location of psychiatric and behavioral health services.

Building upon existing relationships and ongoing discussions, Salud and Centennial formalized operations in 2009 with an agreement for Centennial to provide:
Psychiatric services to Salud Members at the Fort Morgan Clinic for 4 hours/week
Psychiatric phone consultation to Salud physicians across Colorado
Starting in 2013, Centennial and Salud agreed for Centennial to provide:
A bilingual 1 FTE to deliver behavioral health services to Salud Members following Salud's integrated care service delivery model
Coordination of referral to and communication with Centennial regarding the array of services available

Also starting in 2013, Centennial and Salud agreed for Centennial to continue to provide:

- One hour per week of phone consultation to Salud Physicians across Colorado
- Starting in 2015, Centennial and Salud agreed for Centennial to provide:
- Two half-time positions to deliver services to Salud Members following Salud's integrated care service delivery model
- Services include screenings, assessments, individual and group therapy, case management, and physician consultations

e. **Level of managed care and financial risk:** There is no managed care or financial risk in this project.

f. **Activities in Rural and Frontier areas, if appropriate**: Salud and Centennial both deliver services in rural communities of Fort Morgan and Sterling. However, the Member populations are also often drawn from surrounding communities that are even more remote.

g. **Any corrective action plans relating to contract non-compliance and/or deficient contract performance:** There have been no corrective action plans related to contract non-compliance and/or deficient contract performance.

h. **Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved:** There have been no adverse contract actions and/or litigation.

i. **A Project Contract Manager with contact information:**
Centennial Mental Health Center
Elizabeth Hickman, Ph.D.
Executive Director
970-522-4549
lizh@CentennialMHC.org

Salud Family Health Centers
Jonathan Muther, Ph.D.
Vice President of Medical Services
303-820-4725
jmuther@saludclinic.org

SALUD PROJECTS

a. **Project Name and location:** Salud Family Health Centers (Salud), a Federally Qualified Health Center in northeast Colorado. Salud has 12 clinic locations; 4 of the 12 clinics are located in Region 2 at the below locations:

- 1115 Second Street Fort Lupton, CO 80621
- 729 E. Railroad Avenue Fort Morgan, CO 80701
- 5995 Iris Parkway Frederick, CO 80530
- 1410 S. 7th Avenue Sterling, CO 80751

Salud delivers medical, dental, pharmacy and behavioral health care services with the aim of creating community-wide access to comprehensive and integrated care. Salud's model includes multiple projects designed to coordinate physical and behavioral health. Below are a few examples of Salud projects:

- **Behavioral Health:**
  Salud provides a fully integrated system of care and for over 15 years has blended physical and behavioral health in a cohesive model designed to meet the individual needs of each Member. In an effort to normalize behavioral health involvement and identify potential behavioral health concerns, Salud strives to have contact with each Member at least once per year regarding behavioral health concerns. Salud's behavioral health providers are an integral component of Salud's interdisciplinary provider team, and, if necessary, act as the lead health care provider for Members with behavioral health concerns. Salud believes that the integration of behavioral and physical health is crucial to improving health outcomes, decreasing cost and enhancing the client experience.

- **Oral Health:**
  All Salud Members have access to dental services that are integrated into the primary care environment. Dental services are provided to Members at all ages and include general cleanings and exams, diagnostic imaging, surgery procedures and extractions. For Members ages 0-20 and pregnant women of any age, Salud offers medical dental integration (MDI) where a dental hygienist participates in the medical appointment and provides oral hygiene education and fluoride varnish to lower risk of dental caries among children and pregnant women.

- **Care Management:**
  All Salud clinics have Care Managers who are essential members of the interdisciplinary team and identify high risk ACC Members based on claims utilization data (ER utilization, hospitalization etc.), referrals from internal team members or external community resources. Care Managers complete a Health Needs Assessment (HNA) to identify needs within multiple domains including but not limited to: medical, behavioral health, dental and social determinants of health. When appropriate Care Managers create Member centered care plans designed to identify Member centered goals that leverage Member strengths and assets (i.e. family members, local resources etc.). Care Plans help close the loop in overall coordination of care both within and outside the primary care setting and aim to ensure Members access the right care at the right time in the right setting.

- **Comprehensive Maternal Care:**
  Salud offers comprehensive maternity care including prenatal care, Member education, behavioral health screening/intervention; oral health education/assessment/intervention; delivery care; post-partum management. Patients can choose to receive individual prenatal care from our integrated care team or participate in Centering Pregnancy group. Components include: oral health, co-management by Primary Care Provider and OB/GYN, delivery care for both low risk and high risk babies, home visits for high-risk mom/baby pairs, post-partum care and outreach to ensure post-partum visit between 21-56 days of delivery, pregnancy related depression screening.

b. **The population(s) served and number of covered lives:** 76,754 low-income, uninsured residents of Adams, Weld, Larimer, Boulder, Morgan and Logan counties.

c. **Population served:** Low-income and uninsured populations in northeast Colorado. In 2016, Salud supported the health of 76,754 Members via 322,395 integrated primary health care visits. 97 percent lived at or below 200 percent of the Federal Poverty Level (FPL), 62 percent lived at or below 100 percent of FPL. 53 percent were covered by Medicaid; 25 percent were uninsured; 13 percent had private insurance; seven percent had Medicare; and three percent had CHP.

d. **Primary health care services included:** Salud provides the following services, as defined by HRSA's Bureau of Primary Care: General Primary Medical Care, Diagnostic Laboratory, Diagnostic Radiology, Screenings, Coverage for Emergencies During and After Hours, Voluntary

Family Planning, Immunizations, Well Child Services, Gynecological Care, Obstetrical Care (Prenatal Care, Intrapartum Care [Labor and Delivery], Postpartum Care), Preventive Dental, Pharmaceutical Services, Case Management, Eligibility Assistance, Health Education, Outreach, Transportation, Translation, Dental Services, Behavioral Health Services, (Mental Health Services, SUD Services), Optometry, Environmental Health Services, Nutrition, Complementary and Alternative Medicine, Specialty Services (Podiatry and Psychiatry).

e. **Level of managed care and financial risk:** Salud does not manage financial risk. Salud participates in state-wide efforts in Accountable Care: 1) Salud is a member of the Community Health Provider Alliance (CHPA), an IPA which contracts with payers and focuses on care delivery improvements; 2) Salud is a member of the Colorado Community Health Network (CCHN), a CHC association supporting CHCs in policy, payment reform, and clinical improvement activities; and 3) Salud is a member of the Colorado Community Managed Care Network (CCMCN), a CHC association focusing on clinical quality improvement and data integration.

f. **Activities in Rural and Frontier Areas:** Salud has a longstanding commitment to rural and frontier communities and was founded in 1970 in response to the critical health needs of migrant farm workers in northeastern Colorado. In 1969, a large migrant labor camp located in Fort Lupton was closed by the Colorado Department of health due to severe environmental health risks. This housing displacement, coupled with a time of social unrest in north central Colorado, compounded significant health care access needs among the farmworker population and led to a proposal to establish a migrant health program in Weld County. A proposal was submitted to the U.S. Public Health Service by a Denver-based non-profit organization, the Foundation for Urban Neighborhood Development (FUND), with support from the University of Colorado School of Medicine. The proposal was funded under the Migrant Health Act and was selected because it sought to depart from traditional approaches to health care delivery and offered a comprehensive, cross-disciplinary and culturally sensitive model of care to farmworker population that uniquely combined health care delivery with attention to social determinants of health. On July 1, 1970, Salud opened for business in a small apartment in Fort Lupton. A former onion warehouse across the street was later purchased and converted into a small medical and dental facility, which was Salud's home for over a decade. In 1979, Salud acquired its first mobile unit affectionately known as "the bus," the mobile unit brought health care to the many farmworkers in Salud's growing rural service area. Salud maintains a strong commitment to rural communities and continues to offer offers comprehensive integrated primary care services including dental, behavioral health, pharmacy and care coordination services. Additionally, the Salud mobile unit provides care to farmworkers and other isolated populations.

g. **Corrective actions:** None

h. **Adverse Contract Actions or Project Litigation:** None

Project Contract Manager:
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SUNRISE PROJECTS

a. Project Name and location: Sunrise Community Health, northeast Colorado, primarily serving Weld and Larimer counties.

The Sunrise Community Health care model provides integrated medical, dental, and behavioral health for all patients at all Sunrise clinics. Behavioral health services are the direct result of collaborations between Sunrise and the local mental health agencies (North Range Behavioral Health [NRBH] and SummitStone Health Partners). These partners locate counselors within the Sunrise primary care clinics where they work side-by-side with primary care providers, and vice versa. Sunrise clinicians are located within the behavioral health clinics where they work side-by-side with primary care providers. These integrated care teams jointly create care plans and treat patients. Our service model includes the following components/services:

- **Shared Electronic Health Record**
  Sunrise and the Weld County Department of Public Health and Environment implemented a shared Electronic Health Record in 2002. A patient's chart is available to clinicians at Sunrise and Health Department clinics thus ensuring safer and more cost effective care (all allergies, medicines, diagnoses, treatment plans, test results, etc. are available).

- **Sunrise Weld Prenatal Clinic**
  Since 2001, Sunrise has embedded a primary care clinician into the public health setting, thus linking prenatal patients to public health programs.

- **School Based Health Clinic**
  Since 2004, Sunrise has brought primary care medical and dental services to a high needs school in Evans. 95 percent of the kids are on free and reduced lunches, indicating they (and their families) are likely struggling with access to affordable health care as well. Services began via Sunrise's mobile health van and became a permanent clinic in 2006. Today, the clinic is open year round, staffed by a nurse practitioner. Medical, dental and behavioral health services are provided on site as is eligibility screening and care management. Patients have access to pharmacy, lab, and x-ray at the larger Sunrise clinics. NRBH provides the onsite behavioral health services.

- **Opioid Oversight Committee**
  Sunrise has a unique approach to the support and management of our patients with chronic pain—NRBH and the Alliance play an important role in this. We also provide education on this cutting edge approach to others across the state and nation.

- **Oral Health**
  Sunrise directly provides comprehensive primary oral health services to all ages in our Weld and Larimer clinics. We continue to offer one of the most comprehensive programs in the state. Our dental patients average 3.4 visits per year.

b. The population(s) served and number of covered lives: Low-income, under and uninsured populations in northeast Colorado (primarily Weld and Larimer counties). 38,000 served in 2016.

c. Population served: Low-income, under and uninured populations in northeast Colorado (primarily Weld and Larimer counties). In 2016, Sunrise supported the health of over 38,297 patients via 157,000 primary care visits. 84 percent lived at or below 200 percent of the Federal Poverty Level (FPL); 58 percent lived at or below 100 percent of FPL. 57 percent were covered by Medicaid; 23 percent were uninsured; nine percent had private insurance; eight percent had

Medicare, and three percent had CHP. The program served a highly diversified population: 40 percent spoke a different language than English as their primary language. 59 percent were Latino/Hispanic; three percent were from East Africa and Southeast Asia.

d. **Primary health care services included:** Sunrise offers comprehensive, quality, and affordable medical, dental, and behavioral health services including on-site laboratory, radiology, pharmacy, and patient education services. All services are offered to people in need regardless of their ability to pay.

   Relationships and collaborations with local safety net partners help bring comprehensive support services to Sunrise patients. Specialty care is accessed via referrals. In addition, specialists volunteer to provide needed podiatry, ophthalmology, pain management, and gynecology services to Sunrise patients.

   Mental Health/SUD Services:
   Sunrise partners with the local mental health and substance use agencies in our service area to bring co-located and integrated care to our patients. These behavioral health team members work within the primary care teams, jointly creating treatment plans and providing care to patients. Sunrise clinicians are embedded in the behavioral health setting, jointly creating treatment plans and providing care to patients. Sunrise will continue to focus on fully integrated health care and improving care plans and patient outcomes as well as improving referrals to/from medical and to/from behavioral health.

   Oral Health Services:
   Sunrise directly provides comprehensive primary oral health services to all ages in our Larimer and Weld clinics. We continue offering one of the most comprehensive programs in the state. Our dental patients average 3.4 visits/year.

   Pharmacy Services:
   Sunrise directly provides pharmaceutical services in our Larimer and Weld clinics. In addition to our sliding fee scale, Sunrise connects patients as appropriate to the pharmaceutical assistance programs. In 2014, this program provided over $2.5 million in low-cost medications to Sunrise patients.

   Sunrise is a recognized leader in integrated care, advanced Health Information Technology (HIT), safety net collaborations, and professional health education. In addition, Sunrise co-founded the North Colorado Health Alliance, a community collaboration focusing on low-income, under and uninsured people within our service area. Partners include community health, public health, hospital, behavioral health, specialists, local foundations, education, county commissioners, managed care organization, and county social services. Collaborations focus on integrated service expansion; shared HIT infrastructure; community health improvement; regional accountable care activities; and system accountability and efficiencies.

e. **Level of managed care and financial risk:** Sunrise does not manage financial risk in the way this is asking (I think). However, we manage a $34 million budget dependent upon effective utilization of services including direct medical and dental care, pharmacy, lab, and x-ray costs. In addition, Sunrise participates in state-wide efforts in accountable care: 1) we are a member of the Community Health Provider Alliance (CHPA) – an IPA which contracts with payers and focuses on care delivery improvements; 2) we are a member of the Colorado Community Health Network—a CHC association supporting CHCs in policy, payment reform, and clinical improvement activities; and 3) we are a member of the Colorado Community Managed Care Network—a CHC association focusing on clinical quality improvement and data integration.

f. **Activities in Rural and Frontier Areas:** Sunrise has extensive experience serving migrant and immigrant populations. Weld County is a large county—over 4000 square miles—with both urban and rural areas. Sunrise designs its operations with an understanding of the challenges faced by those living in the rural areas. For example, we recognize trips to the clinics in Greeley and Evans are not easily made for those from the rural areas so delivering as much care as possible in one visit is always the goal as well as keeping an eye on length of prescriptions, same day scheduling for tests, etc. From the beginning, we have focused on migrant/seasonal farmworkers in agriculture. Despite the national decline in migrant/seasonal farmworkers, we continue our programming and staffing to reach this underserved population. But we have also adapted as our migrant patients have adapted; we seek them out not only in the fields but now also in dairies; homeless and low-income housing areas; and those supporting agencies such as food banks.

g. **Corrective actions:** None. Sunrise is a high performing CHC compared to our peers for clinical, financial, and operational performance.

h. **Adverse Contract Actions or Project Litigation:** N/A

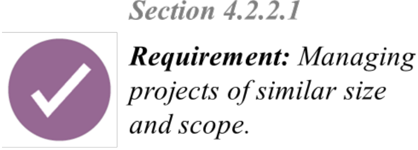
i. **Project Contract Manager:** Sunrise Executive team including:

- CEO: Mitzi Moran (33 years' experience in health care – 19 years CHC experience).
- CFO: Kevin Maddox (25 years CHC experience)
- CMO: Dr. Lesley Brooks (5 years CHC experience +10 years' public health experience)
- CDO (Chief Dental Officer); Dr. Jeremy Johnson (7 years CHC experience)
- COO (Chief Operating Officer): Libby Goode-Grasmick (20 years' health care experience as a chiropractor, administrator in behavioral health and operations at a CHC).
- CWO; Shelly Rios (30 years' experience in health care human resources and operations – 10 of those years at a CHC)
- Director of Quality Improvement: Cindy McDade (20 years' experience in health care – all at a CHC)
- Director of IT: Brad Keil: 20 years' experience in health care – 10 at a CHC; some at public health

BEACON PROJECTS

COLORADO MANAGED CARE PROJECTS

Colorado Health Partnerships, LLC (CHP)



a. Project Name and location: Colorado Department of Health Care Policy and Financing, Community Behavioral Health Services Program for the 43-county South/West Service Area, Colorado Springs, Colorado.

b. The population(s) served and number of covered lives: 467,557 Medicaid Members, including children, adults, older adults, and Medicare-Medicaid eligible Members. Populations include individuals with mental health and SUD, disabilities, and multiple chronic, co-morbid conditions.

As the Behavioral Health Organization (BHO) for the Service Area that includes Region 4, CHP, which includes all of Health Colorado's partners, manages and coordinates mental health and SUD services for Health First Colorado Members. Services managed and coordinated in the community include Intensive Case Management, home-based treatment services, medication management, and community support programs that offer daily living skills training such as budgeting, hygiene, social and recreational skills, housekeeping, and others.

In addition, CHP became one of the first managed care organizations in Colorado to have an Office of Member and Family Affairs dedicated to the psychosocial and resource needs of Members and their families, as well as advancing their recovery. In total, Beacon trained more than 300 peer and family Peer Specialists with many of them currently employed by BHO partner Community Mental Health Centers (CMHCs). Advocates and Peer Specialists provide direct services and participate in program design, quality studies, and system advocacy. CHP has also established informal self-help support groups and Member-run programs, such as drop-in centers, club houses and empowerment centers in the South/West Service Area. These programs offer peer counseling, psychosocial support and community outreach that add to the continuum of care for Members with serious mental illness.

c. Population served: Medicaid

d. Primary health care services included: Primary health care services including integrated mental health and SUD treatment services.

e. Level of managed care and financial risk: CHP is a Prepaid Inpatient Health Plan (PIHP) that accepts full behavioral health risk in the form of a capitated payment from the Department to manage all behavioral health services and supports for the South/West BHO contract.

f. Activities in Rural and Frontier Areas: With more than 22 years serving the South/West Service Area, CHP has delivered high quality behavioral health services to residents of some of the most rural areas in the country. CHP engages in rural and frontier strategic planning sessions to help lead innovation and general transformation of health care in rural and frontier counties by helping communities adopt the managed care principles of quality and access. To meet the needs of rural counties, CHP's partners developed an extensive network of crisis and alternative services that enabled Members to be treated in their local communities instead of driving hundreds of miles to an urban area. School-based treatment and after-school programs, respite homes for adults and children, in-home, crisis support, and homeless outreach services all improve access for Members most at risk. Less than one-quarter of one percent of CHP's Members must travel more than 30 miles to see a provider.

g. Corrective actions: CHP has participated in seven External Quality Review Organization (EQRO) site visits since 2010. Listed below is a summary of the results of each site visit. Full reports on site visit results are available for review.

CHP is amongst the highest performing BHOs in Colorado and has scored 90 percent or higher in its EQRO site visits since 2010.

Fiscal Year	EQRO Score and Corrective Action Plan (CAP)
2010 – 2011	EQRO Score: 96% CAPs implemented for one timely notification for denial issue, and one policy and procedure consistency issue with the Member handbook.
2011 – 2012	EQRO Score: 90% CAPs implemented for two Member information issues, four grievance system issues, and one delegation agreement issue.
2012 – 2013	EQRO Score: 99% CAP for delegation agreement.
2013 – 2014	EQRO Score: 100% No CAP required.
2014 – 2015	EQRO Score: 91% CAPs implemented for six grievances and appeals issues.

Fiscal Year	EQRO Score and Corrective Action Plan (CAP)
2015 – 2016	EQRO Score: 91% CAPs implemented for six credentialing/re-credentialing issues and one coordination and continuity of care issue.
2016 – 2017	EQRO Score: 95% CAPs developed and submitted to the Health Services Advisory Group (HSAG) for approval for two coverage and authorization of services issues.

h. Adverse Contract Actions or Project Litigation: None

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Integrated Community Health Partners, LLC (ICHP)

a. Project Name and location: Colorado Department of Health Care Policy and Financing, Operation of the Regional Care Collaborative Organizations for the Accountable Care Collaborative Program for the RCCO 4 Region, Pueblo, Colorado.

Section 4.2.2.3

Delivery and coordination of physical health care services as a PCCM Entity in the past five years.

b. The population(s) served and number of covered lives: 119,277 Medicaid Members, including children, adults, older adults, and dual eligible Members. Populations include individuals with SPMI, SED, disabilities, and multiple chronic, co-morbid conditions.

As members of ICHP, Health Colorado's FQHC and CMHC partners have extensive experience in the delivery of physical, behavioral, and oral health, with Beacon providing a strong foundation as the Administrative Services Organization. Over the past six years, Health Colorado's staff have worked in concert with partner CMHCs and FQHCs, community-based providers, agencies, and advocacy organizations to address the health care needs of the Medicaid Members in the region, including facilitating recovery and resiliency through Member-run and innovative programs that have resulted in improvement in symptoms, functioning, and quality of life.

For example, during the most recent audit, HSAG noted that ICHP's care coordinators appeared to more widely embrace the comprehensive care coordination requirements of the RCCO contract (i.e., they addressed more than referrals to specialists, including attending to numerous behavioral and social needs). The report further stated that record reviews demonstrated that care coordinators routinely assisted Members with securing: transportation, housing, food, clothing, and financial assistance with utilities and prescriptions. Records regularly included details such as the Member's social and family supports and cultural considerations, and demonstrated a robust and effective system of care coordination. Coupled with Beacon's proven administration, clinical and quality management, and their ability to build and support strong networks of physical and behavioral health providers, FQHCs, rural health clinics, and independent practitioners underscore Health Colorado's position as a well-positioned RAE for Region 4.

c. Population served: Medicaid

d. Primary health care services included: Primary health care services included the delivery and coordination of integrated physical, behavioral, and oral health care services. ICHP staff developed a population health management program that takes into account a multitude of medical and social determinants of health for identifying Members who could benefit from targeted care coordination interventions. The ability to identify and stratify Members based on medical claims information, social determinants of health, and life transitions is crucial to providing adequate support for care coordinators tasked with Member outreach.

e. Level of managed care and financial risk: ICHP is a PCCM Entity that receives a per member per month (PMPM) payment for the Regional population being served and while all risk is held by the Department, ICHP provides key managed care, care coordination activities and functions to help the Department manage their risk.

f. Activities in Rural and Frontier Areas: RCCO Region 4 is a diverse area of 19 counties comprising nine frontier counties, nine rural counties, and one urban county. Approximately 50 percent of ICHP's membership in Region 4 is located outside the urban area of Pueblo. Region 4 can be further divided into four sub-regions: San Luis Valley, Central (primarily Pueblo), Upper Arkansas Valley, and East (the Plains). The sub-regional divisions are largely defined by geographical and cultural boundaries, and each have unique characteristics that require different approaches to meet the needs of Members in those areas. The extent to which a system of care can function within the context of rural and frontier counties depends on the ability to understand the existing relationships and find ways to align goals and objectives.

Over the past six years, Beacon has developed an extensive network of community partnerships that enhance ICHP's health neighborhoods, created structures where state and regional initiatives are executed, and collaborated in building systems for delivering comprehensive medical and non-medical care for Members. Relationships have been established across the region with county agencies, including the Department of Social Services, Adult Protective Services, Child Protective Services, Public Health and Nursing, Single Entry Point agencies, and Community Centered Boards. ICHP's partners have been increasingly involved with agencies across the region and have created collaborative affiliations across systems that are mutually supportive and promote better outcomes.

g. Corrective actions: ICHP has participated in five EQRO site visits since 2012. Listed below is a summary of the results of each site visit. Full reports on site visit results are available for review.

Since 2012, ICHP has never scored below 93 percent on an EQRO site visit.

Fiscal Year	EQRO Score and Corrective Action Plan (CAP)
2012 – 2013	EQRO Score: 93% No CAP required.
2013 – 2014	EQRO Score: 100% No CAP required.
2014 – 2015	EQRO Score: 100% No CAP required.
2015 – 2016	EQRO Score: 97% No CAP required.
2016 – 2017	EQRO Score: HSAG did not score this year's audit. No CAP required.

h. Adverse Contract Actions or Project Litigation: None

i. Project Contract Manager:
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Northeast Behavioral Health Partnership, LLC (NHPP)

a. Project Name and location: Colorado Department of Health Care Policy & Financing, Community Behavioral Health Services Program for the Northeast Service Area, Greeley, Colorado.

b. The population(s) served and number of covered lives: At the time the contracted ended in June 2014, NHPP served 132,113 Medicaid Members, including children, adults, older adults, and dual eligible Members. Populations included individuals with SPMI, SED, disabilities, and multiple chronic, co-morbid conditions.

NHPP successfully managed the Colorado Community Behavioral Health Services Program in the Northeast Service Area from 2009 to 2014. As the BHO for the Northeast Service Area, NHPP provided a wide-range of integrated mental health and substance use disorder recovery-based services that focused on addressing Members' needs holistically and developing personalized care plans that reflect individual goals for recovery. Services provided within the community included:

- Assertive Community Treatment programs
- Certified Clubhouses
- Combined Substance Use Disorder and Mental Health Services
- Drop-in Centers
- Family support, education and training services
- Other integrated services for dual diagnosis
- Peer mentoring for children and adolescents
- Prevention services and early intervention activities
- Respite Services
- Early childhood intervention services
- Warm (telephone support) lines
- Special services for adoption issues
- Recovery services
- Peer services and support services
- Other integrated services for dual diagnosis
- Intensive case management
- Home-based services for children and adolescents
- Evidence-Based Practices (e.g., Multi-Systemic therapy, Functional Family Therapy)
- Vocational and employment services

c. Population served: Medicaid

d. Primary health care services included: None

e. Level of managed care and financial risk: NHPP was a full risk bearing entity that received a single capitated payment from the Department to manage all behavioral health services and supports under the Northeast BHO contract.

f. Activities in Rural and Frontier Areas: NHPP's service area comprised the 12 counties in the Northeast Service Area: two counties that are urban and rural (Weld and Larimer), and 10 counties that are rural/frontier (Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma). To overcome the challenges in these rural and frontier areas, NHPP had established a diverse provider network. Since very few providers practiced outside of the CMHCs throughout most of the Northeast Service Area, NHPP leveraged their contracts with 13 CMHCs to promote innovative solutions and address these gaps.

In order to provide a fiscally responsible and comprehensive suite of services across the entire area, NHPP configured creative service solutions. For example, NHPP implemented the first telehealth in the region in the late 1990s to leverage advanced telehealth technology to reach Members living in remote areas. Telehealth has many possibilities to reach people who have physical or other barriers to go to an office-based visit, including closed-captioned telehealth between a behavioral health clinician or primary care provider and a Member who is deaf or hard of hearing. NHPP also piloted a consultative psychiatric model throughout the Northeast Service Area for practices that do not have access to child psychiatrists. The Colorado Psychiatric Access and Consultation for Kids (C-PACK) program continues to help primary care providers meet the behavioral health needs of children in their practices. C-PACK replicated the evidenced-based Massachusetts Child Psychiatry Access Project (MCPAP) developed by Beacon in 2004, which was the precursor to the National Network of Child Psychiatry Access Programs (NNCPAP).

g. Corrective actions: NHPP participated in four EQRO site visits from 2010 through the end of the contract in 2014. Listed below is a summary of the results of each site visit. Full reports on site visit results are available for review.

From 2010 through the end of the contract, NHPP never scored below 93 percent on an EQRO site visit.

Fiscal Year	EQRO Score and Corrective Action Plan (CAP)
2009 – 2010	EQRO Score: 97% No CAP required.
2010 – 2011	EQRO Score: 99% No CAP required.
2011 – 2012	EQRO Score: 93% CAP for expedited appeal resolution.
2012 – 2013	EQRO Score: 99% CAP for delegation agreement.

h. Adverse Contract Actions or Project Litigation: None

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WHY THIS EXPERIENCE MATTERS

NHP recognizes that each State government has unique physical and behavioral health care priorities, delivery system challenges, and program goals. Fundamentally, the experience that qualifies NHP to be awarded the Region 2 RAE is that the staff that will be operating the RAE live, shop and eat in the communities the RAE serves. Our employees and their children go to the same schools, play on the same local sport teams, and worship in the same places as the Health First Colorado membership we serve. We cannot help but see the community health issues the RAE must address.

Our extensive experience, tenure, technological innovations, and flexible program design implemented within a Member-focused and recovery-oriented philosophy enable us to work in partnership with state agencies, FQHCs, CMHCs, private practice providers, Members, advocacy

organizations, and others to develop and implement Member- and family-centered, cost-effective health care programs.

We know that the successful launch of the next iteration of the ACC program will require engaging an Offeror who will bring the Department a combination of deep and broad experience transforming state Medicaid programs as well as local knowledge and experience working with, Colorado providers in Region 2. We have provided details about our local and national experience in our response throughout this section. Our local Colorado leadership has extensive experience working in and with the RAE Region 2 provider and stakeholder community, experience working with the Department, knowledge of the origins and evolution of the Health First Colorado policies and programs, and the ability to leverage transformational processes learned from other mature Medicaid markets across the country. Our reputation within the state of Colorado along with our extensive experience interacting with providers and our ability to leverage existing staff, tools, and technology already in place in Greely and Colorado Springs and throughout Region 2 will enable us to quickly implement and operate the RAE contract and meet and exceed the Department's goals for the RAE program.

We have also demonstrated through our 20 plus year history serving the Department across different Medicaid delivery models that our organizations are flexible and adaptable. We have constructed this new organization so that we can not only exceed the expectations of the ACC 2.0 RAE contract, but also have the right resources, experience, and assets on hand to evolve with the Department in any aspect of payment, delivery or general system reform including pilot programs. The only thing we can be certain of is change and this organization with its extensive experience and diverse partners and expansive relationships in the community will adapt with the Department to continue to be successful.

OFFEROR'S RESPONSE 4

Provide all of the following:

a. Description of the internal organizational structure, including a delineated management structure. The organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various components and departments of the organization, and be easily understood and accessible by those interfacing with the organization. Describe how the organizational structure facilitates creative thinking and innovative solutions.
b. An organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure.
c. A list of Key Personnel and their resumes. Identify which Key Personnel has the majority of their work experience in behavioral health.

a. DESCRIPTION OF THE INTERNAL ORGANIZATIONAL STRUCTURE

The participating partners in NHP Partners, LLC (NHP) will build upon their previous experience of collaborating with each other to establish a management structure with clearly defined lines of responsibility and designed to facilitate interaction with the Department and Colorado's Region 2 Medicaid Members. In our review of the Regional Accountable Entity's (RAE) Scope of Work, we identified a need for a new type of partnership bringing together local, experienced organizations that serve the physical and behavioral health needs of Members through well designed care coordination, public health education, and provider transformation programs.

NHP's Region 2 RAE will be designed to be client and Member-centric and comply with all the Department's requirements for key personnel and organizational reporting structure. Our Program Officer will be the main point of contact for the Department, with all other positions supporting the RAE reporting up to this individual. We will have a single administrative office in Greeley, Colorado, with all key personnel and the majority of the supporting staff located in one central location.

NHP will be governed by a board of directors composed of the four long-standing, mission-focused organizations with deep experience serving Colorado's Medicaid clients and other populations such as the uninsured. The Board will be comprised of experienced leadership from: Salud Family Health Centers (Salud), North Range Behavioral Health (North Range), Centennial Mental Health Center (Centennial), Sunrise Community Health (Sunrise). The Board will meet monthly to review the key performance measures of the company giving guidance and direction to the Program Officer. The Program Officer will have full authority to execute on the RAE contract.

Company Organizational Chart

These organizations bring the following experience serving Colorado's Medicaid population and the safety-net community:

- Salud serves more than 4,000 uninsured local residents and more than 9,000 Medicaid Members each year.
- North Range serves more than 3,000 uninsured local residents and more than 9,000 Medicaid Members each year.
- Centennial serves more than 889 uninsured local residents and more than 2,500 Medicaid Members each year.
- Sunrise serves more than 9,500 uninsured local residents and more than 21,000 Medicaid Members each year.
- Beacon Health Options (Beacon) offers administrative support for more than 600,000 Colorado Medicaid Members through the Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) programs.

Our Board sees their role as working with the Department as a partnership to aide in the success of the RAE Program for the Members and providers we serve. Our, Senior Management Team, which comprises the key personnel noted in the RFP, will also be available as direct contacts to the Department's similar functional leads. For example, our CFO will be a direct contact with the Department's finance team and our Chief Clinical Officer will be a direct contact for the Department's clinical contacts. In this way, the Department will be able to engage with NHP 's functional leads without delay. We encourage all communication to be in the simplest form to the Department. Our key personnel will be both proactive and responsive answering all emails and returning all calls to state agencies the same business day or within 24 hours.

Governing Board of Directors

The organizational structure of the new entity begins with a highly experienced, local executive leadership team that is in full control of the management of the RAE contract with the Department, as well as the strategy, operations, and governance of the company. NHP will be a locally staffed, structured, and governed organization. It is not a local unit of a national company and will not answer to the instruction or goals of executives outside of Region 2. Because the RAE is a singular, integrated health organization, we have created an executive leadership model, governance model, and management structure that does not delineate between physical and behavioral health functions as was the case in previous RCCO and BHO organizations across Colorado.

Senior Leadership Team (Operating Group)

Our Senior Leadership team includes department heads that report directly to NHP 's Program Officer. The Chief Clinical Officer (CCO) will report directly to the Program Officer. In this way, NHP's Board will maintain a focus on clinical initiatives and key performance measures directly from the CCO. Members of this team are responsible and accountable for the execution of all services performed by the organization in service of the RAE program. This team includes all of the key personnel identified in the RFP, as well as other key leadership roles. Each member of this team is an experienced leader that has served in a past leadership role serving the Health First Colorado membership, and brings a wealth of local experience to their role. Each member of this team is responsible for all aspects of their associated function as depicted in the table below:

Role	Summary of Responsibilities
Program Officer	Our Program Officer is not only our interface to the Department, but also the Chief Operating Officer of the RAE program for NHP. The Program Officer directs the administration of the contract and strategic planning implementation. This senior leader has a direct line of communication to the Executive Team and Governing Board and is empowered to manage the key resources listed below and their staff in the execution of the contract with the following objectives:

Role	Summary of Responsibilities
	• **Get it right the first time:** Meet all contractual deliverables and perform all functions to the expectations and requirements of all constituents including the Department, Members, and providers. • **Enhance satisfaction with our services to the Department and providers:** Identify and implement enhancements to current operations to continually exceed baseline expectations with our program and services. It is simply not good enough to meet the basic requirements of the program. • **Exceed the performance expectations of the program across all key performance measures:** We are rapidly moving to a value-based health care environment and the RAE exists to support this transition with Medicaid providers in Region 2.
Chief Financial Officer (CFO)	Our CFO is responsible for all financial modelling, financial tracking, and financial reporting. The CFO manages the finances of the contract as well as the finances of the NHP organization. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.1 Contractor's General Requirements • Section 5.2 Personnel • Section 5.3 Regional Accountable Entity • Section 5.16 Start-up and Closeout Periods • Section 5.11 Primary Care Alternative Payment Methodology (Primary Care APM).
Chief Clinical Officer (CCO)	Our CCO is responsible for clinical oversight, strategy, and execution. This resource is our external face to the provider community and will work directly with providers as a peer resource to assist with practice performance, transformation and adoption of clinical and operational best practices. The CCO also directs utilization management (UM). This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.8 Health Neighborhood and Community, • Section 5.9 Population Health Management and Care Coordination • Section 5.12 Capitated Behavioral Health Benefit
Quality Improvement Director	Our Director of Quality Improvement is responsible for the management and operations of all quality management (QM) and performance improvement functions of the RAE. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.14 Outcomes, Quality Assessment, and Performance Improvement Program • Section 5.15 Compliance.
Health Information Technology (Health IT) and Data Director	Our Director of Health IT and Data is responsible for the management and operations of all IT and data functions of the RAE. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.13 Data, Analytics, and Claims Processing System
Utilization Management (UM) Director	Our UM Director is responsible for the management and operations of all UM functions of the RAE. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.14 Outcomes, Quality Assessment, and Performance Improvement Program; and

Role	Summary of Responsibilities
	• Section 5.15 Compliance
Member Services Director	Our Director of Member Services is responsible for the management and operations of all Member services, Member communication, and Member engagement functions of the RAE. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.4 Member Enrollment and Attribution • Section 5.5 Member Engagement • Section 5.6 Grievances and Appeals.
Provider Services Director	Our Director of Provider Services is responsible for the management and operations of all provider network development, network management, and provider services functions of the RAE. This leader is responsible for all requirements and deliverables in the following sections of the RFP: • Section 5.7 Network Development and Access Standards • Section 5.10 Provider Support and Practice Transformation, • Section 5.11 Primary Care Alternative Payment Methodology (Primary Care APM).

Authority

Each of the key personnel on the Senior Leadership Team is empowered with the authority to operate their departments in the most efficient manner to meet the goals and objectives of the RAE. However, the NHP organization provides a values-based operating structure that all management and operational staff are expected to adhere to. These values include:

- Our business exists only to service Colorado Medicaid as the RAE.
- All NHP staff will conduct business with the below values in mind. Business decisions will be evaluated based on achievement of the contractual, operational, or financial goal, and measured against the following values:
  - **Integrity:** We earn trust of our client, community, Members, and providers.
  - **Dignity:** We respect others including their needs, differences, and opinions, and factor that in our approach and response.
  - **Community:** We thrive together and exist to build people, process, and technology that has a community benefit that is larger than the RAE program itself.
  - **Resiliency:** We overcome adversity and grow from challenges. We do not avoid difficult conversations, tasks, or projects, but rather see them as an opportunity for growth.
  - **Ingenuity:** We prove ourselves by finding new ways of doing things that provide value to the Department, providers, Members, and our organization.
  - **Advocacy:** We lead with purpose and exist only to serve.

Communication

Open lines of communication and collaboration are critical to success in an organization that is managing all aspects of health like the RAE. As a purpose-built, local organization, NHP benefits from a large local office that houses all full-time employees that serve Region 2. We benefit from real-time collaboration from a highly integrated physical office environment and easy access to the Department from all local resources.

In addition to face-to-face meetings as described above, NHP uses technology to enable real-time communication and collaboration channels that suit individual resources' needs and preferences such as: telephone conferencing, video conferences, web-based meetings, secure instant messenger, and secure email. We also encourage an open-door policy with our Senior Leadership

team so that all staff has equal access to their respective department leaders and the leaders of other functional groups.

While internal communications are important for program execution and collaboration across departments, communications with external partners, providers, Members, and the Department are equally important. While NHP's Program Officer is fully dedicated to act as the external face of our organization to the Department, the Board of Directors and the entire Senior Leadership Team are available to the Department. These key personnel and their staff are also available for External Quality Review Organization (EQRO) audits and quality reviews at our site. At a minimum, the following external communication forums and tools will be used by our organization:

Creativity and Innovation

> **"An innovation will get traction only if it helps people get something that they're already doing in their lives done better."**
>
> **- Clayton Christensen**

We believe innovation can come from anywhere. At all levels of the organization, our colleagues identify community, provider, Member, or even unstated customer needs and are empowered to bring those needs to their colleagues at any level of the organization to discuss and propose potential solutions. Past innovations that have been identified by team members and supported by management for new programs and services to improve service includes:

For example, since the inception of the RCCO, North Range Behavioral Health (NRBH) has dedicated behavioral health staff to be a part of the RCCO Care Coordination team. While they were/are employed by NRBH, these 2 staff "live with" the other RCCO Care Coordinators and focus on BH hotspotter clients

We believe innovation can come from anywhere. At all levels of the organization, our colleagues identify community, provider, Member, or even unstated customer needs and are empowered to bring those needs to their colleagues at any level of the organization to discuss and propose potential solutions. Past innovations that have been identified by team members and supported by management for new programs and services to improve service includes, but is not limited to:

- **Integration of physical and behavioral health services for pain management and opioid abuse/dependence:** with measureable outcomes based on OpiSafe, a technology that incorporates best practices from various disciplines. Providers and practitioners from multiple disciplines participate in the program that primarily serves adjudicated individuals, including: substance use disorder treatment, behavioral health counseling, Medication Assisted Treatment (MAT), primary care, physical therapy, care coordination and other supportive services as needed.
- **Development of a health neighborhood through an Integrated Treatment Team (ITT) approach:** that utilizes data to identify Members for inclusion based on conditions, risk stratification, risk scores, co-morbid physical/behavioral conditions, emergency department/inpatient utilization, pharmacy data and other relevant data points. The ITT incorporates appropriate providers and agencies such as DSS, local mental health, the local Federally Qualified Health Centers, home health, and public health. An integrated treatment plan is created to address clinical and non-clinical needs of Members.
- **Action Lab:** An Action Lab is a community process to collectively develop solutions, goals, and an action plan to address a systems change. A "100 Day Challenge," takes place, where intervention strategies that were developed are implemented into our community. From September 2016-January 2017, NCHA embarked on a community-based Action Lab to create inter-agency interventions to improve responses to non-emergent 9-11 calls that result in unnecessary Emergency Department (ED) visits or arrests. Action Lab Goals:

- Better understand the scope of challenges faced by law enforcement/first responders when working with high utilizers of the system
- Develop better system integration and responses to non-emergent 911 calls to provide law enforcement with alternatives to emergency department and/or jail
- Identify health/human services needs for better system integration of resources

To curate innovative ideas from the Member, provider, and stakeholder community, we will conduct regular stakeholder feedback sessions, forums, and listening sessions. In past session with County Jail medical staff, Colorado Department of Corrections/Youth Services, and Colorado Judicial Branches Beacon identified a need for clinical information to be shared among the 36 independent Sheriffs in rural and frontier regions of southern Colorado. Understanding the need for this information so that Members transitioning to and from incarceration and the community can continue their medication regimen uninterrupted, Beacon developed and implemented JusticeConnect in the BHO South/West Service Area to ensure that Members incarcerated within the criminal justice system receive medically necessary services within two weeks of release.

We identify individuals by first analyzing data from the Colorado Victim Identification Notification System (VINE) that identifies all individuals that have been:

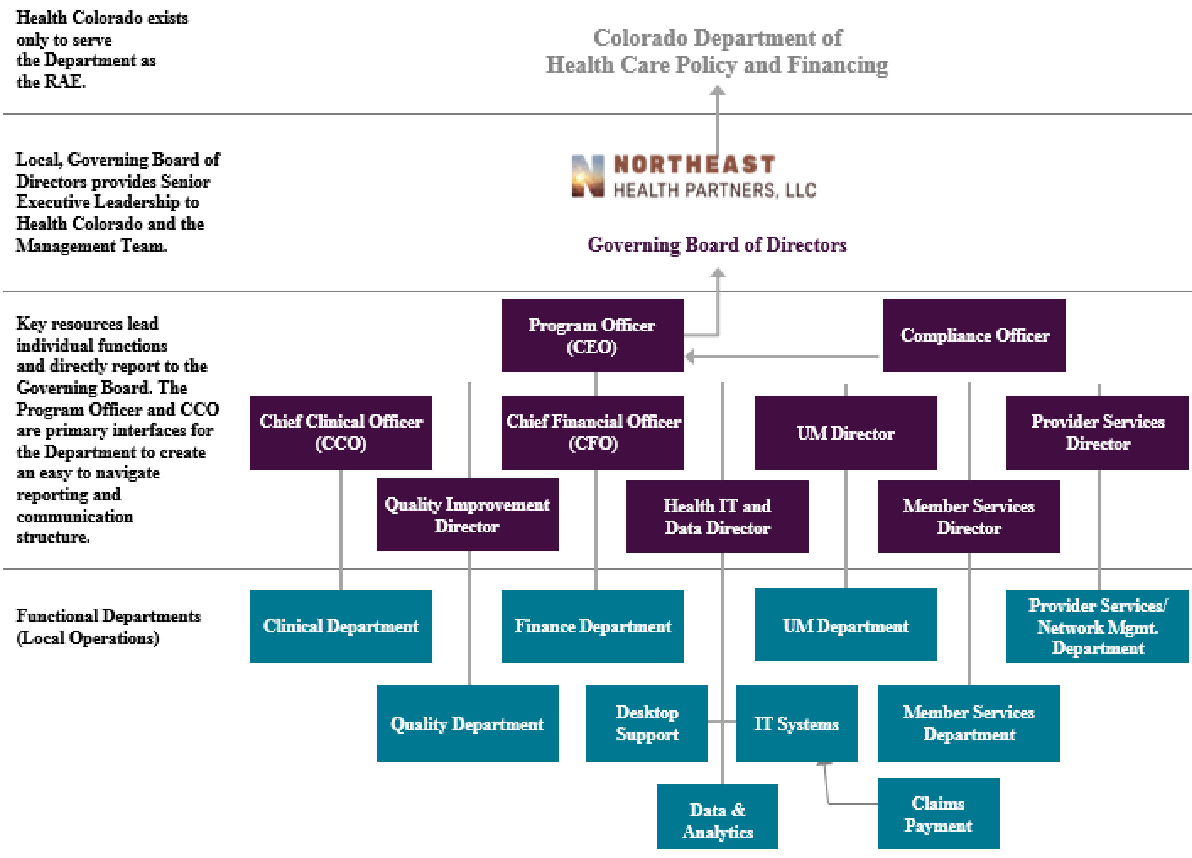
- Detained and processed at the local detention centers in the past 24-hour period
- Incarcerated at a local detention center and county jails across Colorado

Since January 1, 2013, Beacon's JusticeConnect system has processed approximately 137,873 records and identified a "match" of Members with behavioral health and/or pharmacy claims 26 percent of the time.

This data is then compared with Medicaid eligibility data using agreed upon data points to identify a detainee as a "match." Once a match is identified, the process looks for behavioral health authorizations and paid Medicaid pharmacy claims within the past calendar year. This information is then electronically returned to the correctional system and uploaded into the correctional facility's Electronic Health Record system where it can be viewed by authorized detention center medical staff. Detention center medical staff then use this data to address the detainees medical and behavioral health needs. Simultaneously, the data is also shared with the local behavioral health center that assists in providing coordinated care for the individual while detained and on release. A web portal was established that allows the appropriate correctional facility to report pending releases, thereby alerting behavioral health centers to the need to coordinate services within two weeks of release and ongoing thereafter.

b. ORGANIZATIONAL CHART

Below and on the following pages, we have provided our governance structure and organizational charts listing all positions that are responsible for the performance of all activity related to the RAE contract, including hierarchy and reporting structure.



c. KEY PERSONNEL

In the table below, we have identified NHP 's key personnel for the RAE contract in Region 2 and have provided their résumés as **Attachment 2**. In addition, we have identified those key personnel who have had a majority of their work experience in behavioral health.

Key Personnel Role	Key Personnel	Majority Work Experience in Behavioral or Physical Health
Program Officer	Todd Lessley, MPH, RN, BSN	Physical Health (Integrated)
Chief Financial Officer	Gerry Brew, CPA	Behavioral Health
Chief Clinical Officer	Lesley Brooks, MD	Physical Health (Integrated)
Quality Improvement Director	Don Gutstadt PA	Physical Health (Integrated)
Health IT and Data Director	Rob Martin	Physical Health
UM Director	Tamara McCoy, Ph.D.	Behavioral Health

OFFEROR'S RESPONSE 5

Describe how the Offeror will:

a. Ensure adequate essential personnel to perform the functions of the Contract.
b. Train and support personnel to ensure the Contract is carried out as effectively as possible.
c. Fill personnel vacancies to fulfill Contract requirements.

a. ENSURING ADEQUATE ESSENTIAL PERSONNEL

Northeast Health Partners, LLC (NHP) will ensure that we have sufficient qualified staff to meet the requirements of the Regional Accountable Entity (RAE) and to perform the functions of the Contract. For all staff, licensed and non-licensed, we verify with the Office of the Inspector General, General Service Administration, and the Office of Foreign Asset Control that staff have not been excluded from federally funded programs. We do not employ or contract with any individual who had been suspended, excluded, disbarred, or is otherwise ineligible to participate in any federal reimbursement program. Finally, we complete a thorough background check on each staff member prior to employment to check for eligibility to work in the US, licensure validation, social security verification, criminal history, drug use, and education. Additionally, the roles and responsibilities of all senior staff are independent of any other behavioral health provider organization. This clear separation of responsibilities eliminates any potential conflict of interest between employer organizations.

Education, certification, and licensure requirements are established for each job to serve as the basis for needed knowledge and skill, market pricing, competency evaluation, and recruitment. Educational requirements are established based on required academic knowledge and training, level of decision-making and problem solving, written and verbal communication skills, general market and professional standards, and regulatory requirements.

Our talent management strategy is to ensure personnel are able to fully carry out the duties of the RAE contract. This strategy is carried out by our organizational Human Resources processes designed to attract, develop, motivate, and retain productive, engaged staff. This includes a comprehensive new hire on-boarding program and orientation of our existing staff to:

- Acquaint them with the physical structure of the facility and safety/security programs
- Familiarize them with organizational and human resources policies and procedures
- Orient them to our Member population
- Require passing score on our extensive compliance and program integrity training program
- Effect a smooth transition to employment with frequent performance assessments and a 90-day performance review to insure job mastery
- Promote quality work performance and long-term success through ongoing job specific training, annual mandatory training, and systematic performance reviews
- Promote a comprehensive understanding of our mission, goals, and service/ performance expectations

As detailed in our response to *Offeror's Response 4*, key personnel for Region 2 include:

- **Program Officer:** Todd Lessley
- **Chief Clinical Officer:** Lesley Brooks, MD
- **Chief Financial Officer:** Gerry Brew
- **Quality Improvement Director:** Don Gutstadt PA
- **Health IT and Data Director:** Rob Martin
- **Utilization Management (UM) Director:** Tamara McCoy, Ph.D

In addition to the required key personnel, we have also identified the need for additional positions to meet the goals of the Accountable Care Collaborative 2.0 and carry out the functions of the contract as effectively as possible:

- Director, Member Services
- Director, Provider Relations and Network Management
- Medical Director (UM)
- Compliance Officer

These individuals will:

- Be available for meetings with the Department within the Department's normal business hours or outside of normal hours with notice from the Department
- Be available for all regularly scheduled meetings with the Department
- Have the authority to represent and commit NHP regarding work planning, problem resolution, and program development
- Attend meetings, at the Department's direction, with stakeholders as subject matter experts within the state government or with private stakeholders
- Be physically present at the location of the meeting, unless the Department gives prior, written permission to attend by telephone or video conference
- Respond to all telephone calls, voicemails, and emails from the Department within one business day of receipt by NHP. We will inform the Department if key personnel are replaced temporarily due to illness, family emergencies, or other kinds of leave.
- Inform the Department if a key personnel position is vacant and who will be acting as the key position until that position can be filled

b. TRAINING AND SUPPORTING PERSONNEL

NHP's management staff will be highly skilled and experienced. However, the key to what makes our management and provider staff different from most, is our organizational commitment to serving the people of Colorado. Unlike most of our larger competitors, our senior managers do not divide attention between multiple programs across multiple states. All of our efforts are focused on delivering the best possible behavioral health care services right here in the communities where we live and work.

Staff will be provided with ongoing development opportunities, consisting of required, remedial, and voluntary career advancement/personal growth training. For example, clinical staff will be offered educational resources to support access to, and reimbursement for, continuing education units (CEUs) and professional licensure fees.

We will require annual training programs for all personnel using the Relias eLearning system. Relias tracks and reports all trainings to ensure that they have been completed by every employee. Relias offers hundreds of training programs that may be accessed to obtain needed CEU credits as well as additional position trainings required by the RAE contract.

In addition to RAE contract-specific training, required annual training includes:

- Fraud, Waste, and Abuse
- General Compliance
- Confidentiality and HIPAA
- General Privacy and 42 CFR Part 2
- Ethics and Code of Conduct
- Utilization Review Accreditation Commission (URAC)
- Cost Management Strategies and Best Practices

During our annual appraisal process, every staff member will receive a development plan that specifically identifies his/her areas of growth and the means to attain the skills and/or knowledge. Performance evaluations comprise personnel feedback, manager feedback, and rating performance. Areas of evaluation include: accomplishments, competency, and goals. Employees have access to many high-quality interactive eLearning courses in the following categories: Leadership, Management, Productivity, and Technical. Courses such as Managing Meetings for Effectiveness, Influencing and Persuading, Coping with Information Overload, Project Management Essentials, and Communicating Effectively with Senior Executives are just a few examples of offerings. We also have a formal mentoring program where high-potential employees who must meet strict criteria are paired with some of our most impressive and accomplished managers and leaders. The program begins with an in-person meeting between the pairs, and continues with nine months of structured mentoring sessions. This program is integrated with our succession planning efforts.

In addition to providing training that promotes employee engagement and retention, we will offer employees trainings that will educate them to serve a diverse Member population. These trainings will enable staff to better serve Medicaid Members and will include:

- Culture and Disability Competency
- Member Rights and Responsibilities
- Health Literacy
- Understanding Poverty and Social Determinants of Health
- Mental Health First Aid
- ADA Training
- Customer Service Skills for the Medicaid Population
- The Value of Peer Specialists
- Colorado Crisis Services
- Substance Abuse and Mental Health Services Administration (SAMHSA) Principles of Recovery

Employees at all levels and all departments within the RAE will be trained so that we can create a culture of respect for and service to our Medicaid Members.

c. FILLING PERSONNEL VACANCIES

NHP's key personnel will be supported and backed by our unique partnership with Beacon. As a matrixed organization, Beacon's senior national matrix leads are tasked with providing temporary replacements during any turnover of key personnel. All replacements are already well experienced in supporting Medicaid contracts in their specialty, be it Quality Management or Member Affairs. A temporary replacement may be assigned from Beacon's national staff or from another Beacon Engagement Center. The great depth of Medicaid expertise within Beacon provides a stability in operations that is unequaled by other Colorado RAEs.

In addition to the strategies above, we believe staff retention and satisfaction is a proactive strategy to avoiding unexpected personnel vacancies. The foundation of this is our talent management process that focuses on integrating our unique and successful employment brand across all operational functions. Our goal throughout this process is to create and maintain a mission-driven organization whose staff strive to always do their best for the Members that we serve, and to have a committed relationship to this purpose and our organization. Engaged staff that are intrinsically connected to the work they do, perform better, and stay with the organization to continue to do excellent work throughout the course of their careers with us.

Our dedication to retaining staff is evident in our continual efforts to apply our commitment to compassionate service-not only to our external customers, but to our staff as internal customers. We provide creative incentives to meet the needs of our evolving workforce, such as:

- Staff and supervisor training programs

- Competitive pay and benefits programs
- Flexible schedules, telecommuting, and other alternatives scheduling options
- Employee access to onsite training programs for staff development and CEU certification, through the behavioral health community and educational systems
- Development of career paths

One of the key strengths that NHP brings to Region 2 and the Department is the tenure and longevity that our partners' staff have in southeastern Colorado, and with their current organizations. The executive leadership of our partners have grown up and have lived in the region. Moreover, as Colorado Medicaid has evolved, the members of our Governing Board have been there every step of the way. On average, our partners' executive leadership have been in place with their organizations for more than 15 years. This familiarity and experience, specifically in the rural and frontier counties of Region 2, is invaluable as the Department's vision for integrated care continues to unfold across the state.

The legacy that our partners and staff have cultivated in Region 2 through serving community needs has resulted in nearly 60 years of local experience and Colorado Medicaid program experience. We look forward to continuing the great work we have started in Region 2 as the RAE.

OFFEROR'S RESPONSE 6

Describe how the Offeror will use Subcontractors (if the Offeror plans to), and the percentage of work that will be completed by each Subcontractor. Include the anticipated positions and roles the Subcontractor will hold, as well as a plan for how the Offeror will manage the Subcontractor and all Subcontractor personnel to ensure that the portions of the Work assigned to the Subcontractor will be completed accurately and in a timely manner.

Northeast Health Partners, LLC (NHP) is new and purpose-built to serve the Department and Colorado's Medicaid Members as the Region 2 RAE. Beginning with our review of the draft RFP, we identified a need for a unique type of partnership bringing together local, experienced organizations that serve the physical and behavioral health needs of Members, as well as the care coordination, education, transformation, and administrative needs of the Department and the local provider community. This strategic decision was confirmed and strengthened when we reviewed the final RFP and its scope of work.

It is the synergy between progressive managed health care and providers focused on Member and family wellness that create the highly collaborative health care organization of NHP.

NHP will subcontract all administrative services of the Regional Accountable Entity (RAE) contract to Beacon Health Options, Inc. (Beacon). The value of Beacon's subcontract will not approach the subcontracting limit of forty percent of the total value of this contract. NHP has chosen Beacon to provide administrative services in support of our effort to create a purpose-built organization focused on delivering the highest value to the health care system and the Department due to both its familiarity with the Colorado Medicaid program and its strong national corporate resources. Of equal importance is our history of working with Beacon in the past. This past collaboration will allow us to work cooperatively as one unified entity, sharing a common goal of providing an integrated physical, behavioral, oral health, specialty and community, system of care that is Member and family-focused, and delivers the Department's goals of the Accountable Care Collaborative (ACC) Program.

ANTICIPATED POSITIONS/ROLES THE SUBCONTRACTOR WILL HOLD

NHP anticipates delegating the following positions/roles to Beacon:

- Quality Management
- Member Engagement
- Financial Management
- Data Accuracy and Integrity
- Legal/Compliance
- Utilization Management
- Provider Network Development and Management
- Business Intelligence
- IT and Data systems

All activities will be conducted in accordance with the applicable RAE regulations and contract.

MANAGING THE SUBCONTRACTOR AND THEIR PERSONNEL

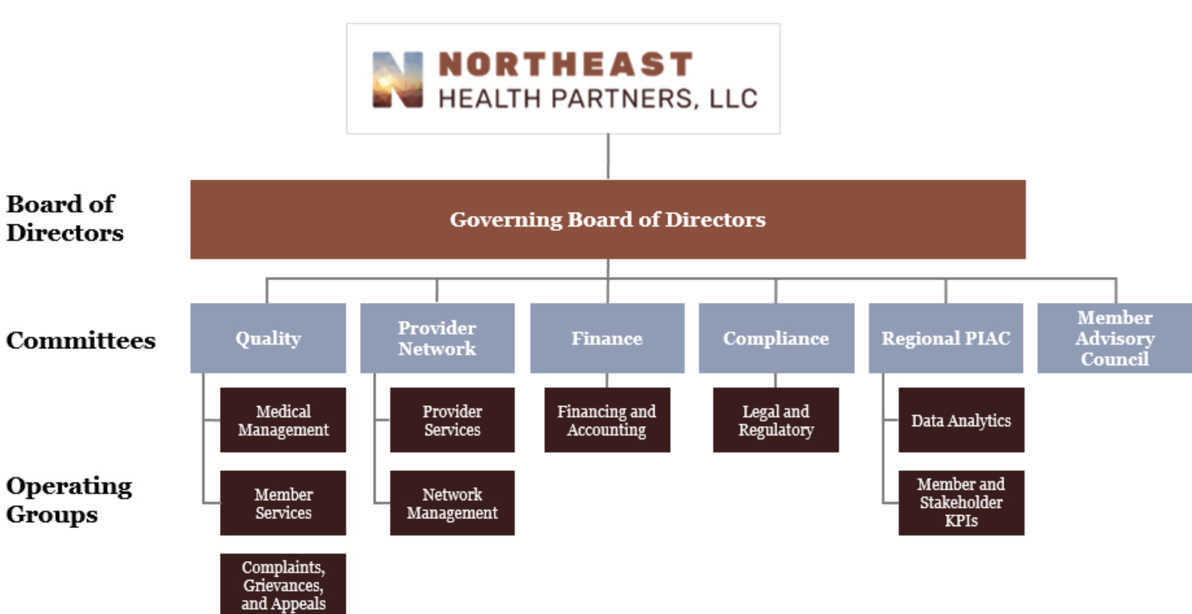
NHP's Governing Board has ultimate accountability for contract and regulatory compliance, and all other work performed under this contract, including the performance of all subcontracted and delegated entities.

Subcontractor Management through our Committee Structure

NHP has a strong committee structure, depicted below, through which we obtain stakeholder input and expert consensus. Each of the following committees may also have established sub-committees or operating groups to assist them in completing their associated tasks. These key committees include:

- **Quality Committee:** Medical Management (UM), Member Services, and Complaints Grievances and Appeals subcommittees
- **Provider Network Committee (PNC):** Network Management and Provider Services subcommittees
- **Finance Committee:** Finance and Accounting subcommittee
- **Compliance Committee:** Legal and Regulatory subcommittee
- **Performance Advisory Committee:** Data and Analytics, and Member and Stakeholder Key Performance Indicators subcommittees
- **Program Improvement Advisory Committee (PIAC)**
- **Member Advisory Council**

NHP's Committee Structure



As noted in the committee structure above, NHP will also seek input on subcontractor performance and program delivery decisions from a Regional Program Improvement Advisory Committee (PIAC) and Member Advisory Board. The Regional PIAC includes Members, family members and/or caregivers, Health Neighborhood provider types, and other individuals who represent advocacy and community-based organizations, local public health organizations, and child welfare agencies.

To facilitate oversight, minutes of each committee are submitted to our governing board, as well as reports representing quality, clinical, Member and family affairs, IT, finance, and compliance activities. All compliance issues that result in corrective action recommendations are presented to the Board for evaluation, approval, and enforcement.

To ensure appropriate oversight, NHP will systematically monitor delegated functions via scheduled submissions of documentation and reports demonstrating compliance with contract requirements and timelines to the Board. In addition to Board review of documentation and reports, NHP staff will audit grievances, credentialing, and denial and appeal processes through an annual onsite audit. Audit results are presented to the Board and the corrective action process is initiated for areas identified as being out of compliance.

OFFEROR'S RESPONSE 7

Describe how the Offeror will administer the PCCM Entity and PIHP as one program with integrated clinical care, operations, management, and data systems.

The partner organizations that comprise Northeast Health Partners, LLC (NHP) all have extensive experience serving the Department of Health Care Policy and Financing (the Department) as both Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) contractors. Building off this experience, we have created a wholly new entity, NHP, which brings together organizations with experience serving the Accountable Care Collaborative Program (the ACC Program), Community Behavioral Health Services Program, and Long-Term Services and Supports (LTSS) populations. Operating under one roof, NHP intends to build on our experience serving each of these programs and integrating our service delivery to better serve Members and to effectively utilize state resources experience and functions with a unified administrative structure. NHP is well-positioned to perform the functions described in this Contract in compliance with pertinent state and federal statutes, regulations and rules, including the Department's 1915(b) and 1915 (c) Waiver Services for the ACC Program. Our past experience and new partnership will administer this new Regional Accountable Entity (RAE) in Region 2 by:

- Implementing a clinical care model that is provider-directed meaning that we will give providers the tools they need to serve their Members and offer a safety net to those that choose to delegate functions to us
- Deploying clinical leadership to the field who carry actionable and impactful information into their meetings with providers to enhance and improve care
- Leveraging an operational model that has been built and refined from over 20 years of experience in Colorado and national experience serving 50 million members, including approximately 14 million Medicaid members across 26 states and the District of Columbia
- Using a local and experienced management team that comes from a combined, experienced organization that is equally focused on all aspects and functions of the RAE program
- Benefiting from an existing technical and data infrastructure that has served both RCCO and BHO programs and is already connected to the Department and State infrastructure, as well as providers within our region.

CLINICAL CARE

Our philosophy on clinical care has evolved over time. We have setup our new organization to differentiate Member-facing and back-office clinical care. Member-facing clinical care is best delivered by providers in their local community. That direct engagement is best supported by telephonic engagement when possible. We believe any model addressing the complex needs of the Medicaid population needs to be built around a well-designed and operated care coordination program available to Members in the community and not from a back-office, remote telephonic location.

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as, "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."[1] This requires that **all** of the individual's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate and effective care. Consistent and

[1] McDonald, Kathryn, et. al. (June 2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Volume 7. Technical Review 9. AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality.

longitudinal monitoring of the population and timely response to individuals experiencing an acute episode is how care coordination transforms "treatment as usual."

This focus on ongoing monitoring, accountability, and responsibility for the population being cared for is a marked distinction from the traditional, non-integrated, reactive model of care. It is no longer enough to treat symptoms or address an isolated issue of an individual's health—that is just one aspect of the many responsibilities of the health care delivery system. Providers and managed care organizations must consistently address the whole person and provide services and resources that improve the overall quality of life of individuals in our communities.

Our goals have also evolved over time. Don Berwick and the Institute for Healthcare Improvement proposed his "Triple Aim" vision to transform the American health care system into one that promotes improved care on such principles as safety, effectiveness, person-centered, timeliness, efficiency, and equity. That transformation, according to Berwick, required an "integrator," an organization that takes the lead role in achieving the care that works. The basic concept of Triple Aim involves three concepts:

1. Improving the individual experience of care
2. Improving the health of populations
3. Reducing the per capita costs of care for populations

EVOLUTION TO THE QUADRUPLE AIM

Over time, the burden of adopting the Triple Aim framework began to wear on the care teams and providers. Care teams began to report that the stressful work they performed and the tools they used or lacked hampered their ability to successfully accomplish the Triple Aim. Physician dissatisfaction was identified as an early indicator that the health care system was creating barriers to high-quality practice. In 2014, Drs. Thomas Bodenheimer and Christine Sinsky published a paper in the Annals of Family Medicine titled "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider." In it, they effectively make the case that the ability to achieve the Triple Aim is jeopardized by the burnout of physicians and other health care providers. They proposed adding a fourth dimension to the three goals detailed in the Triple Aim: "the goal of improving the work life of health care providers, including clinicians and staff." In their paper, they cited that "burnout among the health care workforce threatens patient-centeredness and the Triple Aim. Dissatisfied physicians and nurses are associated with lower patient satisfaction. Physician and care team burnout may contribute to overuse of resources and thereby increased costs of care. Unhappy physicians are more likely to leave their practice; the cost of family physician turnover approaches $250,000 per physician. Dissatisfied physicians are more likely to prescribe inappropriate medications which can result in expensive complications." [2]

Quadruple Aim

NHP will embrace this enhanced paradigm and fill the role of a care team enabler and integrator across the total health and wellness of the Medicaid membership and provider network. We will provide tools, education, support, best practices, and actionable information to providers throughout

[2] Bodenheimer, T., MD, & Sinsky, C., MD. (2014, September 2). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Retrieved June 15, 2017, from http://www.annfammed.org/content/12/6/573.full

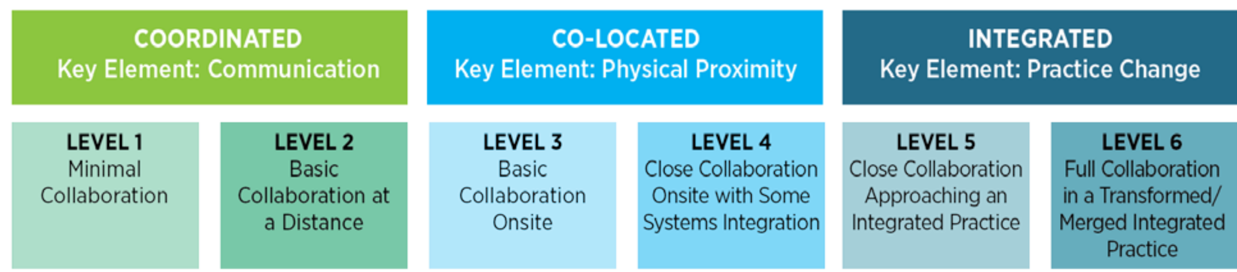
the region to ensure that all parts of the health care delivery system work together to treat Members in a holistic, person-centered manner. Consistent with the goals of the Department, our proposed infrastructure is focused on developing a provider-led regional population health improvement program that links community-based health initiatives with the delivery system, and provides that system with practice-centered tools and supports that reduce effort and fatigue. This will result in better equipped and supported providers that will be able to focus on the right tasks, at the right time, for the right Members.

As the RAE in Region 2, and in concert with the Quadruple Aim approach, NHP's clinical model, specifically as a care coordination enabler, begins with whole-person analytics supported by the new BIDM System. During start-up, depending on BIDM System capabilities, our analytics will be augmented with population analytics and custom algorithms from the health needs survey to identify all of the potential physical, behavioral, psychosocial, and social determinant needs of each Member. The results of these analytic processes will create target lists of Members that require different types of interventions defined in *Offeror's Response 15* and *Appendix I* of this RFP. As actionable alerts and target lists are distributed to care managers and coordinators in the community, Members will be engaged by a single resource that will own their case and assist with them with their most critical needs regardless of where that Member may fall in the spectrum of needs. On engagement, care managers/coordinators will develop a whole-person care plan based on their specific needs. For high-risk Members who have actively engaged with a care manager, this care plan will be updated with every new interaction and major utilization event. For low-risk Members whose claims history indicates little or no major health issues and do not appear on an alert or target list, this care plan may be as simple as continuing to monitor their utilization history on a monthly basis.

INTEGRATION SUCCESS

In addition to adopting the Quadruple Aim as a guiding principle of NHP, we will continue to maintain a clear focus on overall integration as each partner has in their past service to the Department and both RCCO and BHO organizations. In April 2013 the SAMHSA-HRSA Center for Integrated Health Solutions released *A Standard Framework for Levels of Integrated Healthcare* authored by Bern Heath, Pam Wise Romero and Kathy Reynolds. This issue brief expanded, updated and re-conceptualized the initial work of Doherty, McDaniel, and Baird (1996) to produce a national standard with six levels of collaboration/integration that run from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice. The chart below is from this Standardized Framework and has already been adopted by the NHP provider partners.

NHP Standardized Framework



Entering into this new program, the NHP provider partners have already achieved **Level 5** integration as defined in the model presented above. For example, North Range's integrated sites differ depending upon the location. Five sites are Level 5 integrated, two sites are Level 4 integrated, and one site is Level 3 integrated. North Range has two case managers embedded on the current

RCCO care coordination team and that achieves a Level 5 integration. Some of the integrated functions NHP brings to the RAE include:

- Integrated medical and psychiatric case consultations across multiple providers in the region
- Pre-screening for whole-person health using standardized toolsets
- Embedded care coordinators at Primary Care Medical Provider (PCMP) sites, as well embedded PCMPs at behavioral health sites as evidenced by our integration between North Range and Sunrise in Greeley.
- Implementation of the concept of empanelment which is the act of assigning individual Members to individual PCMPs, behavioral health, substance use, or care coordination with sensitivity to Member and family preference.
- Both Sunrise and Salud are current participants in national collaborative on oral health. All Salud and Sunrise patients have access to dental services that are integrated into the primary care environment. Dental services are provided to patients at all ages and include general cleanings and exams, diagnostic imaging, surgery procedures and extractions. For patients ages 0-20 and pregnant women of any age, Salud offers medical dental integration (MDI) where a dental hygienist participates in the medical appointment and provides oral hygiene education and fluoride varnish to lower risk of dental caries among children and pregnant women.

MEMBER-CENTERED CLINICAL CARE

The foundation of the care plan is based on reinforcing the individual's self-monitoring skills and recovery capability. This involves improving their ability to recognize the signs and symptoms of their disease and understand how to stay compliant with any medication they are receiving. For individuals with behavioral health conditions that compound their risk and affect their ability to manage their physical health needs, trained behavioral health clinicians will lead the case and provide an added focus on recovery, resiliency, and independence to maximize the Member's own skills and abilities.

Member-Centered Clinical Care

Health Community Partners
State Agencies and Courts
Care Coordination Team
Care Plan
Social Support Services
Family and Community Support
Individual
Caregiver
Peer Support
PCMP
Behavioral Health Providers
Health Neighborhood Providers
Online and Mobile Resources

The execution of the care plan establishes continuity of care along three dimensions. First, it provides informational continuity by using past events and personal circumstances to ensure current care is appropriate for each individual. Second, it provides interpersonal continuity by establishing ongoing therapeutic relationships between an individual and one or more clinicians. Third, it provides care management continuity through a coherent approach to management of a health condition that is responsive to an individual's changing needs.

While a single case owner will exist for each Member, the case owner may be from a provider or an external agency, such as a Healthy Community partner. Our fully integrated clinical experience will provide access to a multidisciplinary team that will include individuals from different health care disciplines who contribute specialized knowledge in non-hierarchical relationships and who act according to situational demands rather than a traditional organizational role.

Each individual of an organization that appears in the Member's individualized care plan will understand their role and will contribute to specific clinical activities for the Member. For example, a provider managing a complex Member with specific clinical needs for treatment or level of care that may not normally be clinically indicated, will have direct access to our Utilization Management (UM) Department or access through their care manager/care coordinator so that their case can be explained and a determination be made in near real-time. This level of collaboration will prevent the Member from having to wait for a denial and initiating a second-level review to accommodate their needs.

PRESCRIPTION DRUG INTERVENTION PROGRAM (PDIP)

NHP will empower all clinicians to close Member-specific care gaps by deployed advanced analytics that screen medical, behavioral, and pharmacy claims and augment the Department's BIDM System data on a monthly basis. By analyzing claims data for medication issues such as non-adherence, polypharmacy, sub-optimal dosing, and other clinically indicated gaps in care, providers are notified of these gaps creating an actionable opportunity to remedy for the member. Historically, when provided with real-time identification of care gaps, physicians close 60 percent of identified care gaps, compared to a natural change rate of 15 percent, with a corresponding drop in inpatient admissions that exceeds five percent. This type of monitoring has the greatest impact on populations with a higher incidence of health conditions such as our Medicaid membership.

Beacon designed PDIP to integrate with and analyze most pharmacy benefit manager (PBM) data to improve adherence to antidepressants and antipsychotics and prescribing practices among providers. This program combines expertise in psychiatry, psychopharmacology, physical health, and analytics to identify medication-related concerns, addressing problems through evidence-based interventions at both the Member and provider level. This retrospective drug utilization review program for psychotropic prescribing targets poly-pharmacy, non-adherence, sub-optimal dosing, Suboxone, HEDIS®[3] Antidepressant Medication Management (AMM) measures, and fraud, waste, and abuse through provider and member interventions.

PDIP processes approximately 2.5 million claims per week

PDIP's focus on behavioral health medications acts as a complement to most PBMs and business intelligence systems. Our experience indicates that most PBMs manage behavioral health medications more from a "formulary perspective" rather than from a "clinically appropriate" perspective. Because PDIP provides expertise in psychopharmacology, clinically appropriate decision support is provided while improving coordination of care between PCMPs and behavioral health professionals. Approximately 80 percent of PDIP medication-related problem interventions are communicated with PCMPs and not behavioral health clinicians.

We rely on data analysis to identify problems and measure their solutions. Through analyses of an integrated data file (combined prescription, medical, and psychiatric claims), we can identify claims-based, medication-related problems based upon available evidence and established best practices. Ongoing data analysis of medical, prescription, and behavioral health claims data allows us to

[3] HEDIS® is registered trademark of NCQA.

observe and monitor many trends. The relationship of subtle changes to our interventions and the impact on the outcome is critical in continued quality improvement.

ACTUAL PER MEMBER PER MONTH (PMPM) SAVINGS

Medication Adherence Interventions	
Inpatient Admissions $4 PMPM	Emergency Department Visits $1 PMPM
Polypharmacy Interventions	
Emergency Department Visits $7 PMPM	Prescription Medications $111 PMPM

For example, a Member with limited behavioral health history receiving polypharmacy from a PCMP might warrant a PDIP intervention, whereas the exact same drug combination may not trigger an intervention if it were a Member with significant inpatient history under the care of a specialist psychiatrist. This attention to detail prevents messaging fatigue with clinicians as well as unwarranted anxiety for Members.

Similarly, we are thoughtful regarding messaging protocol. For example, in interventions resulting from non-adherence, we will intervene with both the Member and provider. However, in an instance of under-dosing, we will communicate only with the physician so as not to interfere with the doctor-patient relationship. By communicating with the physician only, we are not calling into question the credibility of the doctor in the eyes of the Member.

When analytics identifies a potential medication-related problem, a psychiatric nurse initiates a clinical review process, consulting a clinical pharmacist and psychiatrist when necessary. This process ensures that all clinical factors—behavioral and medical—are considered prior to any intervention. These clinical best practices reduce variations in care, improve clinical efficacy, and limit the collateral effects of ineffective psychotropic therapies. PDIP demonstrates improvement in the quality of a member's care while providing substantial reductions in emergency room visits, inpatient stays, and medication costs.

In 2016, Beacon's health plan clients that used PDIP's innovative technologies to analyze behavior modifications saw an average of $217,380 savings associated with adherence interventions; $475,881 in savings related to polypharmacy interventions; and $9,410 savings associated with suboptimal dosing interventions among inpatient admissions, emergency department visits, or prescription costs.

In addition to generating savings, Beacon has helped Members change their behavior related to medication adherence:

- **199,500 adherence interventions sent**
- **7,643 members with adherence interventions assessed for behavioral change**
- **Medication possession ratio increased 16 percent from pre- to post-intervention**

Beacon also helped prescribers improve the quality of their Members' medication regimens:

- **38,527 polypharmacy and 3,584 suboptimal dosing interventions sent**
- **13,339 Members with polypharmacy and 2,986 Members with suboptimal dosing assessed for behavioral change**
- **62 percent of prescribers discontinued at least one medication among polypharmacy issues**
- **55 percent of prescribers either increased the dosage or discontinued the medication among suboptimal dosing issues**

CLINICAL LEADERSHIP AND ADVANCED ANALYTICS

To further support our Members and the care management/care coordinator community, NHP's Chief Clinical Officer (CCO) will be available to consult on challenging cases, drive the continued strategic direction of the clinical programs, refine our advanced analytics, and develop new criteria for engagement. This includes the development of new predictive models using our machine learning and natural language processing software that can predict events such as an inpatient admission or readmissions. By using our advanced analytics tool that will supplement the BIDM System capabilities our CCO and other key clinical staff will be armed with actionable and impactful information that can be distributed to providers via alerts and via meetings and one-on-one interactions. NHP clinical leadership will provide consultations about this actionable data and how to effectively use it along with the information and insights provided by the BIDM System tools. Our clinical leaders will participate in "grand rounds" for high-volume providers, and advocate on a Member or provider's behalf for UM approvals and determinations or the resolution of complaints and grievances involving medical care issues.

To ensure the success of our clinical programs, all key stakeholders will be involved in the annual review and improvement process and have a voice in assessing the program's performance and how it may be improved in the next performance year.

Our clinical care and operations experts have experience working in both the RCCO and BHO programs. With this experience, implementation functions for the RAE will not be wholly new for NHP. This will allow us to focus on the infusion of additional staff talents and new advancements in process and technology to transition from disparate organizations to a new fully integrated and accountable organization. This new organization will be aligned to better support a fully coordinated, whole-person, outcomes-based system. Supporting the existing provider network and the provision of care management and care coordination at the place of care or from existing trusted relationships, is of paramount importance to us and will continue.

As such, NHP will enhance the strengths of each provider practice and the interconnected health system within the region with analytics, alerts, clinical support, and the provision of clinical and care coordination software that we use for all of our internal operations. NHP will encourage the majority of Member-facing clinical care activity to occur in the community, but will also provide a safety-net for those Members served by providers with the ability to take on these functions. In cases where providers opt-out of providing care management/care coordination for their Members, whether they are a PCMP, Health Neighborhood, or behavioral health practitioners, NHP will ensure that Members have suitable services available to them from another nearby provider using face-to-face or remote engagement strategies. Our fully integrated clinical model is purposefully designed to shore up any gaps the Member may encounter in the service delivery system regardless of where they seek care or from whom they seek care.

OPERATIONS

Our Senior Leadership Team is organized by function. All member, quality, IT, and data analytics services activities are conducted by a singular, integrated Member Services Department, not different departments resembling the legacy RCCO and BHO models or responsibilities. Similarly, our Provider Services Department is a singular unit that performs all network development and management and provider payment, communications, and training functions. This consolidation of departments and functions brings operational efficiencies to the Department, as well as a streamlined and simplified experience for Members, providers, and community stakeholders. This degree of functional integration across our organization is further enhanced by the Department's focus on integrated care, which has resulted in an integrated provider community that is fully capable

of serving the needs of the entire Health First Colorado membership across the full mind and body spectrum.

Leadership

NHP's highly experienced, local Executive Leadership Team is in full control of the management of the RAE contract with the Department, as well as the strategy, operations, and governance of NHP. Our Senior Leadership team includes department heads that report directly to NHP's Program Officer. The CCO will report directly to the Program Officer, but will also have a matrixed reporting relationship to the Governing Board. In this way, NHP's Board will maintain a focus on clinical initiatives and key performance measures directly from the CCO. Members of this team are responsible and accountable for the execution of all services performed by the organization in service of the RAE program. This team includes all of the key personnel identified in the RFP, as well as other key leadership roles.

Authority

Each of the key personnel on the Senior Leadership Team are empowered with the authority to operate their departments in the most efficient manner to meet the goals and objectives of the RAE. However, the NHP organization provides a values-based operating structure that all management and operational staff are expected to adhere to the following values:

- Our business exists only to serve and support Health First Colorado Members as the RAE.
- All NHP staff will conduct business with the below values in mind. Business decisions will be evaluated based on achievement of the contractual, operational, or financial goal, and measured against the following values:
  - **Integrity:** We earn the trust of the Department, the community, Members, and providers.
  - **Dignity:** We respect others, including their needs, differences, and opinions, and factor that in our approach and response.
  - **Community:** We thrive together and exist to build people, process, and technology that has a community benefit that is larger than the RAE program itself.
  - **Resiliency:** We overcome adversity and grow from challenges. We do not avoid difficult conversations, tasks, or projects, but rather see them as an opportunity for growth.
  - **Ingenuity:** We prove ourselves by finding new ways of doing things that provide value to the Department, providers, Members, and our organization.
  - **Advocacy:** We lead with purpose and exist to serve the Department and our Members.

Communication

Open lines of communication and collaboration are critical to success in an organization that is managing all aspects of health like the RAE. As an experienced, local organization, NHP benefits from a large local office that houses all full-time employees that will serve Region 2. We also benefit from real-time collaboration from a local office environment where the majority of our staff work and have easy access to all local resources for the Department.

MANAGEMENT OF NHP

Our desire to provide a new type of organization, with integrated and equal interests and accountability, to serve all Members, and not under-value or over-value any function or population cohort, is demonstrated at the highest level of our organizational governance and leadership. All partners in NHP, regardless of the entity, have an equal voice. Additionally, as a complement to our governance structure, required stakeholder committees, and participation or leadership of those committees (e.g., statewide and regional Program Improvement Advisory Committees [PIACs]), NHP will have a Member Advisory Council that exists to:

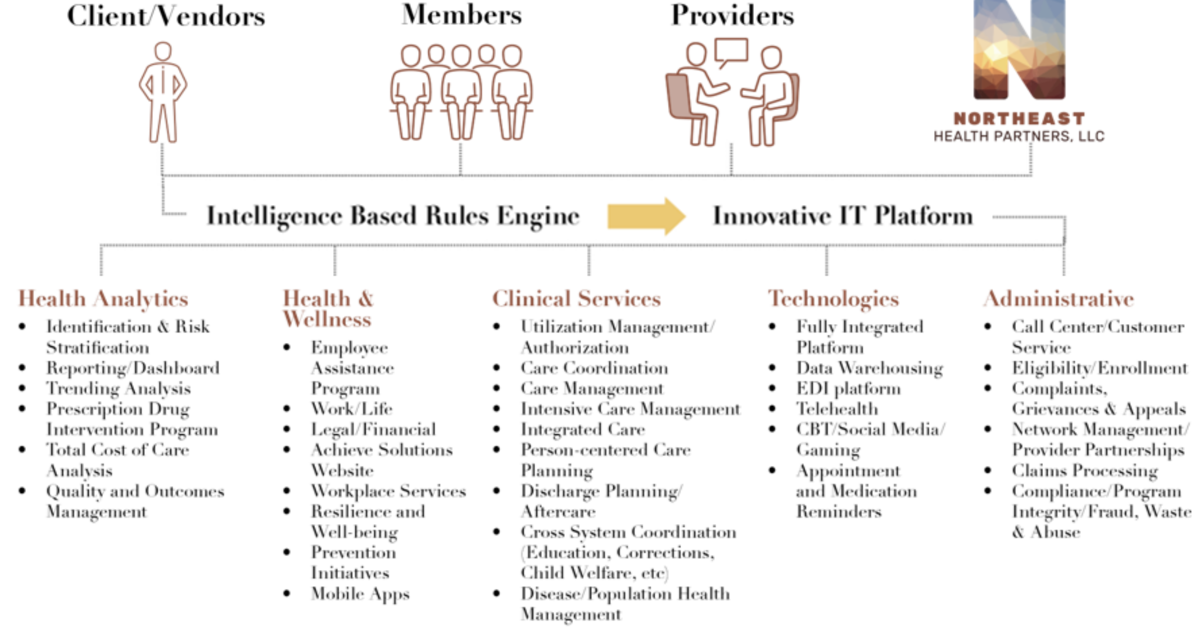
- Afford Members of NHP an opportunity to participate in matters of policy and operation

- Promote effective use of health care services within the RAE Program and to suggest ways and means that the program can better serve Members
- Increase communication between the program and its membership
- Promote understanding of patient and health plan priorities and suggest ways the RAE can better serve Members
- Develop ideas for continuing programs of Member education

MANAGED CARE DATA AND SYSTEMS INFRASTRUCTURE

NHP will operate our RAE using a wholly-owned and operated technology infrastructure provided by our administrative partner, Beacon Health Options, Inc. (Beacon). This system, called CONNECTS, is currently used for BHO and RCCO functions in Colorado. CONNECTS is owned by Beacon, updated on a regular basis, and will fully support the RAE requirements. CONNECTS has been specifically designed to meet program data management and reporting goals similar to those identified by the Department.

This comprehensive management information platform is a suite of fully integrated applications designed to provide innovative data management and reporting capabilities. Graphically depicted below, CONNECTS represents more than 20 years of managed care experience and associated best practices in supporting custom Medicaid programs and facilitating ease of use while adhering to client, state, and federal requirements. This integrated computing environment has significantly enhanced Beacon's ability to improve the coordination of care and service delivery for the millions of members they serve, and will allow NHP to provide customized system enhancements to support the data management and analytic requirements of the RAE.



Data within CONNECTS can be organized at the Member, provider, population, or any other level required by the Department. This means that our platform is truly an enabler of care coordination, rather than a barrier.

NHP is pleased to report that we expect minimal start-up IT activity for the RAE. As a current vendor for the Department, our CONNECTS system has established connectivity with all of the currently available Department systems defined for the RAE.

Since 2005, Beacon has continued to enhance the CONNECTS platform to specifically meet the current and future needs of the complex programs that they manage. Advanced capabilities have been designed throughout the system to further improve coordination of care services, integrated messaging platforms, provide access to providers for electronic submission of utilization management requests, and care management/care coordination activities. As owners of this system, Beacon controls all data exchange development and system modifications with a formal change management process. This means that NHP can quickly and accurately integrate the CONNECTS system with external interfaces such as, but not limited to:

- The BIDM System
- Colorado interChange
- Office of Behavioral Health's CCAR data collection tool
- Multi-payer data aggregator tool for SIM and CPC practices
- PEAK website and PEAKHealth mobile app
- Regional health information exchange
- Electronic consultation and referral tools
- Provider EMRs using standard or custom data exchanges and EDI transactions

From initial eligibility through care management, claims administration, and reporting, all of the CONNECTS applications reside on one common platform. It is designed to guide daily clinical decision making and support utilization of treating providers, facilities, and clinical staff. It facilitates partnering with regional stakeholders such as Health Community partners, social services agencies, specialty providers, hospitals, and Sheriff's departments throughout the data exchange and software development lifecycle to prioritize and rapidly deliver needed changes. This process helps control, prioritize, and streamline the delivery of changes and customizations to IT products and services.

NHP will collect all data defined by the Department, including Member enrollment, care coordination, encounters, and authorizations, as well as all other data needed or required by federal or state laws through weekly imports from our CONNECTS platform and other data sources. All data is formatted and stored as standard data in our Oracle® database, then combined into data models used to provide enhanced reporting capabilities including statistical analysis, decision support, and outcomes management.

Additionally, CONNECTS provides state-of-the-art transaction capabilities for network providers. The user-friendly provider web portal, ProviderConnect, along with the support and educational tools we will offer to providers, will ensure optimal use of Beacon's online systems. This will result in increased use of web-based technology, a decrease in administrative burden for providers, and will enhance our ability to monitor provider performance. NHP's overarching goal is to provide the most efficient and clinically effective management system possible to assist the Department, Members, and providers to maximize care access, monitor appropriate care delivery, deliver quality treatment outcomes, and ensure that resources are well-managed.

Beacon has redesigned the care management platform within CONNECTS to provide a dedicated place for clinicians to document and manage care plans in an efficient, standardized, and comprehensive manner. This upgraded module accommodates multiple levels of treatment plans, including intensive case management and integrated care management, while achieving the following objectives:

- Promoting national platform standardization while accommodating local, negotiated customization
- Addressing accreditation and account specifications as required
- Streamlining workflows and incorporates efficiencies, producing sequential and cohesive documentation in line with the program work processes
- Incorporating industry best practices, meeting contract and market expectations for intensive case management and integrated care coordination programs
- Including a case stratification process to inform resource allocation
- Supporting outcome and operation management reporting

Beacon's significant investment in this technology infrastructure is designed to support highly integrated health care systems, such as the RAE, and support the Department's goals of improving health outcomes. The CONNECTS clinical module incorporates standard industry best practice care management design with enhanced features for behavioral health specific condition management as well as robust inclusion of physical health considerations for a "whole person" needs management and support.

CONNECTS System Modules

Beacon has invested extensively in care management enabling technology, and it is distinctive in several important, practical respects. First, Beacon owns the source code, so when the Department needs a modification or an enhancement of some kind, they can accommodate the request in a timely, cost-effective manner. Second is the fact that the system is one integrated platform. This means that the system is not patched together with complex coding for data transfers, clinical referencing, and reporting. Everything resides on one fully integrated platform. Third is the fact that the system is built for data exchange and reporting. Because it is our business to be a connector between and among providers, Members, and other vendor partners, we realize that the information within Beacon's systems is only as valuable as their ability to port it—and report it—elsewhere.

In the following paragraphs, we describe the various modules within the CONNECTS system that will support the RAE.

NetworkConnect

NetworkConnect is Beacon's Web-based provider credentialing program. It serves as a single repository of documents and activities related to each provider. Operating much like an electronic file cabinet, this system allows for the electronic storage and retrieval of all documents relating to provider credentialing and participation. Because CONNECTS is fully integrated, information entered into NetworkConnect automatically feeds into CONNECTS to help manage claims payments, referrals to specific providers, provider service inquiries, and provider demographic changes, as well as application submission and/or recredentialing submission and review activities. NetworkConnect has the following features and benefits:

- Automated tracking of expired documents (i.e., malpractice and licensure) via a report from IntelligenceConnect, and key timeframes (i.e., recredentialing cycles) to ensure accurate, up-to-date provider information for referral and claims payment
- Secure multi-user, multi-location access to provider data to ensure accurate and timely information is available to all Beacon locations
- Workload management capabilities that support electronic shifting of work among staff as necessary to meet deadlines and expedite provider credentialing
- In-bound and out-bound communication technology via multiple methods (e.g., e-mail and fax) to help maintain provider data accuracy without disrupting the provider's practice
- An audit module, which allows remote access to identified provider files and key elements allowing network audits to occur efficiently (i.e., without travel or movement of hard-copy files)

- "Electronic File Cabinet" providing immediate access to review all provider demographic, credentialing and contracting documentation specific to each provider and facility

CareConnect

The clinical module, CareConnect, is the clinical heart of the care management and utilization review program, offering NHP clinicians an enterprise-wide collaborative treatment planning and health record environment. Accessible 24 hours a day, seven days a week by our clinical team, this system enables our clinicians to identify, authorize, and manage the delivery of the most appropriate, high quality health care services for Members—from the initial point of entry through discharge.

This integrated computing environment significantly enhances our ability to improve the coordination of care and service delivery for the members we serve throughout Colorado.

Whether information is submitted via the telephone, fax, interactive voice response system, or provider web portal, our clinicians review all authorization requests for authorization data. Any clinical data provided, as well as the rationale for decisions rendered, is recorded in CareConnect and becomes an integral part of the Member's record. The care management system automates routine care management processes, which enables staff to focus on the most pertinent clinical data for each Member and easily locate and view historical data summaries to efficiently formulate cases.

The CareConnect application is used for the following processes:

- Creating referrals (i.e., routine, urgent, and emergency)
- Completing and tracking requests for service authorizations
- Performing medication management, inpatient/higher levels of care reviews, and second level reviews
- Managing discharge information and reviews
- Coordinating after-care and follow-up care from referrals.

The CareConnect application is designed to reduce the administrative burden imposed on providers and care managers by providing a platform to gather objective clinical data. As a result, clinicians can concentrate on the needs of Members rather than paperwork. Beacon's state-of-the-art shared clinical record includes the following components:

- Admissions and triage
- Centralized scheduling
- Discharge planning
- Medication tracking
- At-risk crisis plans
- Member demographics
- Member event tracking
- Treatment and service planning (joint care review)
- Bed tracking (bed matching and referral)
- Complaint tracking
- Integrated utilization management
- Referral tracking
- Clinical progress notes
- Crisis tracking
- Objective and standardized assessments

ProviderConnect

The ProviderConnect Web portal allows providers to manage their interactions with us. It is an intuitive application that has achieved wide acceptance and usage throughout the US.

ProviderConnect is Beacon's exclusive web portal for providers. It is very easy-to-use—even for novice users or those who may be uncomfortable in using new technology platforms. As a result, it boasts a

very high rate of adoption by providers in Colorado and Beacon's other programs throughout the U.S.

Beacon's user-friendly provider Web portal, along with the support and educational tools we offer to providers, ensures optimal use of online systems, resulting in increased use of web-based technology and a decrease in administrative burden for providers. **For example, in Colorado, provider adoption is more than 98 percent for the BHO and RCCO contracts.**

Accessible 24 hours a day, seven days a week, providers can view, submit, and execute transactions online via a secure, scalable, and trusted web portal. Through a web interface, providers have real-time access to tools necessary for handling most administrative transactions as well as request services for members. ProviderConnect accelerates provider's workflows by delivering an interactive web-based system for collaborative business processes. Depending on the function accessed within ProviderConnect, providers have read-only or read/write capabilities. Key features of this website include the ability to:

- Check status of a Member's enrollment
- Register a Member for services
- Check a Member's benefit information
- Review and submit requests for authorization of care, as well as the ability to print these requests for their own records; some requests will receive immediate authorization based on benefit
- Review a detailed payment status of submitted claims
- View and submit updates to demographic data for providers
- Submit/attach documents to all submissions
- Directly enter and submit a claim or upload HIPAA-compliant claim files online
- View and print on-line correspondence, such as authorization letters and provider summary vouchers
- Create and view other types of inquiries via a message center

TeleConnect

NHP offers Beacon's interactive voice response technology, TeleConnect, which enables Members and providers to quickly and easily resolve customer service issues 24 hours a day, seven days a week. TeleConnect:

- Improves automated 24-hour service delivery for Members and providers for claims inquiries, requests for standard forms, and Member eligibility inquiries, which allows members and providers to get information at times that are convenient for them, even if it is after Beacon's normal business hours
- Permits providers to submit requests for service via the telephonic interface
- Includes enhanced automated speech recognition to improve the service experience of our Members and providers
- Accommodates clients who are using an alternate identifier to the Social Security Number
- Interfaces with Beacon's comprehensive management information system

MemberConnect

Beacon's MemberConnect portal is a one-stop e-shop where Members are able to complete everyday service requests online 24 hours a day. Via this password-protected site, Members conduct transactions such as eligibility inquiries, claims inquiries, and claims submissions. The site also enables Members to check benefits, authorization and claims status, claims history, claims payments, and view correspondence online. Members are presented with comprehensive and easy-to-read information within seconds.

The toolbar options allow Members to download claim forms, review Member Rights and Responsibilities, and make informed decisions about health care and wellness. For example, the "ABCs of Mental Health Care" page enables Members to comfortably browse articles about how to select a behavioral health specialist, what to expect during treatment, and how to evaluate the effectiveness of the treatment. The "About Care Providers" menu provides descriptions of the various types of care providers available, while the "Treatment Types" menu describes the array of counseling, therapies, and testing methodologies represented in NHP's network.

ClaimsConnect

Via the ClaimsConnect module, we offer the Department a powerful claims payment system that ensures payments are consistent with program participation requirements, including benefit design, eligibility, care management, and provider maintenance. Because all functions are performed within a single system, updates are immediately available to all service and functional areas.

Beacon's claims processing system supports all claims processes involving claims entry, adjudication, payment, and reporting. All provider fee schedules, hospital per diem rates (contracted rates), and individual client benefit plans are maintained online. Automatic claim suspension routines are also performed for those claims that require further examination. These include duplicate claim submission, coordination of benefits, eligibility discrepancies, and authorization edits. Authorizations are used for limiting and/or controlling provider access. Utilization review capabilities are also included in the claims subsystem to enable the connection between the claim being processed and authorizations in the system. The decision as to whether a claim requires an authorization for payment is part of the benefit set-up logic. Additional features found in the claims processing subsystem include the following:

- Online authorization/adjudication capabilities
- Efficient CMS 1500 and UB04 forms screen entry formats for high-volume processing
- Specific/generic service authorization capabilities
- Automatic matching of claim activity to available authorizations
- User defined processing edits
- Online/batch claims adjudication capabilities
- Split payment and member reimbursement capability

ClientConnect

We recognize the increasing desire of many of our stakeholders to have access to online reporting capabilities, administrative processes, and information. Beacon has developed a unique password-protected client web portal, ClientConnect, which will allow 'real-time' access to RAE program information, including membership data, authorizations data, and reporting online. Web access means that program data is far more accessible to the Department and authorized third parties than in a traditional model where reports are continually requested and provided with lag time lost for production. The Department is assured that although data is accessible, it is also secure on Beacon's encrypted HIPAA-secure site.

Within ClientConnect, users may view all Department-specific reporting via IntelligenceConnect, Beacon's online reporting tool. If a report has been designed to include drill-down capabilities, the user can double-click one of the categories in the report to display the underlying records that made up that piece of the report, and then customize reporting based on specific needs. Users can store and print client reporting directly from this resource. To produce reports, users simply navigate and click.

KnowledgeConnect (Business Intelligence)

With an ever increasing need to collect, store, and manage large quantities of data to support client contracts, Beacon has developed a high-performance data warehouse platform. Beacon's data warehouse, KnowledgeConnect, is a database that receives imports from CONNECTS (e.g., CareConnect and ProviderConnect) for reporting purposes. This data is formatted and stored as standard data into our Oracle relational database system. An advantage of this data warehousing technique is the easy insertion of data from external sources, such as pharmacy, disease management, or medical data. The data from these external sources can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.

We have adopted and will employ throughout our operations a fully integrated approach to Business Intelligence (BI). This fully integrated approach is made possible by the strategic application of various products and services supplied by Business Objects™, a recognized leader in the BI realm. Beacon has been successful in the practical application of their products and solutions for both internal and external customers for more than 10 years. IntelligenceConnect, Beacon's collective suite of Business Objects solutions, allows NHP to deliver best-of-breed, enterprise-wide solutions designed to meet all the Department's needs.

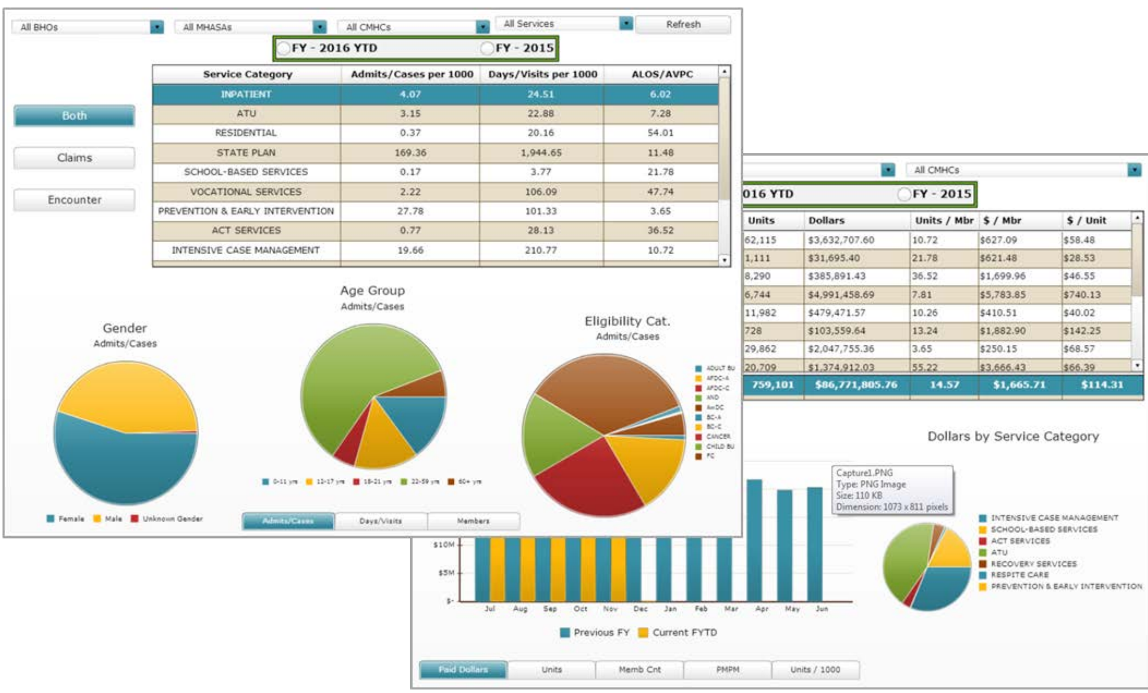
IntelligenceConnect

As mentioned above, IntelligenceConnect is our Web-based reporting and analytics tool. It allows us to furnish standard reports in a format containing graphs, charts, or dashboards. The tool consists of a suite of interactive report dashboards, Crystal Reports, and web intelligence reports (Webi), designed to transform client data into easy-to-read information. Crystal Reports' primary purpose within IntelligenceConnect is the production of reports designed to meet the ongoing continuous needs of our report consumers. Crystal Reports is also used to respond to some ad-hoc reporting requests.

Dashboards

Beacon's market-differentiating, real-time, online dashboard reporting ensures a transparent and collaborative partnership. Shown on the following page, the secure, password-protected online portal enables access to our Web-based reporting and analytics in real-time from your desktop. The Department, providers, and other stakeholders will be able to conduct a variety of analyses across a full range of inpatient and outpatient utilization features, including data on individual enrollment, care coordination, encounters, authorizations, and more. Drill downs on individual sub-group and clinical trends—including division, level of care and diagnosis—are also available. All reports can be printed on demand.

Sample Dashboards



OFFEROR'S RESPONSE 8

Describe the Offeror's governing body and its responsibilities, including a list of members and their credentials. Include a description of how the Offeror plans to address any perceived conflicts of interest among its governing body.

Northeast Health Partners, LLC (NHP) is new and purpose-built to serve the Department of Health Care Policy and Financing (the Department) as the Region 2 Regional Accountable Entity (RAE). In our review of the RFP, we identified a need for a new type of partnership bringing together local, experienced organizations that serve the physical and behavioral health needs of Members as well as the care coordination, education, transformation, and administrative needs of the providers and the Department. This new type of partnership brings four organizations with experience serving the Health First Colorado membership together with equal stakes in the success of the RAE and shared risk in the management of the capitated behavioral health benefits.

GOVERNING BODY AND MEMBERS

The governing body (also known as Executive Team or Governing Board of Directors) of NHP comprises local leaders from each of the shareholder organizations (i.e., partners). Each partner has committed an executive to the organization that will represent NHP's collective interests in the management of the requirements of the RAE. The partner organizations and their seasoned executives were hand-picked from local organizations with capabilities that when brought together into a single accountable organization, have the ability to steer clinical, financial, and operational performance in Region 2 through collaboration with the surrounding health neighborhood, community, providers, and Members for the Department. Each member of the governing board is a full-time resident of Colorado, and has a long history of serving the Colorado Medicaid membership, community, and providers. Many of our governing body executives have even grown up in the communities which NHP will serve and intimately understand the local environment and needs.

To align performance incentives, our organization is an absolutely equal partnership whereby the shareholders, Members, network providers, and the community will all benefit from successful performance. As an example of our investment and dedication to the community, NHP has decided to reinvest a portion of all bonus earnings back into the community in the form of community reinvestment projects.

The governing body is responsible for the strategy, direction and operational oversight of NHP, which exists only to serve as the Region 2 RAE. In addition to providing executive oversight to the program's performance and operations, our governing body has full authority to make key business decisions on behalf of NHP. The bylaws and governance structure of NHP was designed as the result of 20+ years serving Colorado Medicaid in various public-private partnerships. In that time, we have learned valuable experiences about how to construct these types of organizations to serve contracts like the RAE, including how to successfully avoid and navigate potential conflicts of interest, avoid partner conflict, structure a business model that serves the interests of the community and the partners, and to perform at the highest level at all times, even when challenges resulting from policy, finance, or other changes exist.

The construction of our organization began with the development of critically important guiding principles and values that all partners have unanimously agreed:

NHP Guiding Principles

Purpose: NHP exists only to serve Medicaid Members as the local RAE. All decisions are local and focused on service to our customers: Members, providers, and the Department.

Integration: NHP is a singular entity, not a loosely connected collection of domain or product-line experts.

Progress: NHP is built to grow, change, and adapt to delivery system, payment, risk, and other local and national models, both expected and unexpected.

Member-Focus: We focus on our Members first. If we act in their best interest first, other goals will fall into place.

Provider-Centric: We deliver care management at the place of service via trusted relationships as our standard. We address the fourth dimension of the Quadruple Aim by enabling providers to better serve Members.

Stewardship: We focus on precise activities that get results and minimize duplication of services that result in wasted resources.

Responsive: If we enrich the community, we enrich ourselves. As such, we have established and will adhere to a community reinvestment plan whereby a portion of our annual profits are directly invested back into the local community for the benefit of Health First Colorado Members.

Partnership: All partners participate in the risk and rewards of the organization.

NHP Values

Integrity: We earn trust of the Department, community, Members, and providers.

Dignity: We respect others including their needs, differences, and opinions and factor that into our approach and response.

Community: We thrive together and exist to build people, process, and technology that has a community benefit that is larger than the RAE program itself.

Resiliency: We overcome adversity and grow from challenges. We do not avoid difficult conversations, tasks, or projects but rather see them as an opportunity for growth.

Ingenuity: We prove ourselves by finding new ways of doing things that provide value to the Department, providers, Members, and the organization.

Advocacy: We lead with purpose and exist only to serve.

Governing Board Members

NHP's governing board includes the following seasoned, local executives, whose bios have been included in **Attachment 3**, to provide further insight into their experience and history in addition to their credentials:

Name and Credentials	Title and Partner Organization
Elizabeth L. Hickman, Ph.D.,	Executive Director, Centennial Mental Health Center
Todd J. Lessley, MPH, RN, BSN,	Vice President of Population Health Services
Larry Pottorff, LCSW	Executive Director of North Range Behavioral Health
Mitzi Moran,	CEO Sunrise Community Health

NHP's Program Officer, the most senior operational leader within our organization, and the Chief Clinical Officer, the strategic lead for all clinical designs and population health initiatives, will report directly to the Program Officer. This structure empowers the Program Officer to handle day-to-day operational and contract management decisions, while providing a direct link between key personnel and the Governing Board (Executive leadership team).

Other Stakeholder Influence to the Governing Body of NHP

The Governing Body will guide their decisions from internal and external stakeholder groups and feedback. These sources of guidance for the management of the company and its service to the Department as the Region 2 RAE include those Advisory Committees and Learning Collaborative specified in the RFP such as:

- Statewide Program Improvement Advisory Committees (PIAC)
- Regional PIAC
- Quality Improvement Committee
- Operational Learning Collaborative

In addition to these formal forums, the governing body will also receive guidance and feedback from the External Quality Review Organization (EQRO) process; committees (e.g., Quality, Compliance, Provider Network, Financial, and Medical Management); and NHP's own Member Advisory Council that exists to:

- Afford Members of NHP an opportunity to participate in matters of policy and operation
- Promote effective use of health care services within the RAE Program and to suggest ways and means that the program can better serve Members
- Increase communication between the program and its membership
- Promote understanding of Member priorities and suggest ways the RAE can better serve Members
- Develop ideas for continuing programs of Member education

Responsibilities of the Governing Body

The Governing Body of NHP is wholly responsible for the management of the business in our service to the Department as the RAE for Region 2. Their decision-making authority is not subject to external approvals by a larger corporation or national board. The governing body is authorized to make all critical decisions that are required to serve the Department as the Region 2 RAE. This authority is intentionally broad and encompassing to ensure that local control exists for NHP so that we can manage all aspects of the RAE contract and program against the immediate needs of the Department and community without a tedious external approval process from an outside governing entity. The following decisions may be made by the NHP governing body on behalf of NHP:

- All executive level operational decisions to enhance the delivery of services according the terms of the RAE contract
    - Key personnel and department leads are empowered to manage their departments within the parameters of the contract and to pilot and implement enhancements to achieve or improve our performance
- NHP organizational decisions that have local governing body authority so that NHP can fully dedicate itself as a company to the RAE:
    - Property decisions
    - Contracts, agreements, strategic joint venture decisions and other undertakings to conduct the business of the RAE
    - Approve budgets, investments and expenses of the Corporation

- Make any and all expenditures that the directors may deem necessary or appropriate in connection with the management of the affairs of the Corporation and the carrying out of its obligations and responsibilities, including, without limitation, all legal, accounting, and other related expenses incurred in connection with the organization, financing, and operation of the Corporation
- Enter into any kind of activity necessary to, in connection with, or incidental to the accomplishment of the purposes of the Corporation
- Approve the Corporation's response to the request for proposals from any government agency or change order requests from the Department
- Approve additional contributions to capital reserves as required by the Department of Insurance, as required by any agreement of the Corporation, or as otherwise required in the sole discretion of the directors
- Approve or change incentive payment methods applicable to Company providers and other contracts
- Approve or change performance standards and sanctions amongst the partners of the organization
- All organizational decisions such as, but not limited to, adoption of Amendments to the Corporation's Articles of Incorporation, bylaws, or service agreements

- Approve the admission of any new shareholders or members of the governing body
- Approve a merger or consolidation involving the Corporation

CONFLICTS OF INTEREST

As a new, purpose-built organization created to serve as the Region 2 RAE, NHP's company structure was designed and owners selected to specifically meet and exceed the statement of work requirements of the RAE. The simplest way to avoid any perceived conflict of interest is to fully comply and exceed contract requirements. We built a local organization with deep expertise and experience as well as a long history of service to the Region's Medicaid population. The partners in this organization have provided both Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) services and have worked together through numerous delivery system changes. With ownership including physical health delivery, behavioral health delivery, and an experienced Managed Care Administrator we bring diverse backgrounds and expertise to the RAE as well as balance in governance among the governing body.

We have outlined several perceived conflicts of interest below and described the actions we will take to mitigate those. We will also work actively with the Department if any new perceived conflicts are identified during our service of the RAE contract and address those with the appropriate mitigation strategies and changes. As a company that exists only to serve this purpose, we have great flexibility in our organization and management to meet and exceed the needs of the Department. While the shareholders of NHP have been partners in both the RCCO and the BHO, we acknowledge that the RAE is a new and different entity and requires a new fresh creative-thinking.

Provider Referrals

Perceived Conflict of Interest

As an accountable health care organization consisting of four provider owners, NHP may compromise Member choice by making referrals to only the provider partners.

Plan to Address Perceived Conflict of Interest

Beacon will have a delegated administrative services agreement with NHP. Beacon will give each caller at least three referrals to network providers. Each month, recorded calls from the Member Service Line will be reviewed to be certain staff are referring Members consistent with choice.

Administrative Separation from Provider Delivery of Care

Perceived Conflict of Interest

As an Accountable health care organization consisting of four provider owners, NHP providers may dictate policy and guidelines that can create a favorable market position for their services over the other providers in the region.

Plan to Address Perceived Conflict of Interest

As an organization with multiple provider owners, we believe it is critical to have an arms-length relationship with core administrative and managed care functions. These functions include, but are not limited to: utilization management, network development, and network management. To that end, Beacon is a fully delegated administrative services organization that is wholly responsible for these types of managed care functions.

Utilization Management. The utilization management program, including its clinical and business criteria, are defined and implemented by Beacon and leverage Beacon's national expertise and CONNECTS, Beacon's proprietary and confidential management information system and infrastructure. These clinical and business rules, workflows, policies, and procedures are not unique to NHP, which intentionally brings a national managed care approach to the RAE.

Network Development and Management. Beacon is wholly responsible for the network development and network management standards for all behavioral health and substance use disorder providers. Our administrative services agreement holds Beacon liable for fair and even treatment of all providers whether they be owners or network providers by using standard contracts and key performance indicators. In order to further reduce any perceived conflicts of interest around network and access, Beacon will manage the provider network and its adequacy requirements directly against the standards set forth in the RFP using the time/distance and ratio standards.

Beacon's GeoAccess analytics will identify any network gaps that need to be filled. Beacon's Director of Provider relations will also meet with the Department and the Department of Human Services (DHS) annually to prioritize and address gaps that may require collaboration. Beacon will ensure that the RAE network overlaps CORE providers with DHS. We believe that Member choice is critical, and our goal is to exceed the RFP standards to improve choice in service areas within the region where quality provider capacity exists.

In addition, rather than having credentialing decisions managed by a credentialing committee that includes providers perceived as having a conflict of interest based on service area capacity, Beacon will make all contracting and credentialing decisions based on the provider's ability to meet requirements to serve Health First Colorado Members, their specialty, and their location.

Further Prevention of Conflict of Interests

Our administrative partner, Beacon, has a conflict of interest plan in place for their own staff, such as a plan for utilization management clinicians who might make an adverse determination for a NHP Member. Also, all financial reporting and medical loss ratio calculations will be performed by Beacon so that all provider partners' reporting methods and requirements are standardized across the RAE.

OFFEROR'S RESPONSE 9

Describe the Offeror's strategy for member engagement, in accordance with the requirements in Section 5.5.

Northeast Health Partners, LLC (NHP) is committed to providing a comprehensive engagement strategy tailored to Region 2 that will provide all Members with timely, relevant messaging. This sensitive and meaningful communication builds Member confidence in NHP, a trust that fosters independence. We have invested in analytics, consumer messaging, campaign technology, and training to enhance the Member experience developed for the high performing Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO). These assets will prove to be a service to the Department. We bring historical experience and proven innovative expertise to deliver this new program and experience to Members as the Region 2 Regional Accountable Entity (RAE). We built our strategy and designs with an understanding of the population we serve and their distinct needs. A brief review of our analysis is provided below that demonstrates the details we have gathered and considered in the development of our strategy.

The first step in developing a successful Member engagement strategy is knowledge of and experience in serving the population that constitutes your membership. NHP Member organizations have been serving the population of Region 2 in one capacity or another since the mid-1970s. The tables below provide some key demographic, economic and social indicators of the 10 counties that fall within the Region 2 catchment area.

County	Population	Median household income	Median Age	% Uninsured	# Single-Parent Households	% Single-Parent Households
Colorado	5,456,574	$58,942	36.5	12	350,037	28
Weld	285,174	$58,404	34	12	18,521	25
Cheyenne	1,829	$50,379	41.3	18	60	11
Kit Carson	7,758	$39,633	39.4	17	528	29
Lincoln	5,557	$41,510	39.9	12	288	27
Logan	22,036	$43,561	38.1	13	1,159	28
Morgan	28,360	$46,332	36.5	16	2,542	34
Phillips	4,349	$46,805	42.7	16	189	18
Sedgwick	2,399	$39,980	47.7	14	238	51
Washington	4,864	$45,572	44.4	13	213	21
Yuma	10,146	$45,487	38.6	17	642	23

Demographic and Social Indicators				
County	**# Not Proficient in English**	**% Not Proficient in English**	**% Spanish Speaking**	**% Rural**
Colorado	156,646	3.2	11.8%	13.8

Demographic and Social Indicators				
Weld	9,223	3.7	16.5%	20.5
Cheyenne	13	0.7	10.5%	100.0
Kit Carson	311	4.2	13.2%	48.7
Lincoln	293	5.7	9.1%	100.0
Logan	748	3.6	9.3%	29.2
Morgan	2,057	7.8	22.8%	32.5
Phillips	163	4.0	9.2%	100.0
Sedgwick	7	0.3	8.3%	100.0
Washington	40	0.9	4.3%	100.0
Yuma	614	6.6	4.9%	64.9

County	Adult Obesity Rate	Adult Diabetes %	Rates of Smoking%	Free ad Reduced Lunch	Children in Poverty %
Colorado	20.80%	7.40%	16%	42%	15
Cheyenne	24	7.20	14	46%	17
Kit Carson	28	5.3	16	59%	20
Lincoln	24	7.0	17	42%	25
Logan	25	6.0	16	47%	18
Morgan	27	9.6	15	63%	17
Phillips	23	13.3	14	39%	17
Sedgwick	22	5.10	15	53%	24
Washington	23	4.6	14	49%	16
Weld	26	6.3	16	50%	14
Yuma	25	6.5	16	57%	19

FACTORS IMPACTING MEMBER ENGAGEMENT IN REGION 2

- **Socio-economic variation –** While some counties such as Weld align with the Colorado average on Median income, others such as Sedgwick have median incomes that are more than 25 percent below this average
- **Variation in household composition –** Single-parent households range from a low of 11 percent in Cheyenne County to 34 percent in Morgan and 51 percent in Sedgwick.
- **English proficiency variation –** Households lacking English proficiency range from less than 1 percent in counties such as Cheyenne and Washington to nearly 8 percent in Morgan
- **Rural dominance** – All 10 counties in Region 2 have a higher percentage of rural households than the state average with 100 percent of the households in four counties classified as rural.
- **High poverty rates** – All 10 counties have a higher percentage of children in poverty and receiving free lunch than the state average.
- **Significant health issues –** All 10 counties have a higher obesity rate and premature death than the state average.

OUR APPROACH TO MEMBER ENGAGEMENT

NHP's approach to Member engagement starts with our belief that every Member matters, every contact is an opportunity, and every person has unique preferences for how to engage. These opportunities build relationships and provide venues to collaborate with Members and their families. We create an alliance with Members and draw on their feedback to understand how they want to be engaged and what engagement techniques are effective. Simply put, we ask the question, "How do you want to be engaged?" and tailor our interactions according to what we hear. We know that each person has a different preference and each meaningful connection requires a different approach to be effective. The power of face-to-face contacts in the Member's community is harnessed for those most important interactions that shape behaviors and solve the most difficult problems that lead to better health outcomes. We do not consider Member engagement an activity or event; it is an ongoing process of empowerment that requires the participation of the Member, Member's family, NHP, Primary Care Medical Providers (PCMP), behavioral health providers, care coordinators, the Department, and the greater community. It aligns all of those constituents along a single goal which is to activate the Member in their health and health care, and keep them moving towards sustained and continuous improvement.

With this in mind, we have designed a comprehensive Member engagement strategy that provides Members with multiple choices and options to engage with staff, care coordinators, and their health care providers in their local community. A Member can only be considered engaged when they are actively participating in a bi-directional interaction, and are also working towards specific outcome. This outcome might be a new appointment time, a new relationship with a specialist, a change in PCMP, acquisition of specific knowledge, or the use of the tools or resources that are needed to remove a barrier to care.

Successful engagement will also need to span multiple functional areas of the RAE. In each of these that include but are not limited to requirements defined in *Section 5.5* of the RFP, we have built our engagement model on industry best practices and principles of person and family-centered communication, targeted and personalized preference-based messaging, and behavior change. A few key principles we have used to define and design our approach for successful Member engagement include:

1. **We must understand the population we are serving at the regional and micro-regional levels**. This includes understanding the socio-economic, racial, ethnic, language, cultural, religious, demographic, educational (literacy and health literacy), and environmental

characteristics as a population and within certain groups or cohorts of the population. In our region we understand the unique challenges remote living presents and how providers need to be sensitive to that. For example: if two appointments are needed, align them by day of week and time of day so one trip will work. Or, do not put the specialist's 10-minute visit with the Member at 5 pm since the Member living in Yuma probably wants to get up here to Greeley and home on the same day, driving in the light. This knowledge helps us tailor a culturally sensitive and effective message to engage a Member in their care because the family and caregiver network may be large and influential, but can also be a barrier in terms of communication and translation. For example, one of North Range's Early Childhood Programs, HIPPY, works closely with refugee and Hispanic families on school readiness. HIPPY providers speak English, Spanish, as well as Burmese and Somali, Caren, Karenni--and some of these employees have been refugees and single mothers themselves.

2. **We must provide Members with choices as to how they can engage with NHP and the provider and Health Neighborhood community**. Engagement options will include different channels such as text, telephone, email, social media, web and direct mail, face-to-face, and more. The frequency and timing of contacts will vary and differ based on the Member's needs, preferences and the message we are trying to deliver. Levels of engagement and the ability to suspend engagement in targeted educational or health campaigns and reengage when appropriate to allow a Member to focus on their most pressing needs without being distracted by messages we may think are important during a specific season or time of year. We find that Members appreciate the ability to have some influence and control over the amount, timeliness, and intensity of their communications. For example, a newly diagnosed diabetic will have different needs which may require additional information about self-management and activities like daily blood glucose monitoring, which we can provide through our Care4life program rather than messaging around prevention and wellness reminders. If a Member builds a trusting relationship with a representative, care coordinator, or provider, NHP will honor that relationship whenever possible to establish comfort and familiarization with the Member.

3. Finally, **we must respect the Member's time and view any time spent with NHP as an investment of his or her time that must lead to a valuable outcome**. When a Member contacts our Member Services Department with a question, that question should be answered on that initial contact. If an educational message is sent to the Member, that mailer should be culturally sensitive, timely, and provide actionable and useful information. Many of our Members in rural and frontier locations maintain a sense of rugged individuality, western mentality and pull yourself up by the bootstraps. They do not want to be preached to. Thus, we will strive to close the loop on every interaction so that each contact is useful and meets a stated need. In some cases, where our specialist may require time to acquire the right information on behalf of the Member, we will follow our Member-first engagement guidelines for call-backs so that they occur at an agreeable day and time for the Member. If the Member is cannot reached, the information we intended to provide to them will be documented in our CONNECTS platform so that during his or her next interaction with any representative from NHP this can be shared and the goal achieved. If the Member's stated needs are too large or complex to address in a single interaction, we will break it down into small, manageable parts and deliver useful and easily understood information and applied messages. We will invest the time to solve the whole problem, but have the patience to tackle on step at a time.

In addition to the engagement principles described above, we will guide our interactions with proven tools and techniques to understand where Members are in the change continuum so that we can align our communications with their appetite and ability for change. Our person-to-person interactions with Members will leverage Motivational Interviewing techniques and may include the application of Prochaska's States of Change Model to understand a Member's interest and ability in working towards a specific goal. We also continue to evaluate new methods and adopt new

principles, such as modern behavioral economics techniques and theories that distill behavior change into simple formulas that when used correctly can drive meaningful and long-lasting behaviors.

Member engagement with NHP will occur for a variety of administrative and clinical purposes, but engagement with providers is also critical and we believe improving Member engagement by Medicaid providers is also a core function of the RAE. To this end, we have performed ongoing research to understand and measure Member engagement in community behavioral health settings. Research indicates that the following practical techniques should be incorporated by providers to successfully engage Members that present to seek care:[1]

- Referrer explains to Member the clear reason for the referral
- Train providers to give Members an orientation about what to expect in treatment; best done one to three days prior to appointment by letter or telephone call
- An appointment is scheduled as soon as possible after a referral
- Member is given a choice of providers, provider's location, directions, where to park, and times that providers are available
- The first session addresses:
  - Practical issues about coming to treatment such as financial concerns, transportation, scheduling, agreed upon duration for initial episode of treatment
  - Emotional/cognitive concerns about coming to treatment such as support of significant others for coming, cultural beliefs about treatment, and belief in potential for positive outcomes
- Provider addresses these concerns frequently throughout treatment episode to be sure there have been no changes
- Provider asks at the end of each session what more can be done or what more is needed

Research from the Journal of Child Family Studies[2] also states that Members return to treatment most often when they:

- See a strong need for treatment
- Believe treatment will be effective
- Have confidence in their ability to make changes in their life
- Do not have an external barrier
- Have a positive treatment alliance established early on
- Feel treatment is relevant and acceptable to the Member
- Are involved in decisions about treatment such as types of treatment, goals to be met, and scheduling
- Have a provider who is able to convey hope

At the heart of these techniques providers practice empathy, consideration, and Member-centered care. NHP will enable providers to successfully practice by including in our training and education for providers this valuable information. In addition, these topics will be recurring themes in our provider newsletter and Program Improvement Advisory Committees (PIAC).

[1] BJPsych Advances, Volume 13, Issue 6
[2] J Child Fam Stud (2010) 19.629-645 DOI 10.1007/s10826-009-9350-

North Range shares peer and client approved stories in blogs and has been successful working with the Greeley Tribune to print recovery stories as well. These promote hope and break the stigma of accessing care for their own health.

Peer-to-peer interactions are also woven into the NHP engagement model. We have experienced that when Members share their personal story of how treatment was successful for them, what they did to engage in their own treatment, and who they used for support that exercise increases their own engagement and that of those they share with. For example, during one of our recent Lunch and Learns to promote breast and cervical cancer screens, we had a peer specialist share her story of recovery from both cancer and addiction. Her personal story highlights many of these recommendations including seeing a strong need for treatment, belief that treatment would be effective, and confidence that she had the ability to make changes in her life.

Member and Family-Centered Approach

NHP also aligns with the Department's recommendations to promote and advance a person-and family-centered approach that respects and values individual preferences, strengths, and contributions. For example, Centennial recognized that a Member's family who needed rental assistance as they had lost their benefits, the father had lost his job and the family was facing eviction. Centennial coordinated with Cooperating Ministries to share the cost of one month's rent in a new location. Our Care Coordinators, administrative staff, behavioral health providers, PCMPs, and Member Service Representatives (MSRs) who interact with Members and will be educated in person and family-centered best practices. We will certify that our staff members are trained on the person- and family-centered approach, Motivational Interviewing, cultural competencies, and solution/strength-based training to give staff the tools to keep Members at the center of treatment. We will advance the recommendations made from the Department's Member Experience Advisory Council (MEAC) in the regions in which we serve.

Centennial provides radio spots to increase behavioral health awareness on a local Spanish station, JUAN, KRSN 93.1

We will meet our Members where they are and tailor our communication to their needs. We will also continuously listen and analyze our community for shifts and changes that need to be accommodated in our engagements materials, tools and techniques.

NHP understands the best practices for Member engagement and will use industry leading tools, techniques, and practices, but we will also rely heavily on the input of the community to ensure that all communications and messaging can relate to our audience and effectively deliver the required message so that it achieves the planned outcome. As a new Managed Care Organization formed exclusively for the Region 2 RAE program, we will use our Member Advisory Council to engage Members in matters of operation and policy relating to the implementation of a person and family centered approach to all contacts and communications. This committee will meet quarterly providing regular opportunities to discuss and review engagement strategies, messaging, and materials. This mechanism for Member feedback, along with our review and approval process with the Department, will ensure that all materials are well planned, accurate, and effective

These recommendations will be discussed with Members at our Member Advisory Council as well as other stakeholders at forums like Regional PIAC to solicit their expertise in how to implement the Department's recommendations and tailor specifically for our community.

OUR APPROACH TO CULTURAL RESPONSIVENESS

NHP's approach on cultural responsiveness is to listen to Members' concerns that are brought up at different venues, including the Member Advisory Council, Regional PIAC, and interactions with our staff. In the current programs, our staff have used similar committees to gather direct feedback from Members to learn more about the community and specific cultural needs that we should address. Members from different cultural backgrounds participated in these committees and have provided valuable insights about their Member experience within our health care system.

One Member was particularly helpful in raising everyone's awareness about the Hispanic experience. The Member provided feedback to address what the RAE can do to reach out to the Hispanic population and engage them more fully. For example, the Member said that car shows would be a great place to engage Members. We are currently working on and will continue to use non-traditional avenues to engage Members from different cultures and have attended health fairs and other public gatherings to engage with our Members. This Member also educated the committee that many Hispanics refuse to seek help with their health needs due to distrust of the system. Specifically, they equate Health First Colorado (Medicaid) with the "government," and fear the threat of deportation if they become visible within the system. This fear and mistrust leads to increased utilization of emergency departments for primary care purposes, but more importantly, it prevents these individuals from receiving preventative care and/or managing chronic conditions such as diabetes. This Member was able to make some very useful concrete suggestions for the committee to consider that might create a more culturally sensitive approach to engaging Members of differing ethnicities. We will continue to respond to the cultural needs based on recommendations from Members and families.

Delivering Culturally Competent Services

NHP will develop a Cultural Competency policy that ensures that physical and behavioral health services are delivered in a culturally competent manner. To guarantee that the policy is being followed, culturally competency is a standing agenda item at the Advocates Forum Meeting and the Clinical Advisory/Utilization Management/Quality Improvement Committee meeting under the current BHO/RCCO contract. Our plan is to add this as a standing item to the Performance Improvement Advisory Committee for the RAE. We are committed to being sensitive to the needs of all people and cultures and to the communities that we serve.

Cultural competence is achieved by integrating knowledge about individuals and groups of people into specific practices and policies and applied in cultural settings. When health care professionals are culturally competent, they are able to partner and engage Members in their health care. NHP will continue to use independent surveys on culturally sensitive services to keep Members' voice central to delivery of integrated health care services.

The NHP organizations will adopt a non-discrimination policy that confirms that we do not discriminate against Members because of race, religion, gender, age, disability, health status, or sexual orientation in the context of Members receiving care and services from the RAE. We have provided an example of this policy in **Attachment 4.** We affirm that all civil rights, including those regarding freedom from discrimination based on age, HIV infection or AIDS, and disabilities are protected under Title VI of the Civil Rights Act of 1964, the Age Discrimination Act (ADA) of 1975, Section 504 of the Rehabilitation Act of 1973, Public Law 93-112, Americans with Disabilities Act, Public Law 101-336, and in compliance with 42 C.F.R. § 438.206(c)(2).

Cultural, Disability, and Discrimination Training

NHP will employ existing trainings programs that have proved successful such as Bridging the Gap, Bridges Out of Poverty, Relias training modules to educate our internal staff, PCMP providers, and behavioral health providers. These trainings address the health care attitudes, values, customs, and

beliefs that affect access and benefits from health care services. While these trainings have been customized for the respective audience the curriculum remains consistent and addresses the following important elements relating to cultural disability and discrimination:

- Defining culture, stereotype, prejudice, and other terms
- Understanding how values, beliefs, and attitudes influence the way people relate to others who are different from them
- Identifying perceived barriers
- Identifying national standards (i.e., Culturally and Linguistically Appropriate Services [CLAS]) for cultural diversity
- Increasing knowledge of the steps needed to becoming culturally competent

This is then augmented with a capstone topic about discrimination based on poverty and other social determinants of health. The objective of this training is to address the myths and discriminations that occur with those who live in poverty. NHP partner Beacon Health Options (Beavon) also developed a secure website to complete a disability assessment at practices. Trained staff are able to use their smart phone or laptop to complete the assessment and take pictures of sites to document their accessibility and compliance solutions, and then provide them with an assessment of their performance and provide recommendations for the practices of ways they can better accommodate Members with a physical disability.

Culturally Sensitive Member Information

NHP will conduct an annual population analysis specific to Region 2. The data acquired from this business intelligence activity will help us to identify demographic, socioeconomic, racial, ethnic, cultural, and health risk data for the Members that may affect our communications campaigns, channels, messaging, languages offered and health care issues and challenges in our Regional communities. We will also administer a cultural competency self-assessment annually with our partners to monitor our strategic objectives related to our cultural competency plan.

NHP will conduct Member surveys for every Member calling into the call center which identifies race/ethnicity, language preferences for written materials, disabilities which require special accommodations, attitudes toward health care, and provider preferences. We have provided examples of these surveys on the following page.

Cultural Survey

These questions are optional. We would like to know more about you to help coordinate services for you.
If you choose not to answer the questions it will not affect the services you receive in any way.

Assessment Date (MMDDYYYY) 07112017 ☐ Unable to Obtain

DEMOGRAPHIC INFORMATION

How would you describe your Race or Ethnicity? SELECT...
If other or unknown, please specify

What is the primary language you speak at home? SELECT...
If other, please specify

What is your gender? SELECT...
If other, please specify

Do you have a Religious/Spiritual preference? ◯ Yes ◯ No
If yes, what is your Religious/Spiritual preference? SELECT...
If other, please specify

COMMUNICATION REQUIREMENTS

In what language do you prefer to get written communication? SELECT...
If other, please specify

Is it easy for you to read written pages or talk to other people? ◯ Yes ◯ No
If no, what problems do you have?
☐ Don't hear well ☐ Unknown or Unable to Obtain
☐ Don't see well ☐ Other
☐ Hard time understanding written materials
If other, please specify

Would you prefer written materials from your mental health provider in another format other than English? ◯ Yes ◯ No
If yes, what are they?
☐ Spanish ☐ Braille
☐ Audiotape ☐ Other
If other, please specify

DISABILITY ACCOMMODATIONS

Are there any Accommodations you need for a disability? ◯ Yes ◯ No
If yes, what are they?
☐ Hearing Impairments ☐ Unknown
☐ Visual Impairments ☐ Other need for Accommodation
☐ Mobility Impairments
If other, please specify

ATTITUDES/BEHAVIORS RELATED TO HEALTHCARE

Are there others who support you in your recovery? ◯ Yes ◯ No
If yes, who are your supports?
☐ Family ☐ Religious/Spiritual Community
☐ Extended Family ☐ Other
☐ Cultural Community
If other, please specify

Do you use other health practices in your recovery or healing? ◯ Yes ◯ No
If yes, what are they?
☐ Folk, Traditional or Herbal Remedies ☐ Curanderismo/Santeria
☐ Prayer/Meditation ☐ New Age
☐ Shamanism ☐ Other
If other, please specify

Do you have provider preferences? ◯ Yes ◯ No
If yes, what are they?
☐ Cultural Preferences ☐ Age Preferences
☐ Gender Preferences ☐ Religious/Spiritual Preferences
☐ Language Preferences ☐ Other
If other, please specify

When Members call for a referral they will be asked if they have any individual preferences for a health provider. NHP will match these requests with qualified providers because we have collected information about providers' cultural, language, and treatment capabilities and specialties as part of credentialing. We will also gather this information for PCMP providers from all available sources and load that data into our care management system. Through CONNECTS, our Member Service Representatives (MSRs) can accommodate a Member's individual preferences, which includes meeting with a provider who is fluent in another language or sign language. In all cases, we will match preferences as best we can and offer multiple choices for a Member so that we do not assume we know what is best for them.

Language Assistance Services

NHP is committed to providing language assistance services to Members at all points of contact as described in 42 C.F.R. § 438.10 without discrimination. Members' language needs matter and are a priority to ensure they receive culturally appropriate information and services.

To demonstrate our commitment, we hired a Spanish interpreter to attend a women's wellness luncheon because Spanish exists as a prevalent non-English language in the region. Although the interpreter services were not needed during this luncheon, it demonstrated to our Members that we make accommodations to ensure their needs are met.

Each of NHP's partners have developed policies to guide responding to Members with limited English speaking skills and we will merge these into one unified policy for the Region 2 REA. Our policies and procedures outline our processes to assist Members with limited English proficiency, or those who have difficulty speaking, reading, writing, or understanding the English language. We provide assistance for the use of auxiliary aids such as TTY/TDY, American Sign Language, and Relay Colorado. Relay Colorado enables people who are deaf or hard-of-hearing to make or receive personal and business calls in the same manner as any other telephone user. One of our Intensive Care Managers currently uses Relay Colorado weekly to communicate with a high risk Member. Our policies and procedures also inform our Member service representative to easily access interpreter or bilingual services and include guidelines for working with interpreters.

We offer oral interpretation for any language and written translation for state prevalent languages at no cost to the Member. Members are made aware of their right to language assistance through verbal offers or written notification. We provide language assistance at all points of contact, in a timely manner and during all hours of operation. For instance, Members will be verbally offered language assistance if they contact the call center, when they meet with a behavioral health provider, PCMP, or a care coordinator for any non-English language needed. We use Voiance certified interpreters for language assistance. Voiance interpreters receive extensive training on medical terminologies and insurance matters. One way that we know if Members are satisfied with the language services is to ask about their satisfaction at the end of the call. Our care management system tracks Member satisfaction for each telephone call.

We prefer to use expert translators in all interactions, but also understand that Member choice and trust is critical to engagement. With that in mind, we will use the Member's family or friends to provide interpretation services if explicitly requested by the Member and without this accommodation we believe the Member will not engage. NHP also informs Members about language assistance in written formats. The right to language assistance is in Members Rights and Responsibilities which are posted at partner agencies and our website. In any individual Member correspondence, we alert Members of their right to receive information in a non-English relevant language through a tagline. When we send bulk mailings, we print Member correspondence in both English and Spanish. At one of our Member luncheons in Colorado, Members expressed appreciation to our staff for printing health information in both English and Spanish.

OUR APPROACH TO MEMBER COMMUNICATION

NHP recognizes that communication needs to be proactive and bi-directional with our Members. We are responsible for sharing accurate, understandable, and unbiased information with Members and families in ways that will affirm and engage Members. We are also responsible to provide avenues for Members to give feedback on their experience in health care. These avenues include, but are not limited to luncheons, forums, PIACs, and care coordination visits. The goal of bi-directional communication with the Member is to increase their engagement and ownership of their health care.

Our Region 2 RAE staffing will include Member Service Representatives (MSR). Our MSRs will support communications by making outbound verification/assignment of a PCMP and promotion of the medical home initiative. The team will provide education about the program, perform a brief assessment of immediate needs, identifying potential high risk Members and facilitating enrollment into Care Management for timely intervention. During a call with a Member, the onboarding staff member can accomplish a "warm transfer" to a care coordinator if necessary, to

address an urgent issue. In addition, we will use our text messaging capabilities described in Q 15 to reach Members to support wellness and prevention education including information on how to access a PCMP, obtain a wellness visit, alternatives to Emergency Department use, advertise the Department's Nurse Line, nutritional information and seasonal information such as flu shots, preventing spread of the flu, etc.

There are many additional mechanisms for Member input and communication including the Member Advisory Council and Member forums which we will host across the region. The Member Advisory Council will be engaged in developing our Social Determinants of Health Plan as well as the finalization of the Population Health Plan.

Member and Family-Centered Communication

NHP will partner with Members to mutually select effective and appropriate communication guidelines that Members believe are important for effective messaging across cultures. Once norms are developed and agreed upon, the norms will be distributed across the region to provider partners, care coordinators, behavioral health providers, PCMPs, and placed on our website. The norms will be reviewed at our luncheons, forums, and Performance Advisory Committees.

Under the current BHO/RCCO contracts, Beacon delivers an annual communication plan to the Department, and will work with NHP partners to do so under the RAE. To make this plan Member focused, we will conduct surveys with Members when they contact the call center to understand the preferred method that Members would like to receive communication. This information will shape our communication plan to achieve the goals of our Member- and family-centered approach.

Person and Family-Centered Communication through Customer Service

NHP's mission with communication is to provide excellent customer service that is both proactive and responsive towards Members and their families. Our proactive communication will be to inform Members of any changes to Member benefits, opportunities for Members to participate in community activities, and health and wellness information. All communication will adhere to the Department's branding standards. To effectively respond to Members and families, our staff will have ongoing training on customer service. Members will be invited to these trainings to be the lead advisors on what customer service skills are the most important for them.

Our toll-free customer service telephone number will be published on our website and on all written correspondence in a location easy to access. We will promote this line in our onboarding materials and encourage contacts. When a Health First Colorado Member calls that is not attributed to our region, we will assist this Member by contacting the PCMP or applicable RAE. We are here to support all Members and will provide warm transfers to the correct organization to ensure that Members know that they matter and that we are actively supporting them. Our desire is to ensure that all callers are completely satisfied at the end of every interaction and we will measure ourselves against this goal by asking and reporting on a quick wrap-survey asking, "Were your needs met during this call today?" Monthly reports will be run to monitor Member satisfaction with our services and if a Member is not satisfied with services, a supervisor will listen to the call recording to evaluate and address the dissatisfaction.

NHP will continue to provide Member- and family-centered customer service through our call center staff and care coordinator staff that is respectful, promotes dignity, and addresses the unique preferences, strengths, and contributions of each Member and family/caregiver. Our MSRs have the responsibility to provide PCMP, specialty, and behavioral health referrals in our call center. MSRs advocate for Members and families who are unable to navigate the health care system. The MSRs also participate in community outreach to create a connection with Members and staff. The Care Coordinators also serve as advocates for Members to access services that have an impact on social

determinants such as housing, food, or transportation. Additionally, if a Member or family Member calls in with a complaint, the MSR will direct the caller to the Grievance Coordinator for any physical or behavioral health grievance. MSRs advocate for Members and families who are unable to navigate the health care system.

Additionally, if a Member or family member calls with a complaint, the MSRs direct these Members to the Grievance Coordinator for any physical or behavioral health grievance. MSRs use active listening skills to address Members' needs.

Examples of our Member Service Representative (MSR) taking the time to listen to Members needs include:

- A Member who needed help with utilities. Our MSR connected the Member to the local Catholic Charities, who in turn provided $200 in vouchers for this Member.
- A Member who needed an electric breast pump for her premature newborn. The baby could not be released from the hospital unless the mother had one. Only manual breast pumps are covered under Medicaid, and since the Member lived in Salida but delivered in Colorado Springs, she could not get a rental. Our MSR made several calls to WIC and other hospitals in Colorado Springs and Salida to assist. MSR donated a Breast Pump. Member did send a thank you Email to MSR stating that it was a true blessing and the baby was able to gain an entire pound, with a picture of their baby.

Member Service Success Story

Beacon's excellent customer service is demonstrated by their outreach and communication efforts to the Department of Corrections. Beacon sends customer service coordinators to meet with inmates as part of the re-entry program. The focus is to connect and education inmates on their Medicaid behavioral health, physical health and dental benefits. An inmate who was released called Beacon's call center. He said, "I remember speaking with you, and kept your brochure because you said you could help me." The staff member assisted the Member in obtaining dental, physical, and behavioral health appointments. The Member stays in contact with the Member services coordinator and reported that he now has a full-time job and is doing well since his release.

Using Technology to Increase Communication and Member Engagement

NHP recognizes that we can leverage numerous technology tools to address Member engagement. We have tested many technologies in our current service to the Department and have used that experience to design new approaches that can be deployed at scale on our first day of operation as the Region 2 RAE. We highlight a few solutions below:

- **Data Analytics:** One example of how the BHO already uses data for Member engagement is through a weekly report that Beacon's developed for their Zero Suicide Initiative. A report for Community Mental Health Centers (CMHCs) is generated weekly to account for Members discharged from an inpatient hospital setting. Research shows that those who complete suicide, do so in the time following an inpatient admission. We track Members' admission date, discharge date, inpatient facility, and their level of suicidality at time of admission. A report is run on Monday for all discharges that occurred the week before. Members of Zero Suicide Implementation teams at the CMHCs receive this report with the goal to contact Members with a non-demand caring contact. Non-demand caring contacts are an evidence-based practice to prevent suicide.

- **Using Technology for Member Engagement and Population Health:** NHP recognizes that there is a 98 percent open rate for text messages (meaning that 98 percent of text messages

sent are actually opened/viewed by the recipient), and is investing in technology to enhance texting outreach to Members. Approximately 75 percent of the Members in this region have the ability to receive and send texts and in rural and frontier areas of our region text messages are often the most reliable method of communication as they do not require an excellent or high bandwidth digital signal. To that end, we are not only using texting to engage Members in their behavioral health treatment when they chose to seek virtual care, but also in more comprehensive messaging campaigns.

Wellpass Outcomes
• 2x increase in smoking abstinence
• 2x increase in flu shot utilization
• 26% increase in well baby visits
• 18% increase in well child visits
• 44% increase in dental visits
• 40% improvement in appointment attendance

We have invested in a secure, HIPAA-compliant messaging platform designed to help health plans better reach and support their Members while meeting clinical and quality goals. This solution from Wellpass supports text messaging, secure inbox messages, email, automated calls, and allows us to:

- Enroll Members in evidence-based health, wellness and condition-specific messaging programs
- Create custom messaging programs to meet specific plan goals
- Message an entire population (broadcast) or communicate with individual Members (person-to-person)

NHP will use this exciting new technology to enroll Members into health, wellness and condition-specific health messaging programs that are designed to remind Members to go to the doctor, support condition-management, provide education on basic health topics, and close gaps in care. Our featured health programs include:

- Maternal health (Text4baby)
- Pediatric preventive health (Text4kids)
- Adult preventive health (Text4Health)
- Smoking cessation (Text2Quit)
- Diabetes management

We will also use this platform to communicate with Members on a population or individual basis in scheduled intervals and during specific events to support onboarding, appointment confirmations and reminders, and gaps in care alerts (e.g., seasonal flus shots, appointment setting).

- **Online Cognitive Behavioral Therapy (CBT):** NHP partners also have used texting to promote CBT for Members 18 years and older who struggle with anxiety and/or depression through a program with Ieso. The texting outreach was very effective in engaging Members. Members were educated on their behavioral health benefits, and Beacon saw a 97 percent increase of Member engagement when the texting campaign started. Members who engaged in online behavioral health saw a 64.3 percent improvement after entering treatment.

Notice of Privacy

NHP retains the Notice of Privacy Practice on our website link which outlines our privacy practices in detail. We also explain that Members have the right to adequate notice of the uses and disclosures of their PHI, and of their rights and NHP's legal duties with respect to PHI. The Notice contains the elements required under 45 CFR §164.520(b).

Communicating Member Rights

NHP will be active in meeting with Members to provide education and answer questions about their rights through Member forums hosted throughout the region. The goal of these forums is for Members to know their rights in order to be empowered to use their rights. Beacon uses themes to actively engage Members. For example, to educate Members on their rights, Beacon used a theme from the Wizard of Oz. The tagline read, *"You've always had the power, my dear, you just had to learn it for yourself." –Glenda, Wizard of Oz.*

We believe that knowledge is power; if Members do not have the knowledge of their rights, they will not be empowered to use them. The purpose of using themes and object lessons is to engage Members and reinforce the material that is covered.

NHP will have an approved Member's Rights and Responsibilities Policy that supports all of Members' rights. We will distribute Member Rights and Responsibilities as stated in 42 C.F.R. § 438.100 to Members, their families, providers, case workers, and stakeholders. Rights and responsibilities will be provided on our website, at Member forums, at our provider partner organizations, at Healthy Communities, and on request from a Member. We will also distribute these rights through DHS in the counties throughout Region 2. Network providers, CMHCs, Federally Qualified Health Centers, and other agencies that treat Health First Colorado Members will be encouraged to hang the rights and responsibilities in highly visible areas.

Member Handbook

NHP is enthusiastic to collaborate with the Department to create a Member Handbook for newly enrolled and existing Members. NHP is committed to educate and assist Members to navigate their Health First Colorado benefits through clear, easy-to-understand, and Member-centered information. NHP has experience in producing Member Handbooks and is eager to provide region specific information to be incorporated in the Department's handbook. NHP recognizes that much of the required information of 42 C.F.R. § 438.10 is already included in the Department Handbook. NHP will solicit the Member and family's input in any region specific information to include in the Department's Member Handbook.

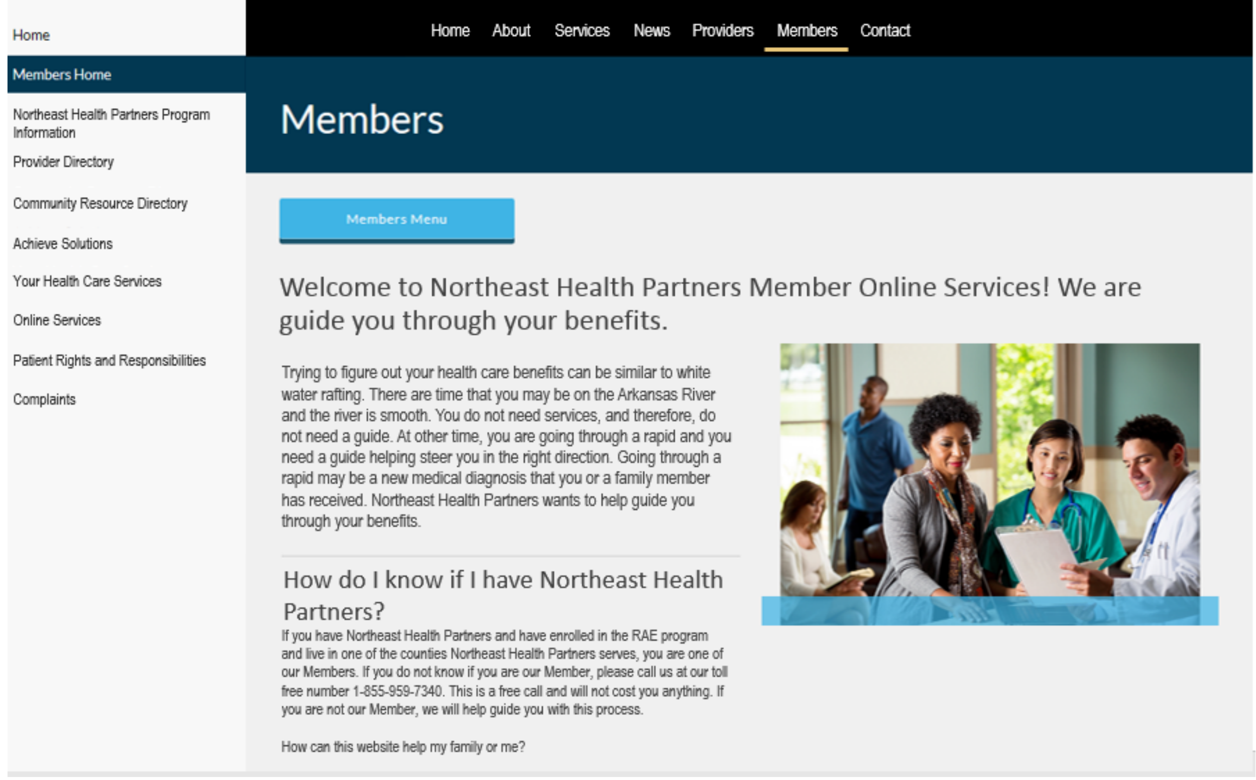
Communication through our Website

NHP will develop and maintain a customized and comprehensive website that includes information outlined in *Sections 5.5.3.8.1 through 5.5.3.8.5* of this RFP. We will model this website on the existing CHP website that has been tested by Peer Specialists and designed using Member input. The Member homepage and resource page were specifically designed for Members and families. We provide an example of our website on the following page.

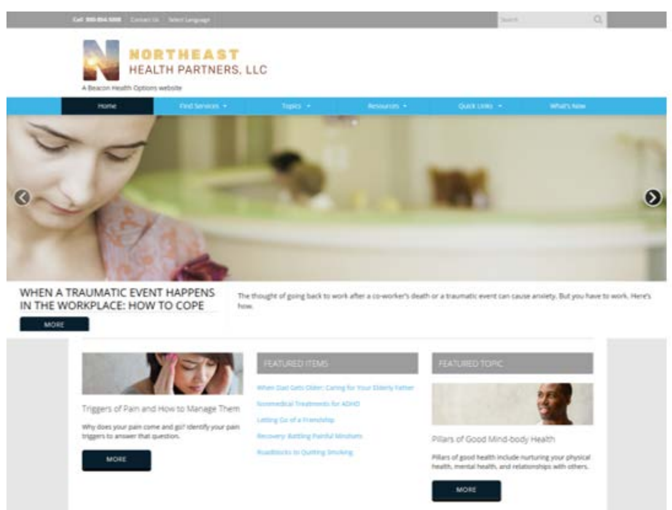
We want Members and families to have information readily available and will include a search feature to help Members access information easily. Our customized and comprehensive website, will be Section 508- and ADA-compliant, and will contain all required information in addition to tools and other information that will help Members understand and easily use their benefits. We will obtain input from Members about the information they find most valuable. Examples of content for Members include, but are not limited to:

- ReferralConnect – Web-based provider directory that allows Members to find providers that meet their clinical, cultural, and language preference.
- Member- and family-centered guidelines
- SAMHSA's explanation on Adverse Childhood Experiences (ACEs)
- Advanced Directives
- Designated Client Representative (DCR) forms
- Release of Information forms

NHP's Member Website



In addition, we will offer Members and providers an additional resource, Achieve Solutions, sponsored by Beacon. This is a web-based resource which has practical, award-winning articles on both physical and behavioral health issues. These articles are updated monthly and are relevant to the regions we serve. An example of this is when there were wildfires in one of our regions, coping and practical information is provided. We track the articles that Members access to track trends and find out what is important to Members. In 2016, Achieve Solutions won the Silver eHealthcare Leadership Award for Best Healthcare Content and the Silver National Health Information Award for "Managing Stress in Your Life," an interactive self-management tool.

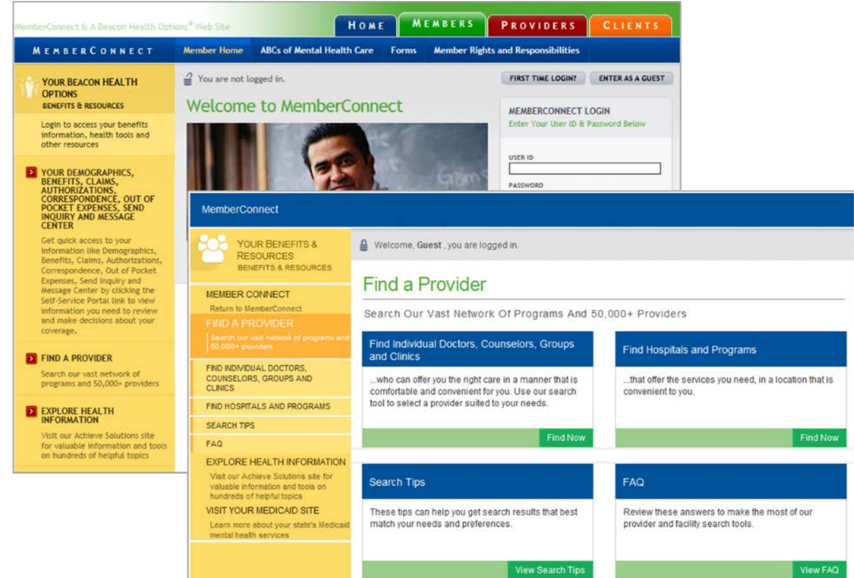


Achieve Solutions is our online library of health and wellness information with more than 3,000 articles, tip sheets, and quizzes.

In addition, with one click from the Achieve Solutions page, Members will have access to MemberConnect, our secure Member self-service web portal. Shown below, MemberConnect will provide Members with access to Health First Colorado Medicaid benefit plan-specific information. MemberConnect will allow Members to:

- Check authorization
- Check claims history and claim payment
- Check claims status
- Search for a provider
- Submit an inquiry to customer service
- View eligibility
- View out of pocket expenses

Member Services Portal (MemberConnect)



MemberConnect is a one-stop e-shop for Members to complete everyday service requests online.

Communication about Termination of Provider Agreements

We understand that changing providers can be difficult for our Members. When we receive notification from a provider of their intent to terminate with our provider network, we send a letter to the Member and offer to help them find a new provider that takes into account their individual preferences. A weekly report was developed to alert Member Services of the Members impacted by providers removing themselves from the network. We send this information to Members at least 15 days from the notice of termination, which is in accordance with 42 C.F.R. § 438.10(f)(1).

NHP will act proactively on the Members' behalf to work with PCMPs who may want to disenroll a Member from their practice. We provide education through provider newsletters on allowable reasons to terminate a Member from a practice. A Member disenrollment/termination may occur when, in the provider's professional judgment, the Member/provider therapeutic relationship no longer can effectively exist due to Member's behavior being a safety concern and/or the Member is non-compliant and the Member disenrollment is a measure of last resort. NHP will develop a Member disenrollment policy in line with State and federal Guidelines. We work to efficiently transition a Member from one PCMP to another PCMP. We notify a Member within 15 days of notification from a provider that they are dis-enrolling a Member from their practice.

Grievance and Appeals Process

NHP will provide information on the grievance and appeals process including State Fair Hearing procedures and timelines to Members. This information will be included in the Member Handbook, posted in provider offices, and on our website. This information includes:

- The Member's right to file grievances and appeals
- The toll-free number to use to file a grievance or appeal by phone
- Requirements and timeframes for filing a grievance and appeals
- Availability of assistance

- The right to a State Fair Hearing, including State Fair Hearing rules
- Appeal rights the State makes available to providers to challenge NHP in the event NHP does not cover services
- Notification to the Member that they may be liable for the cost of any continued benefit should the Member request services to be covered during the appeal or State Fair Hearing request

We welcome and encourage Members or their Designated Client Representatives (DCR) to know their rights to file a grievance, appeal, or State Fair Hearing. We will provide a toll-free number for Members to access this right. A DCR can be whoever the Member designates to represent them including a family member or a specific provider. Our grievance and appeal process complies with 10 CCR 2505-10, Section 8.209, of the Medicaid state rules for the Managed Care Grievance and Appeal Processes and 42CFR438 Subpart F – Grievance System of the federal regulations for managed care.

We view grievances as opportunities to learn from the concerns of Members. A grievance is any expression of dissatisfaction about any aspect of a Member's service that can be filed at any time. NHP uses the terms "complaint" and "grievance" interchangeably. The term "grievance" is from the federal and state standards, but when working with Members, we try to use the term "complaint" because it is a term easier to understand.

Grievances provide opportunities to impact Members' lives and systems. One example of this is from our Grievance Coordinator:

Impacting Member's Lives

"Case of 54-year-old male needing to be referred to a neurologist due to several blackouts sending him to the ER. Case manager has followed him closely for PCP appointments due to ER visits making sure those are scheduled and that Member can make those appointments. During the last PCP visit case Manager supported client to voice referral to neurologist that had previously been brought up to him regarding his health and frequent blackouts. PCP has agreed that this is the next step to take. PCP will send a referral order to neurologist, case manager will then follow up with sunrise Member navigator for referral location. Case manager would provide her contact information for clinic of referral in case clinic is unable to reach client, case manager can be contacted, who will then get a hold of Member. Patient navigator and case manager will work closely to make sure there is referral follow through by PCP and specialty clinic. In case transportation is needed case manager will follow up with Member and provide client with Veyo phone number to schedule the ride at least 48 hours in advance. This will provide Member with a ride to and from appointment. Case manager will also attend appointment with client to specialist clinic and make sure they are aware of additional information that might be needed or would be helpful.

An appeal is any request from a Member or DCR to request a re-examination of an Adverse Benefit Determination. Members/DCRs have 60 calendar days to request an appeal. If the Member receives an Adverse Benefit Determination from an appeal, they have the right to request a state fair hearing 120 calendar days from the date the appeal decision is made.

NHP is committed to assisting, supporting, and guaranteeing the rights of Members and/or DCRs. This includes, but is not limited to: language assistance; continuation of benefits upon request of Member; and an explanation that if original action is upheld, Members may be liable for any cost of continued services. We provide complete details of our grievances, appeals, and State Fair Hearings process in our response to *Offerors Response 10*.

Advanced Directives

Advanced Directives are an important component of Member's rights. NHP will emphasize with Members that their values regarding dying and quality of life will be honored if they are unable to give informed consent due to a physical or behavioral health condition. NHP recognizes that there are many factors whether a Member will make an advanced directive and how they will use an advanced directive. NHP will reinforce with Members that advanced directives should be made when they are not in a health crisis situation. Many Members may avoid conversations about creating an Advanced Directive because it is difficult to talk about dying. We need to be respectful of Member's fears and ensure that a trusted individual is asking Member about their advanced directive. Those trusted individuals may be their PCMP or care coordinator.

NHP will consider Member's cultural competence in creating the advanced directive. In certain cultures, families play an important role in determining the direction of care versus an individual determining the direction of care. People from different cultural, ethnic, or religious backgrounds may have different goals. For example, ethnic minorities may be less likely to make an advanced directive and are more likely to use aggressive life-sustaining treatments. We will respect individual preferences. NHP will not try to predict what someone will want, but rather educate Members on their rights and empower Members to make sure that their health care providers know if they have of an advanced directive.

NHP will place written information about Colorado's Advanced Directives on our website, including state laws, any changes in state laws regarding advanced directives, a description and explanation of medical and psychiatric advanced directives, policies, and limitations to implement policies.

In the event of a change in state law, NHP will reflect the changes to advance directives no later than 90 days after the effective date. We will maintain written policies and procedures on advance directives for all adults receiving medical care that include instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment. Advanced Directive information will also be available in the Member Handbook. Members can request and obtain this information at least annually.

NHP will offer Advanced Directive policy and procedure training sessions for NHP' staff through a Relias training module entitled, *Advanced Directives: What, Why, and When*. NHP will develop an external training module to train Members, family members, care coordinators, Member navigators, medical and behavioral health providers, and stakeholders. NHP will emphasize that there will be no discrimination based on whether a Member has an advanced directive or does not have an advanced directive. We will encourage PCMPs to ask for the latest version of a Member's Advanced Directive.

Other Information

NHP plans to update our website monthly to ensure that essential Member communication is current. We will be responsive to the Department's requests and recommendations for any Member information they believe necessary to improve Member's satisfaction with services. NHP has been proactive to post information on Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits on our website as well as links to the Department's sites.

Member Material Review Process

NHP will continue to include Members and families to test our Member materials to incorporate their recommendations about content and formatting. NHP will leverage its Member Advisory committee to review materials and design new approaches to support a person- and family-centered approach.

NHP will comply with all Department's request to notify them at least 30 days when there is a large-scale Member mailing which will describe the purpose, frequency, and format of the planned Member communication. NHP will make necessary changes to the document to be in alignment with the Department's communication strategies for larger mailings. NHP will submit any materials requested by the Department within 10 business days.

Electronic Distribution of Federally Required Information

All Member information distributed electronically will be compliant with 42 C.F.R. § 438.10, Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA/successor versions. Member information will be readily accessible, prominent on our webpage, printable, electronically retainable, and conform to content and language requirements. NHP will send a hard copy at no cost to the Member within five business days of Member requesting information.

OUR APPROACH TO MEMBER EDUCATIONAL OUTREACH

NHP's approach to Member educational outreach is Member- and family-centered and focused on data provided by Members and families during our contract phase. Member educational outreach will be used to promote healthy initiatives to increase Member's engagement in their health care. We understand that Members and families have been confused when duplicate information has been received from various agencies, and we support a simplified and unified approach to increase Member and family's engagement in their health care services.

NHP's Member Educational Outreach Plan

In adherence with federal and state laws, regulations, policies and procedures, NHP agrees to only participate in Member educational outreach activities approved by the Department. Any strategic Member educational outreach material NHP engages in will be clear, reviewed, and approved by the Department, inclusive of the region served, accurate, and truthful. Some examples of being truthful are to have a disclaimer that Members do not need to enroll with NHP to obtain benefits, that they will not lose benefits, and clarify that we are not endorsed by the Centers of Medicare and Medicaid services, the federal or state government. Our methodology will be outlined to the department, will not include any cold-call Member educational outreach techniques, and will not be in conjunction with the sale of any private insurance. NHP will not engage in any Member educational outreach activities as defined in 42 C.F.R. § 438.104 during our start-up period.

HEALTH NEEDS SURVEY

NHP believes that the results from the health needs survey will help us understand the concerns and perspectives of Members across the counties that we serve. The data will shape Member's health and wellness training. The data from new Members that we do not have any history with will provide information that can translate to meaningful care coordination activities and Member outreach. NHP will identify key trends and themes based on Member responses and will direct our program and policies.

Care Coordination/Member Outreach from Health Needs Survey Results

NHP has reviewed the health needs survey questionnaire and will develop an approach to sort the data into intentional outreach based on Member responses. We will identify Members who have requested personal help for any of their own health care needs or their child's health care needs. These Members will receive a telephone call to listen to Member's preferences for care. Base on Member's preferences and needs, we will link them with either their care coordinator, PCMP, or a behavioral health provider. We will analyze trends across counties to identify if Members have similar goals. Based on individual Member responses and the number of responses per county, Member health forums will be developed to address Member's health concerns. Some examples of outreach and program development based on Member's personal concerns are; 1) target Members

who report one to three emergency department visits to refer to care coordination; 2) When Member reports that they are pregnant and we discover they are pregnant for the first time, we will help link these Members to the Nurse Family Partnership and our Text4baby program which has been measured to produce a 26 percent increase in well baby visits. If they have also cited financial stresses we will also refer to care coordination for participation in WIC or SNAP and 3) If Members report that they need assistance due to social determinants (housing, food), we will have a customer service representative or Member navigator reach out to these Members to provide linkage with community resources.

Regular Data Transfer of Health Needs Survey

NHP has the capability to process a regular transfer of results from the Health Needs Survey through our Information Technology department. Reports from the health needs survey will be developed to align with coordination of care and Member outreach and identify key population themes. The Members' responses from the Health Needs Survey will be integrated into the CONNECTS platform so that this information is available to all Member and provider representatives within NHP. For partner providers, that have chosen to use their own care coordination platform such as an Electronic Medical Record Module, the Health Needs Survey data will be available for access from NHP within the terms of the Business Associate and Data Sharing Agreement for Members attributed to that PCMP from the Department. Review and sharing of this information ensures that NHP has a baseline understanding of every Member at the point of contact. Members reporting significant needs from the Health Needs Survey will be reviewed against our predictive modelling software and population stratification algorithms to determine if Members are repotting clinical or resource needs without corresponding historical claims data. In most cases, the identified Members will be newly Medicaid eligible Members that have either received care from another payer or from the uncompensated care system and would not be identified for care coordination or outreach until encounters occurred and their ADT (admission, discharge, transfer), medication, or claims data processed by analytics solutions offered by NHP or the Business Intelligence and Data Management system. This process could delay outreach by a week or more.

MEMBER EDUCATION ON MEDICAID BENEFITS

NHP's philosophy on Member engagement is that it happens best at a local level. Relationships are a key component to educate Members on their benefits. Currently, NHP partners keep abreast of any Department's communication through the quarterly Member newsletters and monthly "At a Glance." This proactive approach helps to bridge the gap between the Department's communication and Members' knowledge of any changes to Members' benefits or services. We accept the responsibility to know the latest Health First Colorado information and effectively communicate it to Members. We will participate with the Departments' activities to ensure that onboarding and engagement of Members is person- and family-centered.

NHP will design and develop further connections with local Healthy Communities contractors to ensure effective onboarding of children and their parents through outreach, navigation support of Medicaid benefits and education on preventive services. More details about our Healthy Communities approach is provided in our response to *Offerors Response 13*.

MSRs attend trainings and symposiums and are encouraged to read the monthly newsletter that the Department distributes. The reason we focus so heavily on training and education is to know the latest benefits and information that may impact our Members. For instance, we had a MSR attend a training on solution focused integrated care with care coordinators and clinicians. This MSR came back motivated to help Members move toward their desired goal and focus on the solution, not the problem.

Educating Our Members

NHP proactively outreaches to Members and Families on both benefit and health and wellness initiatives. The MSRs generate mailings to alert Members of their benefits and to invite Members to programs such as “Lunch and Learns” and Member Forums. We assimilate lessons we have learned about Member engagement which include the importance of personal invitation, face-to-face contact, and connecting with Members in their community setting.

NHP currently educates Members on their responsibilities which include attending appointments on times, following their treatment plan and respectful behavior at appointments. In efforts to align with COMPACT, we will help Members prepare for their appointments with PCMPs and specialists. Tip sheets will be located on the website.

We plan to build on the successes of our current “Lunch and Learns” and Member Forums to engage Members and promote Colorado’s commitment to become the healthiest state and win the Ten Winnable Battles. NHP adapts “Lunch and Learns” and Member Forums to meet Member’s needs by listening to Member’s concerns. For example, at a recent Lunch and Learn event focusing on women’s wellness, Members asked questions about benefits and how they could obtain an insurance card. Instead of focusing on the content for women’s wellness, we adapted the “Lunch and Learn” to address Member’s needs and placed them at the center of the conversation, because Members’ concerns matter to us. Members responded to these luncheons with a request and desire for continued meeting times to address both their behavioral and physical health concerns. One way to incorporate a Person- and Family-Centered approach in education is to have evaluation forms that solicit Member and Family’s interest for future topics. NHP will be intentional about listing the overlapping topics of Colorado’s State of Health and the 10 Winnable Battles which include: Oral health, Improved Mental Health; Reduction of Substance Use, and Obesity, Healthy Eating, Active Living (HEAL). We will design these forums to address these topics based on Members’ interests.

Peer Specialists are an integral part of Member experience. We have provided peer services for over ten years. We have trained over 300 peers using a consistent curriculum International Association of Peer Supporters (iNAPS), which ascribes to the same ethical guidelines and employs the same core competency for peer specialists adopted by the Department. We have been proactive and helped over 38 peers become credentialed. Beacon developed a peer specialist training focused on substance use disorder have trained many peers in working with those who struggle with substance use disorders. The iNAPs and substance use disorder trainings we provide meet the 60-hour training required by the State.

Educating Parents/Guardian with Child Members on Benefits

We will designate a Member Services staff member to be the Healthy Communities Liaison across the counties we serve within our region. The purpose will be to assist in the onboarding of children and adolescents which is approximately 49 percent of the membership. The primary tasks of this liaison will be to:

- Develop Memorandums of Understanding (MOUs) with all of the Healthy Communities in our region for onboarding activities and sharing of Member information.
- Create an annual onboarding plan with Healthy Communities, Members, and Families. We believe that it is important to know what has worked (or not worked) in the past for Members/Families. This will help shape our onboarding process through the designation of roles and responsibilities for Member outreach, navigation and education.
- Create a master plan in collaboration with Healthy Communities of Member outreach activities. Having a master plan will reduce duplication of onboarding activities.
- Refer any identified child/ Member that needs additional resources based on the Health Needs Survey to the Healthy Communities where Member resides.

- Standardize activities across all Healthy Communities contractors in the region we serve through a monthly meeting.
- Train Healthy Communities about NHP's functions, roles and responsibilities.
- Coordinate with Provider Relations Department to participate in Family Practice Meetings to educate on Healthy Communities and benefits of EPSDT.
- Coordinate with Family and Child Advocates at the Community Mental Health Centers to train on EPSDT and Healthy Community Resources, such as CPCD/Head Start.

Plan for Onboarding Adult Members

NHP will take a proactive approach to onboard Members within the first 30 to 90 days of receiving their benefits. Adults comprise approximately 50 percent of the membership. We recognize this is the critical time to ensure that Members understand their plans and learn how to navigate their plans to increase Member satisfaction and engagement. We will collaborate with the Department on the time frames that they are sending welcome packets to Member to coordinate sending an easy-to-read and understandable question and answer sheet for our region. We will develop a welcome video that will be hosted on our website and promoted through our onboarding campaigns such as direction mail, texting, secure email, or community events and viewed by new Members at their convenience using the technology of their preference. The video will supplement the information provided to Members by the Enrollment Broker and Department and give them specific information about the RAE and how it can serve them.

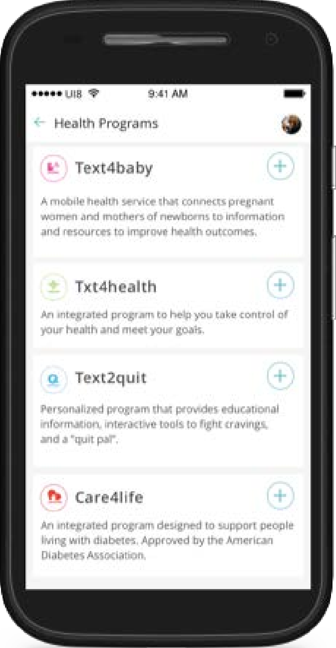
Our Member engagement technology solution from Wellpass provides NHP with a state of the art platform to create and deliver onboarding campaigns to Members at operational start and as they gain or re-gain eligibility and are attributed to Region 2. This onboarding campaign will provide welcome messages with links to our toll-free number, website, and the Departments most important information for Health First Colorado Members (e.g., where to download their PEAK mobile app, access the Member handbook or provider directory), and then graduate into an opportunity for the Member to choose how to advance and continue their virtual relationship with NHP through text-based campaigns and population health programs.

PROMOTION OF MEMBER HEALTH AND WELLNESS

NHP promotes Member health and wellness by engaging Members and families in dialogue during Member forums in their communities. NHP's partner agencies have already developed peer led programs such as wellness walking, wellness cooking, community gardens, and peer-run gardening. NHP will build upon these activities to engage other Members by hosting meetings within our partners to discuss best practices of health and wellness, what is currently working, and what can be improved. We have found that open dialogue about why you engage with your health creates pathways to ideas about how to care for your health. We believe it is important to include Members who have success with a health issue to share their story of lived experience and how they received support through the Health First Colorado system. This approach could also be connected to a Care Coordinator. During one of our Lunch and Learns to promote screenings for cervical and breast cancer, we asked Members to share their personal experience of working with a Care Coordinator to change the prognosis and outlook from "dying" to being on the path to health and recovery. NHP believes that not only educating Member on pertinent topics, but to model ways to recovery will increase Member's participation in their own health.

Supporting Health and Wellness

NHP has developed materials that support health and wellness including the importance of breast and cervical cancer screening, obesity, and smoking cessation. All of these materials have been reviewed and approved by the Department. We will continue to work with the Department in the development and alignment of topics that will support the goal to have Colorado as the healthiest state.



- NHP will deploy high-tech, engaging consumer technology from Wellpass, shown to the right, for Region 2 Members
- Members will have access to Achieve Solutions, an award winning website that has Member-friendly, easy to read documents on behavioral health and wellness.

NHP will share lessons learned during our quarterly advocates/peer meetings and obtain input from Members to stimulate dialogue at the Operational Learning Collaborative that the Department hosts. NHP will also collaborate with the Department on joint initiatives as appropriated and needed. Our goal is to foster prepared, informed, and activated Members who have adequate understanding of their present health condition to participate in medical decision making and self-management.

Some highlights from this report are included below:

- Successfully recruited two Members to participate in the Performance Improvement Advisory Committee by changing tactics of Member outreach.
- Facebook social media presence used to engage Members and updated on a weekly basis with topics about physical and behavioral health
- Women's Wellness Outreach grant program started and Member outreach occurred via analytics-identified cohort for welcome letters and invitations
- Community outreach sites and relationships expanded

Beacon's Member Engagement report closes with an analysis of the information we have gathered and what we have heard from the community. We include trends that have witnessed through our Member, provider and stakeholder engagement and feedback loops and associated lessons learned. These trends and lessons learned set the stage for our goal settings and objectives for the next member engagement periods and reporting cycle. Like many of our other programs such as Data and Analytics, Network Development and Management and Quality, we employ a continuous quality improvement approach to the important duty of gathering feedback from Members, providers and stakeholders and applying it to the services we deliver on behalf of the Department.

Member Engagement Report Feedback

"The Department would like to extend our appreciation for a well written deliverable report. The report clearly identified the different aspects of Member, provider, care coordinator, and stakeholder involvement in the region. It is reassuring to know that you are committed and involved in this process, and works with community partners to provide support as needed. Well done for thinking outside of the box and extending the PAC meeting to different locations and different groups of people. The Department would like to congratulate you on your award for 'Best Healthcare Content" website. It is excellent to read how much Care Coordinators have a positive impact and are an integral part of Member care. It is encouraging to learn that you take Member Service grievances seriously and takes steps to address them accordingly."

– RCCO Contract Manager

OFFEROR'S RESPONSE 10

Describe how the Offeror will handle grievances and appeals.

Northeast Health Partners, LLC (NHP) believes that Member grievances, complaints, and appeals are invaluable. They not only indicate Member satisfaction, but also inform us on ways to improve our services. We view grievances as opportunities to learn from the concerns of our Members. We also believe that a properly functioning grievance and appeals process is a critical element to achieving the Department's goal for the Regional Accountable Entity (RAE) of greater accountability and transparency.

If we have failed at providing quality services, we use that experience as an opportunity to make program and system change. We reframe grievances or complaints as opportunities to "fail forward." As John Maxwell writes in *Failing Forward*, "Determining what went wrong in a situation has value. But taking that analysis another step and figuring out how to use it to your benefit is the real difference maker when it comes to failing forward. Don't let your learning lead to knowledge; let your learning lead to action." While they rarely occur, we use complaints and grievances to lead us to action and provide better health care, health outcomes, and Member satisfaction.

MEMBER- AND FAMILY-CENTERED GRIEVANCES AND APPEALS

NHP encourages Members and family members to know their rights. We will provide Members with written materials, and will conduct an outreach upon enrollment to educate, inform, and answer questions. We will also provide this information in Spanish and will provide interpreter services if needed. Members are informed that they have the right to appoint anyone they wish, including a provider to act as their Designated Client Representative (DCR) to file a grievance, appeal, or State Fair Hearing. We will ask the Member to provide us with a DCR form and a Release of Information (ROI), which are found on our website, if a request is for someone other than the Member or legal guardian. The ROI applies to physical health, behavioral health, and substance use disorders. NHP will protect a Member's health information by not investigating a grievance or appeal until we have all the legal paperwork from the Member, legal guardian, or DCR. If the Member presents a grievance about NHP internal processes, we will not require an ROI.

We believe that knowledge is power and when a Member or family member know their rights, they are empowered to act on their own behalf. We will use creative avenues such as Member Forums to train Members and families on their rights and responsibilities. We provide visual communication aides for Members who have low literacy skills to aid in the retention of information. We comply with 10 CCR 2505-10, Section 8.209, of the Medicaid state rules for the Managed Care Grievance and Appeal Processes and 42 C.F.R. 438 Subpart F - Grievance System of the federal regulations for managed care.

NHP is committed to assisting, supporting, and guaranteeing the rights of Members, legal guardians, and/or DCRs. We provide excellent customer service and listen to the Member, legal guardian, or DCR when they call and make an initial request for a grievance, appeal, or State Fair Hearing. Members are never discriminated against for wanting to file a grievance, appeal, or State Fair Hearing. We thank Members for taking the time to act on their own behalf. The ways that we support Members includes, but is not limited to:

- Providing a copy of the DCR form located on our website
- Explaining and providing assistance with any required forms or paperwork
- Educating Members of the procedures and timelines to file a grievance, appeal, or State Fair Hearing
- Helping Members make informed decisions
- Requesting charts and documents at no charge to the Member

- Coordinating meetings between healthcare professionals
- Linking Members with language assistance
- Providing information in Member's preferred language
- Setting up interpretive services
- Providing our toll free numbers including a Teletypewriter/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability
- Technical assistance

If a Member or family member believes there has been retaliation for filing a grievance, appeal, or State Fair Hearing, the Grievance Coordinator will investigate this as a new grievance and/or direct the Member to contact the State's Ombudsman. Retaliation is taken seriously because it impacts a person's freedom to express their opinions and exercise their rights, both of which are critical elements of recovery. Retaliation could be defined as an adverse action taken against a Member in response to or motivated by, or in connection with a Member's grievance. We inform Members that they cannot lose their Health First Colorado benefits or be treated with any disrespect by providers for filing a grievance, appeal, or State Fair Hearing. As the RAE, we empower Members to be advocates for their health care.

Making it Easy for Members and Families to File a Grievance

NHP partnering organizations have an extensive history of helping Members and families file and resolve grievances for both behavioral and physical health issues. A grievance is any expression of dissatisfaction about any aspect of a Member's service, other than an adverse benefit determination, that can be filed at any time. We understand that it may be uncomfortable for some Members to file a complaint based on cultural background, fear of retaliation, or learned helplessness. We strive to make Member's experience a positive one through active listening, apologizing for an offense they felt they incurred, and making it easy to file a complaint. NHP uses the terms "complaint" and "grievance" interchangeably. The term "grievance" is from the federal and state standards, but when working with Members, we try to use the term "complaint" because it is a term easier to understand in health literacy standards.

Members can file a grievance orally or in writing at any time. Information about how to file a grievance will be posted on the NHP website, our partner websites, and at our partner locations where Members receive treatment and other provider sites. Rights/responsibilities and grievance information are listed in both English and Spanish. Contact information to reach the State's Ombudsman is also posted at these sites. An easy-to-read brochure on how to file a grievance will be developed in English and Spanish to include in Member's intake packets at the Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), and Primary Care Medical Provider (PCMP) offices. We educate network providers and PCMPs about Members' right to file a grievance through various avenues, including provider newsletters, trainings, and the use of peer specialists and peer advocates through our partner organizations.

Just as the "no wrong door" approach provides Members with a universal gateway to community services, NHP offers Members a "no wrong door" approach when filing a grievance. This approach promotes a short interval between the grievance that occurred and helping Members alleviate any stress from the grievance. NHP will also train an identified staff at the providers' office on procedures to file a grievance. This training will include: 1) active listening; 2) the federal and state requirements in managing a grievance; and 3) the grievance database. We understand that not all providers will have an identified staff member resolving grievances and those providers will have information to direct Members to the NHP Lead Grievance Coordinator. We will supply the provider's identified representatives a detailed job aide to ensure that all grievances are managed consistently.

Our Clinical Care Managers and Member Service Representatives (MSRs) who work in our call center are trained on the process of how a Member/Legal Guardian/DCR can file a grievance.

Members who contact our call center with a grievance are directed to the Grievance Coordinator. We also post our Grievance Coordinator's direct toll-free number on our website to make it easy for a Member to file a grievance.

Members can also choose to file a grievance through NHP's Grievance Coordinator or with the Ombudsman for Medicaid Managed Care. If a Member or family member contacts the Department's Ombudsman to express dissatisfaction with the care or lack of care they are receiving from NHP, we will have a designated staff member to be the liaison between the Department and NHP. This staff member will be proactive to investigate and resolve the concern and keep the Department apprised of the progress through efficient communication and will inform the Department when the issue is fully resolved. Our staff has experience in participating in Creative Solution meetings to collaborative with the Department and the Member/family members to brainstorm solutions to the problem.

MEMBER AND FAMILY-CENTERED GRIEVANCE PROCESS

Members who file grievances are encouraged to voice their concern. NHP's Lead Grievance Coordinator or identified staff at providers' offices are trained in active listening, empathy, and communication skills to ensure that Member's concerns are properly understood. We explain legal paperwork is required for us to fully investigate the grievance. Our Lead Grievance Coordinator or the provider's identified staff express appreciation to the Member for bringing the grievance to our attention and invites the Member to contact us with any additional concerns. A grievance acknowledgement letter is sent to the Member/legal guardian/DCR within two business days of receiving a grievance. Below, we have provided our work flow for our grievance process.

NHP's Grievance Process Work Flow

Member/ DCR/Parent/ Guardian
- Member wants to file a grievance.
- Member may contact CMHC, Ombudsman or NHP.

CMHC
- Member calls or speaks with CMHC Advocate directly.
- CMHC Advocate handles Grievance and responds.
- CMHC investigates Grievance, and enters it into system.
- If Member is unhappy with CMHC resolution, Member may reach out to NHP or Ombudsman.

Northeast Health Partnership
- Member calls NHP Call Center or Grievance Coordinator toll-free.
- Call is transferred to NHP Grievance Coordinator.
- NHP handles Grievance and responds.
- NHP investigates and enters Grievance in system.
- If Member is not happy with resolution, Member may contact Ombudsman or Appeal to CO State Medicaid.

Ombudsman for Medicaid Managed Care
- Member calls
- Ombudsman may contact NHP for assistance.
- Ombudsman maintains all records and discusses resolution with Member and NHP.

CO State Medicaid
- Member calls
- CO State Medicaid reviews Grievance.

Upon receipt of legal paperwork, the Our Lead Grievance Coordinator/identified staff conducts a full investigation of the grievance and aims to resolve the grievance within 15 business days of when the grievance was filed. NHP will request an extension if the Member requests an extension or to ensure

that the grievance is thoroughly addressed and the extension is in the Member's best interest. If an extension is requested, we will send the Member written notification within two business days of the extension and indicate that we have up to 14 calendar days to resolve the grievance.

The Lead Grievance Coordinator/identified staff will talk to others who may have had a part in the grievance to obtain their perspective on the Member's complaint. We contact the Member if additional information is needed. The Grievance Coordinator/identified staff consults with other NHP staff who have the appropriate expertise before deciding on a resolution. For example, if a grievance is about a privacy issue, we will contact our Compliance Officer. Clinical grievances are reviewed with a clinician to obtain their expertise. Upon thorough review of pertinent information, the Grievance Coordinator/identified staff will make a decision about the resolution.

NHP will monitor those making decisions to ensure there is no conflict of interest with the complainant. Examples include if the grievance is about the identified staff member or Grievance Coordinator or if the Grievance Coordinator/identified staff have a relationship with the Member outside of the grievance. We will ensure that the Grievance Coordinator/identified staff was not involved in previous levels of review or decision-making, or is a subordinate of anyone who was. If the decision is about a clinical issue, the decision maker will be a health care professional with clinical expertise to treat the Member's condition or disease. Any grievances about providers that generate a quality of care issue will be elevated to the Quality of Care Committee.

Our goal has always been to resolve the grievance as efficiently and thoroughly as possible. We consistently resolve grievances under the 15-day turnaround time. The Grievance Coordinator/identified staff generates a letter to the Member with all of the required information including the date that the grievance was received, date grievance was resolved, the steps taken to resolve the grievance, the resolution, and the offer for Member to file a grievance with the State's Ombudsman if they are not satisfied with the resolution. The Member is provided with the information that they need to file a grievance with the Ombudsman.

Grievance and Appeals System

The Grievance Coordinator or identified staff at the provider site records data from each grievance in the NHP grievance database. The grievance database is a secured web-based site in which can be accessed from any location to record grievance data. The grievance database has the capability to create reports, monitor trends individually and systematically, and provide average turnaround times for the resolution of a grievance. A quarterly report is generated which summarizes the data and is reviewed at the appropriate committees. We review the content for accuracy and identify trends and lessons that we can learn from the grievances. This report and feedback is provided and presented to our Medical Management committee where NHP will assess the data and makes recommendations for systematic improvements. This report is also submitted to the NHP board for review. The quarterly report with break-out counts of grievances and an analysis of the grievances is sent to the Department 45 days after the end of the reporting period.

Provider Grievance Process

NHP is committed to timely resolution on provider inquiries, complaints, grievances and appeals. Providers have the opportunity to voice complaints by contacting Provider Relations in writing or telephonically within 10 business days of the event that gave rise to the event or from the time the provider first became aware of the event. Providers are encouraged to provide all documentation about the complaint, a clear and concise description of the nature of the complaint, and how the action allegedly violated the provider agreement. We ask the providers to offer the specific remedy requested for the resolution to their grievance. Provider Relations staff reviews the documentation and investigates the concern. Staff will attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint.

If the provider is not satisfied with the response received, a Level Two complaint may be filed within 10 business days of receipt of the response from Provider Relations. The Level Two complaint will be reviewed by a different Provider Relations staff than those who made the first determination. All complaints are reviewed and fully processed until the provider is satisfied, does not file a timely complaint or appeal, or exhausts their right to appeal.

NOTICE OF ADVERSE BENEFIT DETERMINATION

NHP understands that it may be stressful for Members when behavioral health services are denied. We aim to be clear in our written communication to the Member to reduce any additional stress when a notice of adverse benefit determination is received. We provide clear details about what services were denied, the reason for the denial, and we provide recommendations for alternative services. In 2014, our partner's created a position for a Coordinator to make certain that Notice of Adverse Benefit Determinations letters are sent to Members or legal guardians in a timely manner.

Prior to mailing the Member/legal guardian a Notice of Adverse Benefit Determination letter, the letter is reviewed by a supervisor to ensure our objectives of Member-friendly language, clarity about the specific adverse benefit determination, and the reason for the determination are met. All letters are in an easily understood language and format, and are available in alternative formats for Members with special needs. Members can request the letter in the prevalent non-English language in their region. The Notice of Adverse Benefit Determination letter contains clear information that the Member, Member's family, a representative of a deceased Member, or a provider acting on behalf of the Member has 60 days to file an appeal with the filing deadline date. An appeal packet on how to file an appeal is attached with each notification and contains the following information:

- Our toll-free contact information to request an appeal
- Our willingness to assist in any way when requesting an appeal
- Members' right to request an appeal or to have another representative, including the provider to file an appeal on their behalf with a signed DCR form
- The steps to file an appeal or grievance
- The process to request expedited appeal
- The process to request a State Fair Hearing
- The right to request a continuation of benefits during the resolution of an appeal and an explanation of when Members may be responsible to pay for any continued service
- The timelines required to file an appeal
- Process for denied Child Mental Health Treatment Act (CMHTA) services
- Process for services that may be covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

We attach Notice of Adverse Benefit Determination letters to the Member's electronic record. We have developed a tracking system for every notice sent to a Member to make sure that deadlines are met and letters are readily available if a Member requests it in the future.

HANDLING APPEALS FOR THE CAPITATED BEHAVIORAL HEALTH BENEFIT

NHP have expertise in managing appeals for the capitated behavioral health program for Health First Colorado Members in compliance with 42 C.F.R. § 438.400. An appeal is any request from a Member, legal guardian, or DCR to request a re-examination of an Adverse Benefit Determination related to a denial or limited authorization of a requested service or the reduction, suspension, or termination of a service that we authorized. NHP will direct Members to contact the Ombudsman for Health First Colorado to file any grievances related to any physical health adverse benefit determination. Members/DCRs have 60 calendar days to request an appeal for either their behavioral or physical health benefits.

Our Appeal Coordinator is responsible to guide Members/legal guardians/DCRs through the appeal process and simplify the process. During the initial verbal request, we determine if the request is a standard or expedited appeal and communicate the following:

- If the request is for a standard appeal, the Member will be informed that they need to follow up the request for an appeal in writing
- Timeframes the Member has to provide additional information they would like considered in considering their appeal
- Explanation that supporting information may include medical records, case files, or anything a Member believes is pertinent to support their appeal
- Our acceptance of additional information in writing or in person
- Our assistance to request records at no charge to the Member
- Member’s opportunity before and during the appeals process to examine their case file
- Our timeframe to make a decision
- Member’s right to request an extension of up to 14 calendar days to process the standard or expedited appeal
- Our process to notify the Member if we need an extension to make an appeal decision of up to 14 calendar days for a standard or expedited appeal
- Circumstances for continuation of benefits during an appeal

The Appeal Coordinator sends an acknowledgement letter to the Member/family member/DCR within two calendar days for all requested appeals. If the NHP needs to request an extension to process the appeal, they will notify the Member of the reason for the extension within two business days for either an expedited or standard appeal.

Members/legal guardians/DCRs requesting a standard appeal needs to follow up the request in writing. An expedited appeal does not need to be followed up with a written letter. The Appeal Coordinator reviews the expedited request with a medical doctor to determine if a standard appeal would jeopardize the Member’s life, health, or ability to attain, maintain, or regain maximum function. If the expedited request is approved by the medical doctor, we will process the appeal and provide a resolution and notice which will not exceed 72 hours to the Member, legal guardian, or DCR. We communicate the results of the expedited appeal by telephone and in writing. If the expedited appeal request is denied, the Member/legal guardian/DCR will be contacted immediately by telephone and have written notification within two calendar days to explain the reason for the denied expedited appeal request. The Appeal Coordinator communicates with the Member/legal guardian/DCR that the expedited appeal request was denied, explains that they can file a grievance for the denied request, and explains the timeframes of a standard appeal.

The Appeal Coordinator works with the Member/legal/guardian/DCR to ensure that all documentation that they want considered in the appeal is received prior to sending the appeal to a health care professional within the necessary timeframes. Our health care professionals have the proper licensure, clinical expertise, and will not have been involved in any previous level of review or decision making. Upon decision of the appeal, Members/legal guardians/DCRs will be notified in writing, not to exceed 10 business days for a standard appeal and 72 hours for an expedited appeal. The notification letter includes the appeal decision and the information used to make the appeal decision. If there is a partial or complete adverse appeal determination, we explain the Member’s rights for a State Fair Hearing.

Upon receipt of an Adverse Appeal Determination, Members/legal guardians/DCRs, have the right to request a State Fair Hearing 120 calendar days from the date the appeal decision is made. The Member has the right to a State Fair Hearing if we do not adhere to notice and timing requirements for their appeal. The Member/legal guardian/ DCR can request an expedited State Fair Hearing and

the Department will make a determination for the expedited State Fair Hearing if certain conditions exists within 72 hours of meeting the criteria. Our Appeal Coordinator will assist the Member in the requirements needed to set up a State Fair Hearing and ensure that our health care professional is present at the hearing.

Timeframes for Resolution of Grievances, Appeals, and State Fair Hearings

Action	Timeframe
Grievances	
Member files a grievance	Members can file at any time
Written acknowledgement of a grievance	Within two business days of filing
Resolution of Grievance	Within 15 business days of filing
Notice of Extension to Resolve Grievance	Within two business days
Extension of Grievance	Up to 14 calendar days
Appeals	
Notice of Adverse Benefit Determination	Sent on date that adverse decision made when it is a denial of payment
If determination is for termination, suspension, or reduction of services already authorized	At least 10 days before the date of determination for already authorized services
If determination is made upon verification of probable Member fraud	At least five days prior to the date of determination
Appeal Request	Members request within 60 calendar days of notice of adverse benefit determination
Acknowledgement Letter	Within two business days of request
Standard Appeal Decision	Within 10 business days of request
Expedited Appeal Decision	Within 72 hours of request
Denied Expedited Appeal Request	See standard time frames
Notice of Extension to Resolve Appeal	Within two business days
Extension of Appeal Decision	Up to 14 calendar days
CMHTA Decisions	Two business days, or five business days if parent agrees
State Fair Hearings	
State Fair Hearing Request	Members request within 120 calendar days of adverse appeal notice or upon exhausting the appeal process
Expedited State Fair Hearing Request	Department makes determination within 72 hours
State Fair Hearing Decision	Within 90 days of request

Continuation of Benefits

NHP safeguards Members' benefits to ensure they continue during the course of an appeal when the authorization period has not expired for previously authorized services. When a Member requests that their benefits continue during an appeal and we agree to the continuation of benefits during the appeal, we continue the authorization until the Member withdraws the appeal request. If the Member does not file a State Fair Hearing within 10 days of an adverse appeal notification or when an adverse State Fair Hearing decision is made, the authorization expires. Notification of the determination is sent to the Member and provider when we deny a service authorization request or

authorize anything less than requested. When an authorization determination is made in support of the Member, we authorize the services within 72 hours of the reversal of the decision.

Resolution and Notification of Appeals

Notification of the determination is sent to the Member and provider when we deny a service authorization request or authorize anything less than requested. When an authorization determination is made in support of the Member, we authorize the services within 72 hours of the reversal of the decision.

COLLABORATION WITH OMBUDSMAN FOR MEDICAID MANAGED CARE

NHP supports Members and families to use the Ombudsman for any concern that they may have, including but not limited to grievances, appeals, retaliation, administrative law hearings, or community resources. We provide the Ombudsman contact information on our website, in our brochures, and in Member correspondence. We recognize that Members and families may feel more at ease with an external advocate. Our staff have worked in collaboration with the Department's Ombudsman to help resolve any concern that a Member has as expeditiously as possible. As an existing provider of both Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) services to over 700,000 Health First Members, we already have a policy in place of working with the Ombudsman.

GRIEVANCE AND APPEALS REPORT

The staff of NHP partners has been successfully submitting the required quarterly Grievance and Appeals report to the State with all of the required information for over 20 years, and have been responsive to any questions that the Department has to clarify information in the report. As the RAE for Region 2, NHP will continue to submit this report and include any physical health complaints that are reported by Members.

OFFEROR'S RESPONSE 11

Describe how the Offeror will develop a network of PCMPs and Behavioral Health providers, inclusive of providers listed in 5.7.1.3. In the response, describe how the Offeror will:

a. Allow for adequate Member freedom of choice amongst providers
b. Meet the unique needs of the populations in its region
c. Ensure sufficient capacity to serve diverse Members with complex and special needs
d. Support the participation of smaller practices in its network, particularly in Rural and Frontier areas.

Northeast Health Partners, LLC (NHP) is committed to providing an accessible, culturally sensitive, and Member-centered network that offers high-quality, general and specialized physical and behavioral health services to meet the needs of our Members. We delegate provider network development to our administrative agent, Beacon Health Options, Inc., (Beacon), and benefit from the extensive statewide behavioral health and substance use networks that they already have in place, as well as honor the established Regional Care Collaborative Organization (RCCO) provider business relationships and contracts the current RCCO already has in Region 2. Within this structure, NHP will enter into the Regional Accountable Entity (RAE) contract with a fully functional network that will provide the Department of Health Care Policy and Financing (the Department) with a risk-free transition, and providers with a painless conversion from their Behavioral Health Organization (BHO) and RCCO experience to the RAE.

Our network strategy will be based upon having a comprehensive understanding of the Health First Colorado membership we will serve. From our past experience serving this membership and as demonstrated in the table below, the two primary challenges we will face is assuring we are able to address households that are not proficient in English and expanding our reach into rural areas of the region.

Demographic and Social Indicators				
County	**# Not Proficient in English**	**% Not Proficient in English**	**% Spanish Speaking**	**% Rural**
Colorado	156,646	3.2	11.8%	13.8
Weld	9,223	3.7	16.5%	20.5
Cheyenne	13	0.7	10.5%	100.0
Kit Carson	311	4.2	13.2%	48.7
Lincoln	293	5.7	9.1%	100.0
Logan	748	3.6	9.3%	29.2
Morgan	2,057	7.8	22.8%	32.5
Phillips	163	4.0	9.2%	100.0
Sedgwick	7	0.3	8.3%	100.0
Washington	40	0.9	4.3%	100.0
Yuma	614	6.6	4.9%	64.9

NHP recruits' providers who have demonstrated experience providing care using a Member-centered model. They must possess the needed clinical specialty, cultural background, licensure

level, and they meet the criteria for participation in our network. Member choice of provider is a paramount concern, which we factor into our network development and design.

a. FREEDOM OF CHOICE

We encourage and empower Members to exercise their right to select and/or change providers from our diverse network based on their needs and individual preferences. We offer Members a wide array of decision support tools and personal support through our member services department and guide Members through the decision process making sure to keep them in the driver's seat and only offering additional guidance when requested. We do not believe in steering a Member to a specific provider, but rather promote their reliance on their own preference to select the provider that is most likely to align with their needs and most convenient for them to access. When a Member needs to select a provider, we offer them access to our provider directory via our website, in hardcopy, and/or review with them on the telephone. When asked for recommendations for a provider, we provide the choice between a minimum of three providers within their acceptable area and preferences. In the case of rural and frontier areas, telehealth options may also be included.

If a provider wishes to participate in our Disability Competent Care (DCC) Assessment, we will provide requesting Members with information regarding practices that meet their accessibility needs.

As evidenced by the tables on the following page, NHP brings an established behavioral health network that far exceeds the Department's standards, and collaborative agreements already in place with the current RCCO with Primary Care Medical Providers (PCMPs) across Region 2. Behavioral health providers are directly credentialed and contracted with Beacon specifically for the Health First Colorado program, which will be retained as part of the NHP network. Beacon has established processes to closely manage the overall network for adequacy according to the Department's standards, allow for Member choice, and accessibility to services based on unique needs of the population in Region 2 under the RAE program for both physical and behavioral health. We will leverage Beacon's existing network and enhance that network to meet the RAE standards to manage network access and identify areas for network development to meet time and distance standards and practitioner-to-Member ratios, detailed below. We appreciate that provider networks cannot be static and must respond to Member needs. Only diverse networks can successfully offer adequate choices so that Members can develop long-term, successful relationships with providers that meet their clinical, behavioral, religious, emotional, and individual needs.

Region 2 Behavioral Health Providers			
RAE Standard	**Provider Count**	**Members**	**Actual Ratio**
1/1,800: Adult Mental Health Provider/ Adult Members	162	41,319	1:255
1/1,800: Pediatric Mental Health Provider/ Child Members	142	39,114	1:275
1/1,800: Substance Use Disorder Provider/ Member	147	41,319	1:281

NHP brings a large and diverse network and provider community to the Department on Day 1 so that we can focus on impacting KPIs and practice transformation rather than building new relationships and infrastructure. Our existing network and relationships include:

Beacon continuously tracks and monitors the strength of its statewide behavioral health and substance use networks. This existing experience is directly applicable to the network strategy of the RAE and delivers a robust and diverse network to Members that offers the freedom of choice. Geo-mapping software (GeoAccess) is used to map where the attributed Region 2 RAE Members reside and relate that to the locations of the providers' sites. These geo-mapping management reports provides information on the adequacy of the network to help us ensure every Member has a choice

will allow for timely identification of any network deficiencies, and will inform provider support staff of the target areas where stronger provider recruitment efforts are needed.

Provider Relations will recruit providers that Members have identified as preferred providers who are currently not in the network. Members may request to see a provider due to continuity of care, distance to home or work, familial affiliation, or other reasons. All recruiting efforts will be exhausted to bring the provider into the network including multiple outreaches over the phone, electronically, and in-person to communicate the benefits of their participation for themselves and the Medicaid Member(s) they currently serve. Additionally, we will leverage the relationships that providers currently in the network have with providers who are hesitant to join the program. We understand for providers, the peer-to-peer relationship and direct communication between colleagues is very important to learn of the real experience of participating in the network. Finally, network providers will be engaged to offer recommendations on how to better outreach to hesitant providers such as letters of support written by network providers.

We will also make efforts to educate Members about the program and the diverse network of providers available. NHP, through our administrative agent, Beacon, has extensive experience with designing, developing, printing, and distributing materials that are user-friendly, cost-effective, informative, and appropriate for Members in Medicaid programs. The materials sent to Members will include both the ACC Program Member handbook, as well as the RAE provider directory. These materials will clearly communicate the:

- Goals of the program
- Member’s right to opt-out of the program
- Member’s right to pick any PCMP that they choose
- Breadth of providers (i.e., PCMPs, specialists, and other service providers) available through the network to support Members

b. MEETING THE UNIQUE NEEDS OF THE REGION 2 POPULATION

Understanding and monitoring the demographics and needs of the population in Region 2 is every bit as important as monitoring the network developed to serve the Region. To successfully develop an adequate and competitive network, we not only must meet the objective time/distance and ratio standards, but also the specific needs of the regional population. NHP has invested in analytics to understand the needs of the Region 2 population and uses this intelligence to understand the network needs of our Members. We bring historical experience and a willingness to do new things to deliver this new program and experience to Members and providers as the Region 2 RAE. Our strategy and designs have been built with an understanding of the population we serve and their distinct needs. A snippet of our analysis is included below to provide some insight in the details we have gathered and considered in the development of our strategy and will continue to use as the Region 2 RAE.

With this knowledge in mind, NHP’s commitment to work with the existing RCCO network that already includes PCMPs; independent behavioral health practitioners; Essential Community Providers, such as the Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs), Rural Health Clinics, substance use disorder providers, school-based clinics, and technical and care coordination integrations and support models with hospitals, social service agencies, local Sheriff’s departments, the Department of Corrections, and other Health Neighborhood providers.

Pre-Implementation and Implementation activities

During pre-implementation NHP will work with CoAccess, the current RCCO, to establish NHP provider contracts. To ensure a smooth transition NHP will acknowledge current provider business relationship and agree to terms that meet the RAE and Department requirements.

During implementation NHP will work with providers by assessing their current operations. Contracts will be executed based on the provider agreeing to the requirements of a contributing, collaborative, or accountable provider.

Post-Implementation and on-going activities

During post implementation NHP will work for providers to ensure they have the tools and capabilities to meet the contract requirements of contributing, collaborative or accountable providers.

While working on stages 1 to 3, NHP will consider all willing physical health, behavioral and substance use provider. Contract will always start with the required Medicaid contracts, assessment, NHP contracting, and transition support.

Understanding the role of the RAE, data exchange, quality measurement, reimbursement, provider tools are a part of each stage of implementation.

To continue this success and improve our network diversity to continue to meet the needs of the Region 2 population, we will implement a three-phase plan to identify those who need to be recruited into the RAE network to support the program as it grows and meet the unique needs of the population. These phases include:

Phase 1	NHP already has a robust statewide behavioral health and substance use network, as well as established relationships with physical health and Health Neighborhood providers via our partners' existing experience in the Region 2 BHO and RCCO. We will communicate the transition to the new RAE model to all providers, but will not need to develop a brand new Medicaid network in the region. We will determine which PCMP and behavioral health providers participate in Medicaid, but are not currently working with the RAE network. Then we will use our GeoAccess mapping software to identify any of the gaps or weaknesses in the existing networks against the new RAE time/distance and ratio standards to use in the development of our recruitment strategies.
Phase 2	NHP will enhance provider supports and enhance or develop relationships with the full Region 2 delivery system of care, including specialists and hospitals, to build a sustainable and integrated health care network for Medicaid Members.
Phase 3	NHP will leverage and enhance our reporting capabilities and metrics based on RAE standards and objective regional contract goals to monitor on-going network adequacy and access to high-quality general and specialized care from our comprehensive and integrated provider network.

Phase 1

In order to develop and maintain a strong physical and behavioral health network in the region, we will have an interdisciplinary work group (the NHP Provider Network Committee [PNC] to evaluate current network and identify those providers who need to be recruited into the RAE network. The workgroup will include representation from provider relations, clinical care coordination, member services, and quality department members. Member representative(s) from the community will also be part of the committee.

The workgroup will use the current list of providers participating in Medicaid, utilization data, and historical claims information to cross-reference against providers who are currently contracted with RAE to identify key practices and providers who are currently providing services to Health First Colorado Medicaid Members. Our population needs will be considered as we work to recruit new providers. Additionally, we will incorporate GeoAccess mapping in order to identify the gaps and weaknesses in the network so appropriate recruitment strategies can be developed and implemented. The workgroup will also consider recruiting providers that a Member requests that the Member would like to see and are not currently in network, but meet Medicaid criteria. Those providers will be presented to the PNC, and the PNC will conduct due diligence to ensure that the provider meets credentialing criteria. With our large existing network and diverse provider footprint in Region 2, we anticipate less time will be spent on Phase 1, with more focus to Phase 2 activities.

Phase 2

In the second phase, provider recruitment efforts will focus on expanding the network to develop partnerships with full scope system of care. We will use the PCMP, CMHCs, rural health clinics, FQHCs, hospitals, substance use treatment centers, and other provider types already in place through the NHP network, along with their recruiting and relationship building skills, to further engage additional providers such as hospitals, specialists, dentists, pharmacists, and Indian Health Care Providers, as available, located in the Region 2 to coordinate quality care for the Medicaid membership.

The PNC will work in collaboration with Clinical, Quality, and Care Coordination staff to develop an engagement plan that aligns with our performance improvement projects, care coordination activities, and key performance indicators (KPIs). Core components of our provider partnership approach include:

- Executing Memorandums of Understanding (MOUs) with key specialists and dentists in Region 2 to coordinate care with Medicaid Members
- Providing specialists with technical and administrative support to resolve concerns with the Department, such as claims payments or utilize data systems and technology
- Designing and implementing financial supports or incentive programs for specialists that are engaged in the network, including flexible funding pool for providers who work in the COUP program
- Identifying capacity gaps and offering assistance from nearby provider partners to providers at capacity
- Collaborating to align KPIs amongst PCMPs, hospitals, and specialists
- Advancing the use of telehealth capabilities to specialists to see Members in frontier or rural areas, or who otherwise would not be able to travel to the specialist’s office
- Developing and implementing strategies and tools to increase care coordination with hospitals for discharge planning, timely access to follow-up appointments, and to reduce avoidable re-admissions
- Collaborating with Health Neighborhoods: participation in collaborative, boards, and other organizations where their input on the path forward for care is valued and used for decisions
- Training and adopting the Care Compact in new practices
- Developing additional rural access programs across the region
- Expanding capacity and access to specialists with support and/or incentives to make them available to see Region 2 Medicaid Members. This may include one-day hosting for non-regional specialists in a local Region 2 setting.
- Leverage practice to practice relationships for specialists and dentists to treat Medicaid Members

The Provider Relations Department will leverage these partner relationships with those providers who currently participate in Medicaid to encourage them to join the Accountable Care Collaborative

(ACC) Program. We anticipate that with the involvement of FQHCs and CMHCs, providers who already know and work within the community will provide validation for the program, and will make initial recruitment efforts simpler. All efforts to bring new providers into the network will include education on the goals of the ACC Program, as well as an overview of the requirements and benefits of being a participating provider. Written agreements will be executed with all providers who support the principles of medical home, accountable and collaborative care, and agree to join the network.

Our Chief Clinical Officer (CCO) will also play an important role in Network Development and Network Management activities. The CCO will:

- Provide recommendations for recruiting providers based on the clinical needs of specialties, type of Members served, or trends in single case agreements (SCAs)
- Identify providers in the area who provide the services needed to meet the needs of Members
- Support recruiting efforts by conducting peer to peer outreach to providers with specialties needed to meet needs of Members
- Meet face to face with key providers in our Region to deliver and discuss performance, transformation, and utilization of tools and services provided by the RAE, as needed
- Host Town Halls for Region 2 providers

Phase 3

In the third phase, our PNC will use quality data to explore value-based reimbursement strategies and potential for tiered networks to further incentivize those providers who have demonstrated quality care. We will implement metrics and reporting to monitor network adequacy and accessibility. Further details of the network monitoring and quality network review is provided in our response to *Offeror Response 12*.

During all phases, our network management focus will be towards development, support, and transformation of the network. We will collaborate with providers where they are, and ensure they meet the guidelines of the State innovation model of integration. Our goal is to not only work to build a robust network, but also have a quality network that has the capacity and ability to serve Members, to the satisfaction of our Members.

Primary Care Medical Provider (PCMP) Network

NHP will initially utilize the RCCO's current provider network of physical health providers in Region 2 that meets the RCCO's current network time and distance standards. NHP will use analysis and maps that are demonstrated below to assess and build their network.

NHP will never be satisfied with the status quo and will always refine and enhance our network to serve the Department and Medicaid Members in Region 2. Our continuous improvement activity will include implementation of various strategies including:

- Develop a comprehensive transportation plan so Members can see providers in other RAE regions if necessary
- Develop a plan to assist Members with attribution to a different RAE if their primary residence changes or their preferred/existing PCMP is located across a nearby border and they believe they have been incorrectly assigned to the Region 2 RAE or other Member attribution scenarios as defined in the RAE contract that allow for such change
- Continue to provide 24-Hour Nurse Advice? Line and Behavioral Health number through contracted providers
- Offer telehealth to Members for both physical and behavioral health services
- Facilitate travelling specialist appointments to local health centers to create access to services if Medicaid providers are not sufficient to meet the demand

NHP's Essential Community Health Providers

NHP Partnership consists of two FQHCs who are primary care providers with a proven track record of success, who have provided quality care to Coloradans for decades. These community-based and Member-directed public and private non-profit organizations are the backbone in the provision of care for the medically underserved. Our primary care provider's strengths include:

- Serving all Members regardless of ability to pay for services
- Being located in high-need areas
- Providing comprehensive primary health care to Members
- Being governed by community boards, of which 51 percent of the board must comprise Members
- Operating as non-profits or public agencies with a mission to provide health care to low-income individuals and families

NHP uses multiple strategies to help meet the diverse needs of our dynamic, yet vulnerable Member populations. Some of these include:

- Creating long-standing relationships and agreements within communities served to help address Member needs beyond the clinic doors including specialty care (including lab and radiology), mental health, transportation, and public health programs. Community linkages with Head Start and area schools increase venues for outreach activities and improve referral networks (for children and their families) to strengthen the overall efficacy of the healthcare programs in the geographic service area.
- Hiring qualified professional people who are compassionate, open-minded, patient, and respectful to all populations to provide the most effective care
- Encouraging cultural competency and inclusiveness

These providers have a long history of supporting special populations. In 1969, a large migrant labor camp located in Fort Lupton was closed by the Colorado Department of health due to severe environmental health risks. This housing displacement, coupled with a time of social unrest in north central Colorado compounded significant healthcare access needs among the farmworker population and led to a proposal to establish a migrant health program in Weld County. A proposal was submitted to the U.S. Public Health Service by a Denver-based non-profit organization, the Foundation for Urban Neighborhood Development (FUND), with support from the University of Colorado School of Medicine. The proposal was funded under the Migrant Health Act and was selected because it sought to depart from traditional approaches to healthcare delivery and offered a comprehensive, cross disciplinary and culturally sensitive model of care to farmworker population that uniquely combined healthcare delivery with attention to social determinants of health.

Sunrise has extensive experience serving migrant and immigrant populations that populate Region's 2 rural and frontier areas. We began in 1973 as a migrant health clinic focusing on providing preventive and acute health care services to these hard to reach, vulnerable, and under-served populations. Since then, Sunrise has been the health care home for migrants and immigrants from Central and South America. Recently, we have become the health care home for many of the area's newest refugees from east Africa and Southeast Asia.

NHP affirms that we will offer to contract with all Essential Community Providers including FQHCs, school-based health centers, rural health clinics, community safety net clinics, as well as with most other private/non-profit providers and substance use disorder providers. Through our efforts to expand integrated care, we have a growing capacity to serve individuals with complex physical and behavioral health needs. Currently, our partners contract with or provide integrated services with all the FQHCs in the service area.

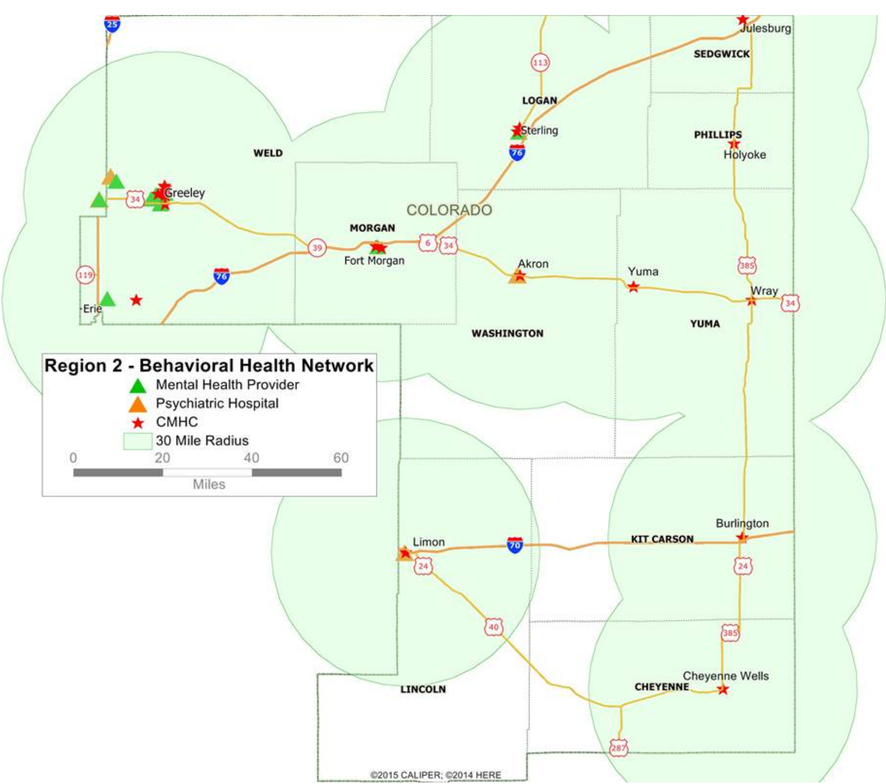
We have systems in place to make payments to FQHC providers at a rate of 100 percent of the cost of covered services furnished for physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers.

Hospitals

Hospitals, like those connected with the Banner Health and UC Health system, play an important role in Region 2. They not only provide acute care, inpatient and outpatient procedures and care, but also serve as medical hubs that allow us to see our Members before transitions of care back to the community or other levels of care, such as long-term care. NHP will leverage our existing experience and lessons learned in working with these providers, such as Banner Health (Greeley, Brush, Sterling), UCHealth (Greeley), and Neighbors, to enhance our relationships for key activities, including care transitions, engaging the Member in care coordination, and working with these providers to use actionable data (e.g., CORHIO ADT feeds) from NHP to better service their Medicaid Members.

Specialty Behavioral Health Network

Providers are available throughout the contracted region to provide comprehensive mental health care from inpatient and outpatient services and substance use disorder services. NHP has a network of behavioral health providers that complies with the network time and distance standards. Based on the diagram below, our current network of behavioral health providers allows Members a choice of at least two behavioral health providers within their ZIP code or within the maximum distance for their county classification. The majority of the membership is covered with providers within a 30-mile radius, which is the requirement for urban counties. If the 60 and 90-mile radius is applied to the rural and frontier counties, respectively, the entire contracted region would have full coverage. For rural and frontier areas, network providers are within the maximum distance for their classification; however, the distance measurement does not account for the terrain that may increase travel time to arrive at the provider's service location, especially during inclement weather.



Licensed Prescribers

NHP has developed strategies to outreach to available licensed prescribers, including Advanced Practice Registered Nurses/Advanced Practice Nurses, Physician Assistants, Nurse Practitioners, MDs, or DOs. We have experience that has succeeded in increasing the number of prescribers to meet the practitioner-to-Member ratio. However, Region 2 geography does not have an abundance of licensed prescribers willing to work with Medicaid population. Members also access providers in Denver and Fort Collins.

Community Mental Health Clinics

In addition to our strong network in the counties of Region 2, our network has CMHCs across the state of Colorado. Each CMHC provides a full continuum of services to Medicaid Members including psychotherapy, medication management, case management, substance use disorder treatment, intensive in-home services, consultation to Members in long-term care settings, school-based services, and integrated behavioral health in primary care settings. All CMHCs provide dual diagnosis treatment services and are highly skilled at treating Members with complex conditions. Many operate Acute Treatment Units or residential treatment facilities. Members have a choice of behavioral health providers in our network and a significant majority choose to receive services through the comprehensive system of services offered by regional CMHCs.

Substance Use Disorder Providers

NHP will work to ensure a smooth transition with existing SUD Provider from the current BHOs network. Beacon has experience in two Colorado BHOs with substance use disorder providers. This includes credentialing, monitoring, and training. In addition, Beacon has experience across the state of Colorado to provide crisis stabilization services, long and short-term residential treatment, and outpatient services.

Mental Health Providers

NHP's mental health provider network will have expertise in serving special populations or have specialty to provide varying modalities of care. Out of respect for Member choice and to ensure specialty behavioral health expertise, we have contracts with independent practitioners, private/non-profit organizations, essential community providers (including FQHCs, rural health centers, school-based health centers), as well as integrated primary care practices serving Members with complex physical and co-morbid behavioral health disorders.

Inpatient Psychiatric Hospitals

Inpatient psychiatric hospitals are critical to ensure Medicaid Members have access to all levels of behavioral health care. NHP, through Beacon's existing network, has relationships with psychiatric hospitals across the state of Colorado to provide inpatient psychiatric services. Technically, there is not an "inpatient psychiatric hospital" in Region 2. North Ridge does operate an ATU. NHP Members will be able to access inpatient psychiatric services right across the border in Larimer County at Clear View Behavioral Health. We will also use Mountain Crest hospital is in Larimer County.

Telemedicine

The co-occurrence between chronic health conditions and mental illness is clearly established in other research (SAMHSA). Despite this clear link, by some estimates, 60 percent to 70 percent of patients leave medical settings without receiving treatment for behavioral health conditions, even though this increases the odds that they will have difficulty recovering from their medical conditions. Failure to recognize and appropriately treat behavioral health conditions has a significant impact on health outcomes and costs: patients with these diagnoses use more medical resources, are more likely to be hospitalized for medical conditions, and are readmitted to the hospital more frequently.

To support all PCMPs and especially those in rural and frontier areas, NHP will expand its use of innovative telehealth and provide effective tools that ensure Members have access to care in a timely manner. We will address social barriers for Members to ensure they received the treatment they need. Through Beacon, we will offer telemedicine to allow Members to seek care for psychiatry or other specialty needs, where the network has challenges in recruiting providers or there simply is no provider that can meet the Member’s needs within an accessible distance. Members do not need to travel long-distance for an appointment and neither do providers. Telemedicine eliminates travel time and expense, as well as personal or work time spent waiting at the provider’s office. And because the technology is interactive, Members will receive a seamless treatment modality in a convenient way.

Ieso Digital Health

An exciting new program for telemedicine is typed conversation using the internet. Beacon partners with Ieso Digital Health to outreach Medicaid Members to provide online cognitive behavioral therapy (CBT) for Members with common depressive and anxiety disorders. Ieso uses a secure and HIPAA compliant, Web-based platform to deliver real-time typed conversation with licensed and credentialed therapists. The use of written conversation disinhibits Members, making them more likely to disclose thoughts and feelings openly and candidly. Typing also provides an opportunity for more embedded learning than face-to-face CBT due to the method of learning by reading and writing, rather than speaking and listening. Members can read through the transcripts after their sessions, to reinforce their learning. As the session cannot be overheard, therapy is entirely private, unlike video or telephone communications. This is another format to provide access to quality and timely care to Members in a discrete and flexible manner. It also allows Members to have choice of providers, delivery of care, and flexible schedule.

Since the initiation of the program in November 2016, 199 Medicaid Members have had their first treatment session with a CBT therapist; 99 percent of Members who entered treatment with Ieso had severe or severe to complex behavioral health needs. Those Members who completed their CBT treatment and were eligible for outcome evaluation, saw a reduction in reported depression and anxiety levels based on PHQ-9 and GAD-7 tools, respectively.

Psychiatric Access Programs

Psychiatric access programs provide PCMPs with access to psychiatric specialists, and assist with providing the education, training, consultation, and referral resources to be able to provide psychiatric medications to Members in their own practices minimizing the need for referrals to outside specialists. These services also help them assess which Members can be maintained at the PCMP level of care, and which would be better served by a referral to psychiatrist.

Using this model reduces demand for the limited psychiatric resources, and ensures that the complex cases are referred to the psychiatrists, thus optimizing the resources we do have. The co-occurrence between chronic health conditions and mental illness is clearly established in other research (i.e., SAMHSA). Despite this clear link, by some estimates, 60 percent to 70 percent of the individuals leave medical settings without receiving treatment for behavioral health conditions, even though this increases the odds that they will have difficulty recovering from their medical conditions.

- This program aligns with studies that also suggest that Members who are provided mental health services in the primary care setting (mostly referring to integrated models) are 50 percent more likely to comply with their mental health treatment recommendations.
- Some data collected from the two year grant for Colorado Psychiatric Access and Consultation for Kids (C-PACK):
    - 89 percent of PCMPs screen more individuals
    - 87 percent of PCMPs used more screening tools

- 88 percent of PCMPs were more comfortable addressing behavioral health issues in primary care settings
- 64 percent collaborated more with behavioral health specialists

Beacon offers a behavioral health component to ensure that Members receive individualized care and referrals to behavioral health providers, which increases the Member's engagement to services. Of the psychiatric consultations preformed in 2016, 91 percent of the cases were able to be maintained by the primary care physician who completed the consultation.

The use of psychiatric access services also fills the gaps for network adequacy for rural and frontier areas who do not have nearby access to psychiatry resources available. We will address this barrier through the provision of Telepsychiatry. By providing consultation services to primary practices, psychiatric access services enable PCMPs to address psychiatric medication needs for their patients. Being able to do so in the primary practice setting that a patient has already chosen increases the Member's compliance with their treatment plan, satisfaction with their primary provider, and overall experience.

Access to Care Standards

NHP will ensure that our network is sufficient to meet the requirements for every Member's access to care to serve all primary and care coordination, as well as behavioral health needs. Our network will enable the Member to choose the most appropriate provider to provide the standard of care to meet his or her needs regardless of the Member's eligibility category.

Network Sufficiency to Support Minimum Hours

NHP ensures that our network is sufficient to support minimum hours of provider operation to include coverage from 8:00 a.m. to 5:00 p.m. MT, Monday through Friday. We require all contracted providers to meet all access standards as stated in the Health First Colorado regulations.

Evening and/or Weekend Support Services

In order to support the access and availability timeframes, NHP will collaborate with existing providers (i.e., CMHCs, FQHCs, and select PCMPs) to have Member-centric and family-centered care practices that meet their needs, one of which is availability outside of standard business hours. Drop-in centers, warm lines, respite, acute care facilities, intensive case management, and home-based services, as well as expanded clinic hours are available during many evening and weekend hours. To meet the needs of working parents, expanded hours are regularly available for youth and family, and they include such services as family therapy, groups, home-based services, educational and skills training classes, and more.

Our call center will have a toll-free telephone number that provides Members with 24/7 access to behavioral health clinical staff. For physical health needs our clinical evening staff will utilize provider and Medicaid Nurse Advice line. Staff members are available to respond to emergencies as well as more general questions related to Member benefits, names and locations of network providers, or queries regarding community resources. Comprehensive call center phone statistics, including call volumes, average wait time, and number of dropped calls are monitored on an ongoing basis to ensure clinical staff are easily reached.

In addition, all network physical and behavioral health providers are required to have practices open during regular business hours for provider operations during 8:00 a.m. through 5:00 p.m., Monday through Friday, except holidays. Also, they are required to make after hours support services available for urgent and crisis contacts on a 24/7 basis. This availability across our entire network of independent practitioners and behavioral health center providers is monitored by NHP.

Access to formal crisis services is also available through any hospital emergency department. Our behavioral health mobile crisis teams will go to any safe location (Police departments, schools, even personal homes), not just ER's.

Access to Clinical Staff After-Hours

NHP's call center also has a toll-free telephone number that provides Members with 24/7 access to behavior health clinical staff. Our call center staff will be available to respond to emergencies, as well as more general questions related to Member benefits, names and locations of network providers, or queries regarding community resources. Comprehensive call center phone statistics, including call volumes, average wait time, and number of dropped calls are monitored on an ongoing basis to ensure clinical staff are easily reached.

Appointment Availability and Access Standards

NHP has established processes and procedures to meet and monitor the standard for appointment availability. Contracted providers are required to meet each of the access standards as stated in the Health First Colorado regulations. Specific information for routine access will be gathered during the initial authorization process for outpatient care. Beacon conducts quarterly quality activities to ensure compliance with these standards. These activities may include random contacts to providers to measure timeframes for routine and emergent appointment access. All network providers are required to offer:

- **Urgent Care Services:** Providers must offer urgent appointments available within 24 hours to Members. Provider partners and many independent providers keep open appointment times available to enable them to meet urgent Member needs so symptoms do not escalate into an emergency condition or place the health or safety of the Member or other individual in serious jeopardy.
- **Outpatient Follow-up Appointments:** Outpatient follow-up appointments are required within seven business days after discharge from an inpatient hospitalization.
- **Non-Urgent Symptomatic Physical and Behavioral Health Visit:** Providers must offer appointments to non-urgent, symptomatic care visits within seven days after a Member's request. Members should not be placed on waiting lists for initial routine service requests.
- **Well Care Visit:** Providers must offer appointments within one month after the request, unless an appointment is required sooner to ensure the provision of screenings in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines.
- **Emergency Behavioral Health Care Services:** As an experienced BHO, Beacon has a network in place to meet the crisis response time in one hour of contact in urban and suburban areas and two hours in rural and frontier requests. NHP will continue to meet and monitor the standards for emergency response times.

c. SUFFICIENT CAPACITY TO SERVE HIGH-NEED MEMBERS

Since NHP has established relationships with providers in Region 2, we anticipate that there will be no disruption in the system of care. The use of psychiatric access services fills the gaps for network adequacy for rural and frontier areas who do not have sufficient psychiatric resources available. By providing consultation services to primary practices, providers are able to address psychiatric medication needs for Members. Being able to do so in the primary practice that a Member has already chosen increases the Member compliance with their treatment plan, satisfaction with their primary provider, and overall experience.

Special Experience Among our Providers for High Need Members

Without the experience and expertise of our provider network, the Members we serve would not receive the services they need. Seeking out and securing providers, especially specialty providers

who offer convenient locations or a particular communication skill, is vital. These are high priority providers, and therefore require a high priority for recruitment. These providers include those who:

- Align to primary care and are co-located in an integrated model
- Demonstrate care coordination activities and tools to ensure optimal health outcomes
- Are located in the service areas that are considered rural or frontier where there are few providers, or few providers within the RAE distance standards
- Provide treatment in a foreign language, American Sign Language, and/or have specific cultural experience

Our PCMP and behavioral health providers will include many who demonstrate experience through documented training and/or employment related history that is confirmed by NHP. The table below includes details of the categories of expertise these providers possess.

Experience working with Specialized Population	Licensed Prescribing Providers in all Areas
• Elderly or Geriatrics • Child Welfare and Foster Care Competent • Criminal justice involved Members • Physically or developmentally disabled • HIV/Infectious disease practitioners as possible PCMPs	• Advanced Practice Registered Nurses/ Advanced Practice Nurses • Physician Assistant • Nurse Practitioner • MD/DO (Board Certified Child and Adult Psychiatrists)
Licensed to work with Specific Populations	**Behavioral Health Treatment Modalities**
• Pediatrics • Geriatrics • Internal or Family Medicine • Obstetrics and Gynecology	• Psychological Testing • Neuropsychological Testing • Behavioral Medicine • Assertive Community Treatment (ACT)
Specialized in working with Specific Diagnosis	**Specialty Services**
• Co-Occurring Disorders • Eating Disorders	• Oral Health • LTSS • Ancillary services • Social services • Other specialties

Recruitment

We anticipate that most Medicaid providers in physical and behavioral health that are currently not in NHP's network will proactively seek to join the network. Through the workgroup under the PNC, NHP will assess on an on-going basis network development needs and opportunities. We will recruit practitioners for the physical and behavioral health network in geographical and specialized areas where the workgroup identifies a need. We anticipate the more rural and frontier areas of the statewide network will have greater recruitment need.

To recruit these providers, our provider relations staff will stress the positive aspects of participation in the Region 2 NHP RAE program, such as:

- Per member per month (PMPM) provider payment
- Alternative payment model that allows for incentives based on quality of care
- Additional volume to their practice
- The opportunity to provide for a needed community resource

- Benefits for the Medicaid Members served through the RAE program
- Resources and trainings available to support the practice
- Health reform increases for Medicaid payments to PCMPs

NHP staff will educate providers on the various tools and resources that are available to them to enhance and improve their daily interactions with Medicaid Members.

In addition to communications via email and telephone, our staff will visit providers' offices to inquire about participation. Staff will provide informational seminars at local facilities throughout the region to meet with providers and office staff and respond to questions. The use of electronic communications will also be used to send fax and email blasts to providers informing them of the opportunities for participation. In addition, this communication method serves as an ongoing source of information sharing and education.

Another potential avenue for recruiting providers into the program will be physician-to-physician communication. Using existing relationships, we will request key providers in under-served/low participation areas assist in recruiting other providers. Medical staff at our partner FQHC and CMHC organizations, as well as at Beacon, may also directly contact non-participating providers to encourage participation.

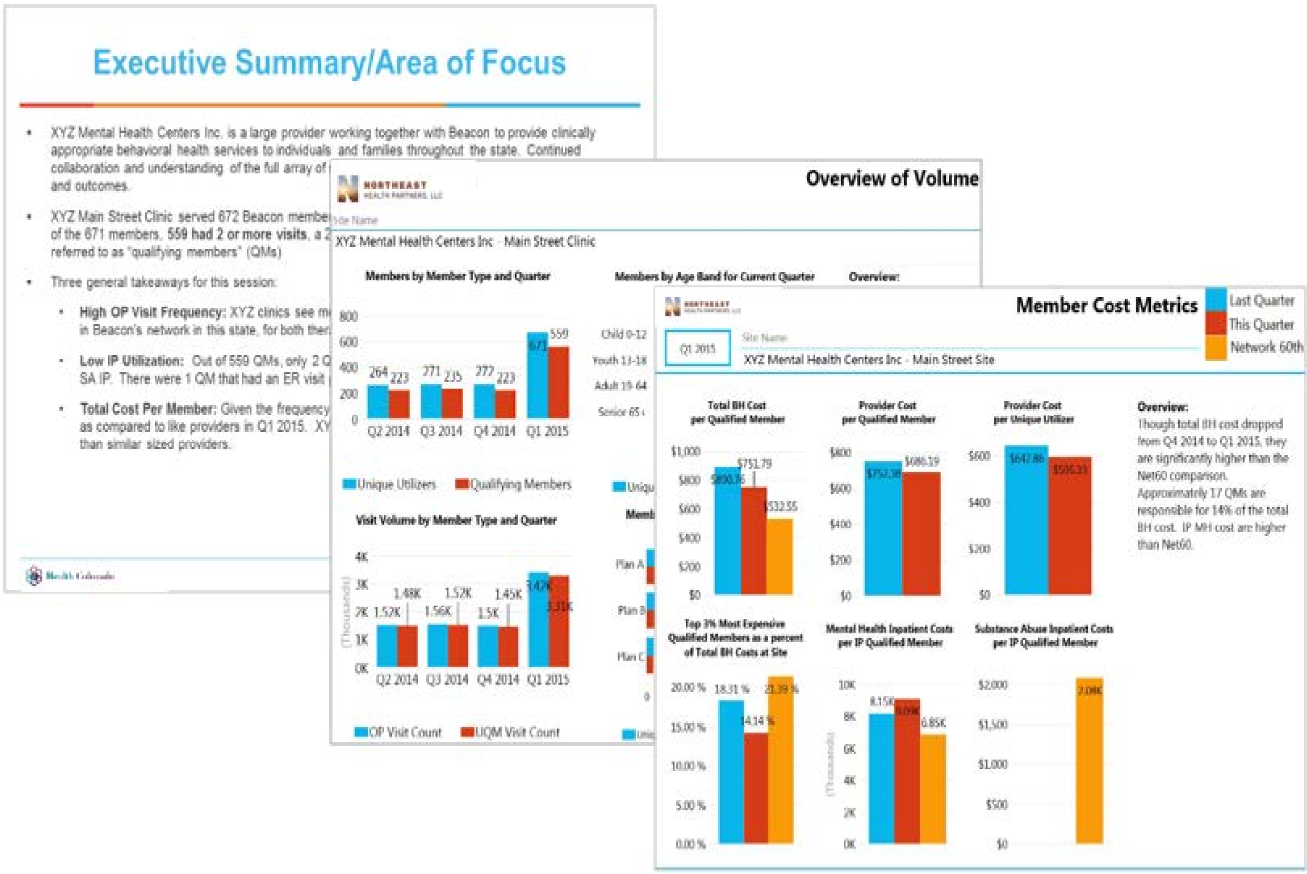
In the cases where efforts have been exhausted to recruit specific providers, the PNC will review the reasons provided for not joining the network and assess if it is a trend or specific to the provider and the impact it would have on the network. This will help identify strategies to successfully recruit providers into the network.

During the recruitment process, our provider relations staff will work with physical and behavioral health providers to ensure they are completing all required credentialing and contracting documentation. Providers who are new to Colorado Medicaid will be asked to register with the Department. Once their information is verified, providers will be asked to complete and execute required written agreements with NHP. Provider support staff will review all responsibilities and participation requirements with providers to ensure they are fully aware of the expectations that accompany program participation. Our staff will respond to any questions and address any issues/ concerns they might have regarding participation.

Our provider relations staff will also collaborate with providers to drive provider performance improvement year-over-year through education and data, and identify top-performing providers for innovative programs and pilots. They will serve as a liaison between NHP and the provider. A Provider Relations Manager will monitor and interpret provider utilization data, oversee data analysis to understand root cause of an outlier utilization, and engage providers to discuss and help remedy outlier utilization.

In addition to using the Department's BIDM investment, our staff will also have access to additional reports and business intelligence that will provide them a provider profile, shown on the following page that contains useful clinical and practice performance information that can be used in their interactions with providers. NHP's Director of Provider Relations will work extensively with our Chief Clinical Officer to develop, manage, and support provider practice functions for the NHP network.

Provider Profile Reports



Network Adequacy Plan and Report

NHP will notify the Department in writing of any unexpected material changes to the network or network deficiency that could affect service delivery, availability, or capacity within the provider network. This notification will include information describing how the change will affect service delivery, the availability or capacity of covered services; a plan to minimize disruption to the Member's care or service delivery; and a plan to correct any network deficiency.

We will also develop a single Network Adequacy Plan and Report for both the PCMP and behavioral health network that includes information as outlined in RFP *Section 5.7.5.1*. We will submit this report annually to the Department. We will also develop a quarterly network report that will contain requirements outlined in *Section 5.7.5.3* of this RFP.

d. SUPPORTING SMALLER PRACTICES

NHP recognizes that the Region 2 RAE covers some geographic regions that do not have an abundance of providers, with majority of providers located in urban or suburban areas. Special recruitment and retention efforts are in place for providers and practices in the network that serve the rural and frontier areas. As an existing partner in the Region 4 RCCO and BHO, Beacon has experience in developing and retaining smaller practitioners in the network to meet adequacy requirement and Member choice in rural and frontier areas.

Our Partners' Experience in Rural and Frontier Areas of Region 2

Care coordinators are fully aware of when services are needed outside of a region; our care coordinators, case management, and call center staff assist in locating providers with specialized services that not available in frontier and rural areas.

Our Provider Relations Department will assign representatives to communicate with small volume providers and office staff regularly to ensure they have the information and tools needed to adhere to program requirements. They will conduct on-site visits throughout the rural and frontier areas such as Burlington, Cheyenne Wells, Wray, Holyoke and Julesburg, to obtain demographic updates, determine if any problems exist, conduct trainings, and share any relevant information or data such as the number of Members each provider has on their active roster. These visits usually result in requests for technical support to address immediate and important issues to the provider. We recognize the importance of meeting our providers where they are—both at their location and level of preparation.

Provider relations staff use these interactions to build trust and rapport with the provider and its practice. This allows further discussions on the importance of practice transformation and offers on-going operational support that integrate into practice transformation:

- Education principles of the Medical Home
- Cultural competent care
- Disability Awareness
- Enhanced Primary Care Factors
- State Innovation Model (SIM) Cohort
- Comprehensive Primary Care Plus (CPC+)

OFFEROR'S RESPONSE 12

Describe the Offeror's approach to managing its Provider Network, including how the Offeror will:

a. Certify Providers as meeting the Accountable Care Collaborative criteria
b. Credential Providers
c. Notify Providers regarding selection and retention
d. Monitor and ensure compliance with access to care standards

Northeast Health Partners, LLC's (NHP's) administrative agent, Beacon Health Options, Inc. (Beacon), has managed provider network services for the past 22 years under the Behavioral Health Organization (BHO) contract in the South/West Service Area, and through the Region 4 Regional Care Collaborative Organization (RCCO) contract since 2010. As such, NHP will leverage this experience and delegate provider network management to Beacon. Beacon has evolved their network management approach to meet the changing needs of the State and Medicaid Members served. NHP will continue to build on that foundation to manage the network for the Regional Accountable Entity (RAE) in Region 2.

a. CERTIFYING PROVIDERS THAT MEET ACCOUNTABLE CARE COLLABORATIVE (ACC) CRITERIA

Recruited providers who show interest in participating in the network will be assessed prior to contracting to ensure they meet or exceed the requirement to serve Medicaid Members. In addition, NHP will contract with providers currently in the Region 2 network. The Primary Care Medical Provider (PCMP) Practice Assessment will allow NHP to certify providers as meeting or exceeding Accountable Care Collaborative (ACC) Program criteria and contract requirements, as well as additional requirements that may be developed over time based on quality measures and collaborative partnerships with high-performing providers.

Providers will receive a Scope of Work and payment structure based on the tier of provider, in addition to the base contract with all requirements placed on NHP and the providers through Medicaid. The Scope of Work will inform the provider of their roles and responsibility as a PCMP in the network, delegated core functions, and performance measures. During the recruitment and on-boarding process, NHP's provider relations staff will review all responsibilities and participation requirements with the providers to ensure they are fully aware of the expectations that accompany program participation.

NHP's Provider Network Committee (PNC) will receive results of the initial assessment to develop a provider support plan to ensure that provider meets and exceeds the ACC Program requirements. Additionally, periodic assessment with agreed-upon criteria and timelines will be conducted for providers based on the service level they provide to ensure they continue to meet or exceed ACC Program requirements. We will consider how to leverage existing State-sponsored incentive programs to conduct the assessment to reduce administrative burden for providers and stimulate participation in initiatives such as Enhanced Primary Care Factors, Comprehensive Primary Care Plus (CPC+), and the State Innovation Model (SIM).

b. CREDENTIALING PROVIDERS

Behavioral health providers will be contracted on a fee-for-service model through competitive contracts based on specialized services, location served, and level of integration with physical health system. Fee schedules that include an increase for providers who provide specialized treatments or culturally competent services such as services in other languages will be considered.

NHP's PNC will be responsible for oversight, quality, and performance monitoring of the network and credentialing process. We will only contract with providers that are fully credentialed and meet all of the requirements to care for Health First Colorado Members.

A sub-committee structure will support the PNC and monitor the day-to-day activities relating to provider networks. The Provider Services Sub-committee will review grievance, compliance, network development, provider support, and network development activities. The Network Development Sub-committee will review access and credentialing activities, and will successfully contract with various providers who meet Medicaid standards and are dedicated to the Medicaid and Medicare-Medicaid population. The Director of Provider Relations and Network Development, with oversight from the PNC, will ensure that all providers are entered into the credentialing system and review and affirm that they meet all requirements.

NHP's Committee Structure

NORTHEAST HEALTH PARTNERS, LLC

Board of Directors
- Governing Board of Directors

Committees / **Operating Groups**
- Quality
  - Medical Management
  - Member Services
  - Complaints, Grievances, and Appeals
- Provider Network
  - Provider Services
  - Network Management
- Finance
  - Financing and Accounting
- Compliance
  - Legal and Regulatory
- Regional PIAC
  - Data Analytics
  - Member and Stakeholder KPIs
- Member Advisory Council

NHP, through our delegation of provider credentialing and re-credentialing to Beacon, operates an independent and arms-length credentialing program that meets the requirements of the Medicaid RAE program and federal guidelines and credentials any provider contracting for our behavioral health network.

Initial Credentialing Process

NHP's administrative agent, Beacon, brings a robust and thorough credentialing process that includes all appropriate policies and procedures to maintain an NCQA-compliant program, including re-credentialing of providers at least every three years. Our program aims to credential all new providers within 90 days and to ensure that providers are able to be paid for services delivered to Health First Colorado Members through single case agreements during the credentialing process.

Individual Providers

Physical Health Providers: NHP understands that the Department credentials and contracts with all physical health providers and creates the comprehensive physical health network for the fee-for-service component of the program. We will rely on credentialing performed by the Department and

build our network of physical health care providers from the universe of Medicaid credentialed providers. Our provider relations staff will work with physical health providers to ensure they are completing all required written agreements on time. Providers who are new to Medicaid will be asked to register with the Department. Once their information is verified, they will be asked to complete and execute required written agreements with NHP.

Behavioral Health Providers: Beacon credentials and contracts with behavioral health providers. Those interested in participating in our network must complete an application, which includes appropriate licensure. We use the credentialing team at Beacon to conduct primary source verification of licensure, education and training, evidence of graduation and specialty training, and valid Drug Enforcement Administration (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate. Beacon also completes CMS-required federal program exclusion checks. Beacon contacts the provider's office, if applicable, to complete the application and acquire additional needed documentation.

Organizational Providers

Beacon follows current NCQA guidelines in credentialing acute care facility providers (including behavioral health treatment programs). As a prerequisite for participation or continued participation, organizational providers must:

- Be in good standing with state and federal regulatory bodies
- Have been reviewed and approved by an accrediting body
- Have an onsite assessment conducted if the provider is not accredited and a CMS or state survey is unobtainable; minimum credentialing criteria includes:
  - Current, unrestricted license, or certificate of occupancy, depending on state requirements
  - Currently accredited or certified in all service locations where services are provided to Members by at least our recognized accrediting agencies or by CMS survey or state survey
  - Must be in good standing with Medicaid or Medicare, as appropriate and is not on the Officer of Inspector General (OIG) sanctions or Office of Personnel Management (OPM) sanctions
  - Professional liability insurance
  - Advance directive policy must be in place for hospitals and long-term care acute care hospitals
  - W9 required during initial credentialing

Credentialing Systems

Through NetworkConnect, Beacon's proprietary network credentialing application, we are able to monitor and research all provider files electronically. NetworkConnect comprises the following features and benefits for credentialing:

- Automated tracking of expired documents (e.g., malpractice and licensure) and key timeframes (e.g., re-credentialing cycles) to ensure accurate, up-to-date provider information for referral and claims payment
- In-bound and out-bound communication technology via multiple methods, helping to maintain provider data accuracy without disrupting the provider's practice
- An audit module that allows remote access to identified provider files and key elements facilitating network audits to occur efficiently and effectively
- Workload management capabilities that support electronic shifting of work among staff as necessary to meet deadlines and expedite provider credentialing

In addition, the system has the following tools:

- Primary source verification, including automated access to key verification sources such as licensure boards and the National Practitioner Data Bank
- Auto-population of critical claims payment data, resulting in quick and error-free loading of client-specific fee codes
- Field-level security and ongoing tracking of every system transaction to support quality control monitoring
- Efficient credentialing “approval” process based on system triggers and embedded credentialing criteria
- A repository for quality of care concerns, which allows and links the information for review by the quality management, clinical operations, and provider relations teams
- Easy access to pre-populated provider profiling reports

NHP, through our administrative agent, Beacon, has written policies and procedures in place to prohibit the discrimination against any provider or group of providers for participation, reimbursement, or indemnification when that provider or group of providers is acting within the scope of his or her license, or certification under applicable state laws or statutes, solely on the basis of that license or certification. Furthermore, if we decline to include an individual or group of providers in our network, we will give the affected providers written notice of the reasons for our decision and their right to submit a formal written request for an appeal.

Re-credentialing Process

NHP’s re-credentialing process includes reviewing:

- Verification of licensure (and information on sanctions or limitations on licensure)
- Board certification if the provider was due to be recertified or the provider indicates that board certification was obtained since the previous credentialing process
- DEA or DPS controlled substance registration certificate (if applicable)
- Current professional liability insurance coverage and updated claims history
- Sanction or restriction information from Medicare and Medicaid in accordance with the verification sources and time limits specified for the initial credentialing process
- Provider performance data including but not limited to member complaints, quality of care, and utilization management data

Between re-credentialing cycles, Beacon will monitor ongoing issues including:

- State board sanctions
- OPM/OIG reports
- Utilization review outliers
- Claims history
- Loss of license
- Member complaints
- Internally identified potential quality of care concerns

On-Going Credentialing Monitoring

NHP is supported by Beacon’s Credentialing Department to routinely monitor credentialed practitioners and facility/organizational providers for sanction activity. Beacon screens disciplinary action or sanction reports on a monthly basis to identify excluded providers as determined by CMS. When we discover that a network provider has been excluded, the provider file is flagged for notification of termination or recommendation of action.

Compliance with Americans with Disabilities Act (ADA) Access Standards

NHP, through Beacon’s credentialing and re-credentialing process, assesses providers on whether they meet ADA compliance standards to ensure the availability of some ADA-compliant providers in our network.

We have readily available providers that can provide services directly to Members who have alternative means of communication. Under the ADA, providers must provide effective means of communication for Members and family members who are deaf or hard-of-hearing. We currently contract with independent providers who can provide physical and behavioral health services in American Sign Language across Region 2 and the State. For Members that need sign language interpretation services, we arrange for and assist providers and Members with a sign language interpreter. Providers and Members are educated on how to receive these services through our Member and provider handbooks and through educational opportunities.

c. NOTIFYING PROVIDERS OF NETWORK SELECTION AND RETENTION

As the administrative agent for network development, Beacon details how providers can join the network via their website. Their website offers information on how to submit a letter of interest to Beacon for consideration. Additionally, it includes a toll-free number that providers can call should they need guidance on the process or request status of their application.

Selection Notification

Providers will be kept appraised of the contracting process and their status through contract execution. Once physical health providers are certified as meeting the ACC Program criteria and behavioral health providers complete the credentialing process and their contract is signed, the assigned provider relations staff will inform the provider of their selection into the network and will provide them with a copy of their executed contract.

Provider relations representatives will review provider responsibilities and participation requirements as outlined in their contract with providers to ensure they are fully aware of the expectations that accompany program participation. This will include general information and administrative support, training, and tools and resources available. The provider service representatives will respond to any questions, and address any issues/concerns they might have regarding participation.

Retention Strategies

Beacon is dedicated to providing excellent customer services for our providers. To help assist with provider retention, provider relations staff will follow-up with the provider on a periodic basis to develop good will and strengthen professional relationships. Beacon's strong provider relations and training program offers Medicaid administrative support, clinical tool support, and practice transformation. Provider relations representatives will create a Practice Transformation Plan with the provider based on assessment findings, practice goals, medical home standards, and NHP's focused social determinants. The practice will be connected to educational materials, available resources tools and data systems, and trainings on best practices that will support them in furthering their efforts to achieve their practice goals. Our provider relations representatives will further assist providers with quality activities and help them meet practice goals.

We will conduct provider trainings and orientations for both existing and new providers in high-volume Member service areas. These training and orientation sessions include information regarding NHP's Medicaid policies and procedures required for participation in the network, including utilization management, quality management, and regulatory requirements. Provider trainings and orientations also equip providers to complete required processes and to file necessary forms, reports, and claims. Provider trainings are conducted both in-person and virtually to allow flexibility for busy providers. Additionally, all provider and Member materials will be available through our website.

Beacon will also establish self-service tools and multiple interactive training platforms to enhance communication with the provider offices. This will allow providers to select a modality that best fits their practice and ensure all providers receive the same level of training. This approach will

especially benefit smaller practices or those located in rural and frontier areas who may not be able to travel or leave their offices to complete training. Additionally, we will work to create training content that meets continuing education criteria, whenever possible. Training platforms will include:

- Live and interactive Webinars
- Library of training videos on the website
- Provider online services that includes a curated library of Practice Support Tools
- Semi-Annual travelling town halls
- Annual seminars
- Solution-focused Learning Collaborative where providers can have in-depth discussion and learning on trending clinical issues, impacting key performance indicators (KPIs) and social determinants

Beacon has also developed a comprehensive communications infrastructure that ensures that providers are both informed about programs and services and offered an opportunity to provide meaningful feedback. These communication strategies include social media, newsletters, email blasts, and alerts, to name a few. Additionally, providers have access to self-service tools and interactive trainings platforms to stay engaged in the network and enhance Member care in the region. Staff will use continuous contact with provider offices to build strong relationships to maximize communication and efficiency. This, in turn, should help reduce the number of providers terminating from the network while also providing increased dialogue to encourage providers to remain in-network.

We recognize the importance for Members to be treated by providers that are culturally competent, speak their own language, and can relate to the Member. We place a premium on recruiting and retaining providers that reflect the ethnic and cultural background or competency of the local membership in the diverse communities across Region 2. We have established reports to monitor the diversity of the network against the membership demographics and based on these reports, our Beacon has, for example, been able to track the increased recruitment of Spanish-speaking providers into the network at all levels of licensures.

d. MONITOR AND ENSURE COMPLIANCE WITH ACCESS STANDARDS

NHP's PNC, which reports to the Quality Committee, is one component that oversees provider monitoring efforts to ensure that providers are accessible and available in compliance with Department and CMS access standards, as well as oversee network management and practice transformation activities. The PNC will include representation from all NHP's provider partners, provider relations, quality, care coordination, and member services staff. A Member representative will also be a part of the committee. The PNC will meet on a monthly basis. In order to ensure that sufficient deliberation is allowed to the various components of compliance with access to care standards, each month during the quarter will have a different agenda. A sample agenda is provided below:

Agenda	Meeting Month
Network Development	January, April, July, October
Provider Support Programs	February, May, August, November
Practice Transformation Plan	March, June, September, December

The goals of the meeting structure are as follows:

- **First Month of each Quarter:** Assess network development needs and opportunities. Information resulting from monitoring efforts will be analyzed by the PNC to address network

weaknesses, as well as development opportunities, and assess availability and access to care to ensure network adequacy based on Medicaid standards.

- **Second Month of each Quarter:** Assess provider support programs for network providers and identify training opportunities based on best practices, data driven needs, or regional trends.
- **Third Month of each Quarter:** Develop and evaluate activities to engage new providers or improve existing Practice Transformation organizations.

Monitoring Network Development

Throughout the year, Beacon will conduct monitoring activities to ensure that providers are delivering the highest quality of care to our Members. In order to be consistent with industry standards and the contract with the Department, Beacon will conduct annual formal reviews of provider performance. These areas of monitoring include: access to care standards, 411 audit results, contract compliance audit results, average resolution time for grievances, and mental health engagement results. The PNC, which reports to, and collaborates with the Quality Committee, will identify and address any network changes or deficiencies of network adequacy and access to care.

The PNC will be responsible for developing on an annual Network Adequacy Plan and Report, using it as a guide to monitor the network adequacy and identify strategies for addressing any network deficiencies or changes. Specific monitoring activities for network adequacy will include:

- Patient/Member load monitoring
- GeoAccess software and density reports to monitor regularly to determine access issues.
- Evaluating shortages in specialties with the annual needs assessment, including numbers, types, and specialties of providers available to membership statewide; this type of assessment helps to identify potential overload of Members for a provider, who may be in high demand, because of a specific need (e.g., a provider who speaks a foreign language)
- Reviewing reports identifying providers not accepting new Members and access to care and provider disenrollment reports to help identify a potential gap in providers
- Reviewing and monitoring provider caseload ratios to ensure that they meet standards and are appropriate for accepting new Members.

Access to Care

NHP understands the importance of access to care for Medicaid Members. Beacon will gather data on access to care on a routine basis through a variety of mechanisms and will cross-reference the data against grievances and member satisfaction data to ensure the following standards are being met:

- An individual with emergency needs is seen within one hour for urban or suburban areas and within two hours for rural areas.
- An individual with urgent needs is seen within 24 hours
- Routine services are available within seven business days

Beacon will continue periodic monitoring of member access to care and determine network adequacy. We will use various mechanisms that may include secret shopper and after-hour crisis response time testing, as well as including relevant questions within the Colorado Client Assessment Record (CCAR) tool. We will consider other mechanisms to ensure effective and efficient monitoring for physical and behavioral health providers. The findings will be reported to the Quality Committee for review and recommendations will be sent to the PNC for action. These actions may include targeted provider training and/or focused secret shopper, testing, and monitoring.

Other Monitoring Activities

An annual review of the Quality and Performance Program Plan evaluation will also be conducted on our provider network. This review, conducted in consultation with the Quality Improvement Director, will indicate provider access issues (e.g., not meeting access to care standards), complaint and grievance data regarding availability and accessibility (e.g., waiting lists), patterns of poor quality care, and Member and/or provider satisfaction survey information regarding access issues. Other activities include analysis and trending of information on appointment availability (obtained during site visits), the authorization process, or from access and data reports tracking engagement and follow-up treatment, which will also be used to determine access concerns for any level of service.

This list of provider network monitoring methods is not meant to cover all network development activities, as some activities are initiated because of new areas of emphasis as a result of PNC findings or recommendations (i.e., a new benefit or newly covered diagnosis).

Provider Profiles

We understand the importance of data to drive system change and apply data to augment our comprehensive quality management and improvement process. Beacon's provider practice improvement program promotes quality management through data analytics and information to drive continuous performance improvement and improve member outcomes. Relying on Beacon's information management system, we will be able to bring a wealth of data and reporting resources to providers and assist them with meeting quality and performance goals.

In Beacons' reporting solutions from the data warehouse that is fed by the Departments systems, we are able to see claims that will indicate the members that PCMP is serving such as their conditions, acuity, outpatient cost, and total cost of care. We integrate data from multiple datasets, including medical, pharmacy, and behavioral health claims and create customized dashboard reports to assist in tracking outcomes. Beacon will leverage the State's BIDM System to obtain available provider data, in addition to data collected through our current data sources to ensure we have a 360-degree review of the providers in the network.

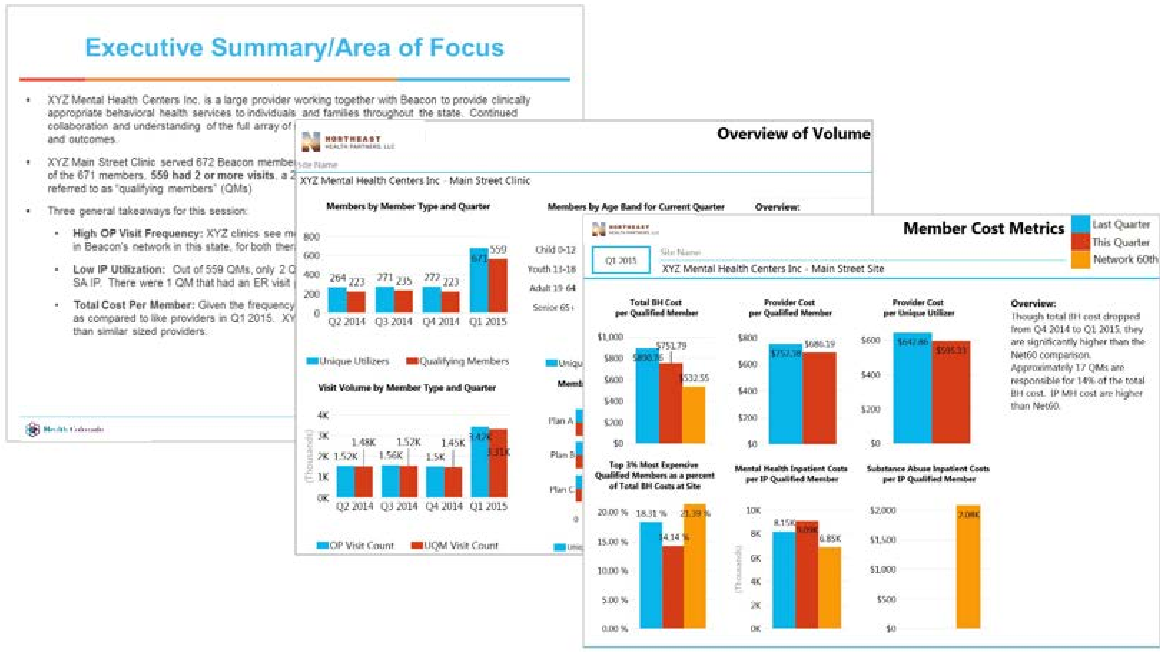
Beacon performs both scheduled and ad hoc provider profiling by the provider relations team. We monitor behavioral health provider practice patterns against regionally-based data. Provider relations staff develop and share provider profiles, shown on the following page, which includes more than 20 metrics that are benchmarked against like providers across the state. Profiling metrics include the following:

- Utilization metrics such as visits per utilizer, average length of stay, average number of outpatient visits, admits/1,000, readmission rates, incidence of outlier behavior such as long-term outpatient treatment and high frequency appointments, and up coding
- Administrative metrics, such as claims payments and complaints data
- Pharmacy utilization such as prescription drug prescribing patterns
- Quality measures such as HEDIS mental health follow-up rates
- Member satisfaction

Beacon will also evaluate those outpatient providers with high no-show rates and those providers with Members who only attend one post-discharge visit with no follow-up. This information is reviewed on a facility-by-facility basis. For high-volume facilities, this information is shared with the facility by using a blinded comparison to other facilities, with instances of unusual patterns of utilization discussed. Information on Members is also tracked, such as high-dollar claims, readmissions, and diagnosis; review of these items allows us to offer Intensive Care Management services when it is needed. For outpatient care, metrics include:

- Length of stay
- Members seeing multiple providers
- Providers seeing multiple family members
- Providers' rate of admission to higher levels of care
- Quality of care and quality of service

Provider Profile Reports



Provider Audits

Beacon will perform standard, random auditing of the treatment records of providers to ensure that practices adhere to standards of practice which reflect appropriate physical and behavioral health care management. In addition to random audits, the following triggers will alert staff to the potential for a provider audit:

- Potential quality of care issues
- Appeals
- Instances of possible over- or under-utilization
- Suspected or alleged fraud, waste, or abuse
- Potential high-volume practitioner
- Instances of poly-pharmacy
- Adverse incident investigations
- Review of a case requiring Intensive Care Management
- Review of emergency room records to determine whether the care was provided for a covered mental health diagnosis

OFFEROR'S RESPONSE 13

Describe how the Offeror will support and establish Health Neighborhoods in the region, including how the Offeror will define Health Neighborhoods and address requirements in Section 5.8.2.

Building a Health Neighborhood is a process–one that we have evolved over 40 years as individual safety net providers and more recently as delegated providers through the Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) programs. This process that is both a longitudinal and a multi-pronged commitment, one that we are excited to engage in with the Department and the many Medicaid providers in Region 2.

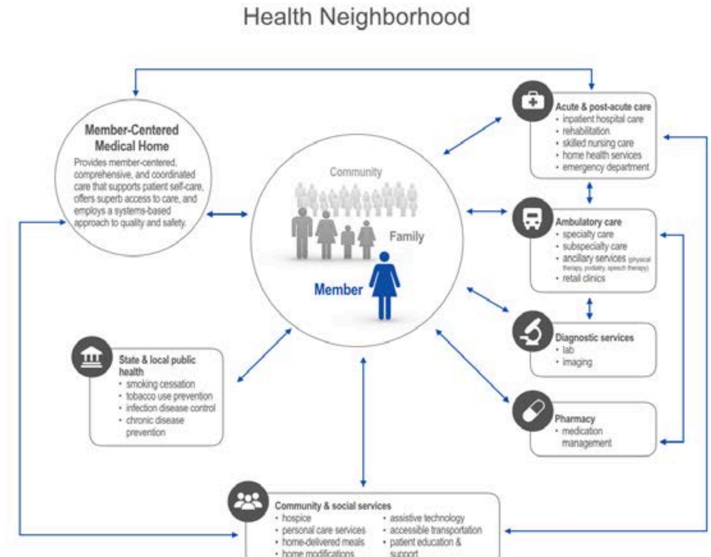
Although Northeast Health Partners, LLC (NHP) is a new corporate entity, the partnership among the 'owner' organizations is longstanding, and has been serving the residents of the 10 counties that comprise Region 2 for many years. As a member of the community and by serving vulnerable populations in Regional Accountable Entity (RAE) Region 2, we have gained an in-depth knowledge of our communities and the resources available. We have established relationships across the full spectrum of Health services. This deep network of community relationships has enabled us to design our administrative and clinical supports to ensure that Members receive assistance and advocacy while increasing Member access to appropriate Medicaid services and benefits that positively impact their lives.

Our approach to building the Health Neighborhood is characterized by the following values:

1. Leveraging our long-established relationships across the spectrum of health and human services providers and organizations throughout the Region
2. Maximizing technology to support analytics, communication, coordination and innovation across the Health Neighborhood and among community partners
3. Participating actively as a good neighbor in local, regional and state collaborations, initiatives and policy-making consortia to develop meaningful solutions that improve health and well-being of Medicaid Members and their families

NHP believes that building a Health Neighborhood will require actions at many levels including:

- Maximizing technology
- Reinforcing and expanding relationships across the Health Neighborhood to encourage communication, address barriers and support access to specialty care resources
- Leveraging Department and other state resources such as the Primary Care-Specialty Care Compact to foster proactive communication, collaborative Care Management and planning across diverse settings



Our response to OR 13 describes our multi-faceted approach and addresses all three components.

Framework for NHP Health Neighborhood

NHP defines the Health Neighborhood as the "delivery of coordinated care which is facilitated by consistent communication, collaboration, and shared decision making between a variety of providers, and other social support organizations." [1] Under this definition, a well-functioning medical neighborhood is described as having these key features:

- Clear delineation and agreement of neighbors' roles
- Shared clinical information to support shared decision making, supported by IT systems
- Use of care teams to develop individualized care plans
- Ensured continuity of care when Members transition between settings
- Member preferences in decision making
- Strong community linkages for clinical and non-clinical needs

NHP will work to support a Health Neighborhood across the full range of providers included in the Department's definition:

"A network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, local public health agencies, and county social/human services agencies that support Members' health and wellness."

Common barriers to a high-functioning health neighborhood are also well known and some include:[2]

- No/few financial incentives
- Lack of staff/time for coordination
- Fragmented services vs. an integrated delivery system
- Limited IT infrastructure and interoperability

NHP's TECHNOLOGY APPROACH TO STRENGTHENING COMMUNICATION, COLLABORATION AND EVALUATION

As individual providers and through the BHO and RCCO programs, we have developed a variety of technology solutions, connections, and processes that facilitate communication across provider sites, support Care Coordination and improve access.

- Providers have established relationships with Colorado Regional Health Information Organization (CORHIO), in which CORHIO alerts are sent directly to clinic IT systems.
- There is a process by which the clinic and CORHIO coordinate to match admit, discharge and transfer (ADT) CORHIO hospital data (inpatient and Emergency Department [ED]).
- Clinics receive daily ADT data from all CORHIO participating hospitals, which allows them to identify Members and initiate the Care Coordination/Care Management.
- Care Coordinators and Care Managers are co-located or fully integrated. As an example, in Sunrise clinics, North Range's embedded team members have full access to Sunrise's chart enabling them to obtain clinical data, document Member needs, gather pertinent clinical information (such as current medications), and see and/or help contribute to the Care Coordination plan.

[1] Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011.
[2] ibid

- Care Coordinators and other clinical staff use a CORHIO tool, Patient Care 360, to access a secure web-based portal that provides access to real-time Member information to better coordinate care. PC360 contains details regarding the Member's visit to the hospital (inpatient and ED) including lab results, hospital notes, diagnostic imaging and medication lists.
- A variety of telehealth solutions described below improve access and address scarce resource conditions that are characteristic of our rural and frontier community.

Use of Technology

Under the auspices of the RAE, NHP will continue the technology solutions in place that are successful and expand our capabilities to capture technology innovations and new resources that we will have available. Our administrative agent, Beacon Health Options (Beacon), offers a range of technology solutions to address our specific needs and support the Health Neighborhood. Our provider partners, Region 2 hospitals, many other Primary Care Medical Providers (PCMPs) and specialists have implemented technology solutions that will support easy communication and full interoperability through a variety of integration options provided to them by NHP. We will work with those providers to develop a communication strategy that is most relevant for their environment and strengthens relationships with PCMPs and the other organizations in the Health Neighborhood. Consistent with the Department's effort to promote the use of electronic consultation software, there are providers who are currently using electronic consultation software solutions either through their own Electronic Health Record (EHR) systems (e.g., PCMPs and behavioral health teams in integrated practices) and across institutions through CORHIO, health information exchanges such as Carequality/Surescripts or Beacon's CONNECTS Platform. These are different options to reach the same goals:

- Improve collaboration and communication to achieve more seamless health services for Members
- Improve outcomes by sharing data such as diagnostic test results or care coordination plans
- Reduce costs
- Increase provider participation in the Health Neighborhood by reducing barriers such as ineffective referral processes or communication and high no-show rates of Members
- Share claims data as appropriate
- Support telehealth solutions

For some, they have already implemented CORHIO and will be able to leverage a fully interoperable system offered by our state health information exchange. CORHIO offers one avenue for providers to be able to communicate through a secure health information exchange (HIE) network that gives hospitals, laboratories, long-term and post-acute settings access to secure Member information across the state.

Beacon, our administrative agent, will work with providers to expand that approach where appropriate. For some of our providers, linking their EHR systems through nationally recognized interoperable data sharing tools is an alternative approach.

Secure Health Information Exchange

One example used in Colorado is Carequality/Surescripts National Record Locator Service (Carequality/Surescripts service) that provides physicians with electronic access to critical Member health information located outside of their native EHR systems. This service locates Member records within third-party EHRs, electronic document repositories, or other HIEs and facilitates the exchange of relevant Member information with the requesting care provider's EHR system.

The Carequality/Surescripts service provides several benefits to participating practices. Member health outcomes are improved by offering providers real-time electronic access to discoverable Member records located throughout the country. It reduces the need for processing clinical record requests manually and allows providers from third-party HCOs and EHR systems to securely exchange clinical data. The Carequality/ Surescripts service supports transmission of Consolidated Clinical Document Architecture (C-CDA) These C-CDAs are a snapshot of information broken across 17 sections:

- Advance Directives
- Alerts, Allergies, and Adverse Reactions
- Encounters
- Family History
- Functional Status
- Health Care Providers
- Immunizations
- Medical Equipment
- Medications
- Payers
- Plan of Care
- Problems
- Procedures
- Results
- Social History
- Support
- Vital Signs

Providers in and out of Region 2 in Colorado use this approach to connect securely with Members across the spectrum of the Health Network. All Office of the National Coordinator (ONC) recognized Certified Electronic Health Record Technology (CHERT) applications are required to both import and

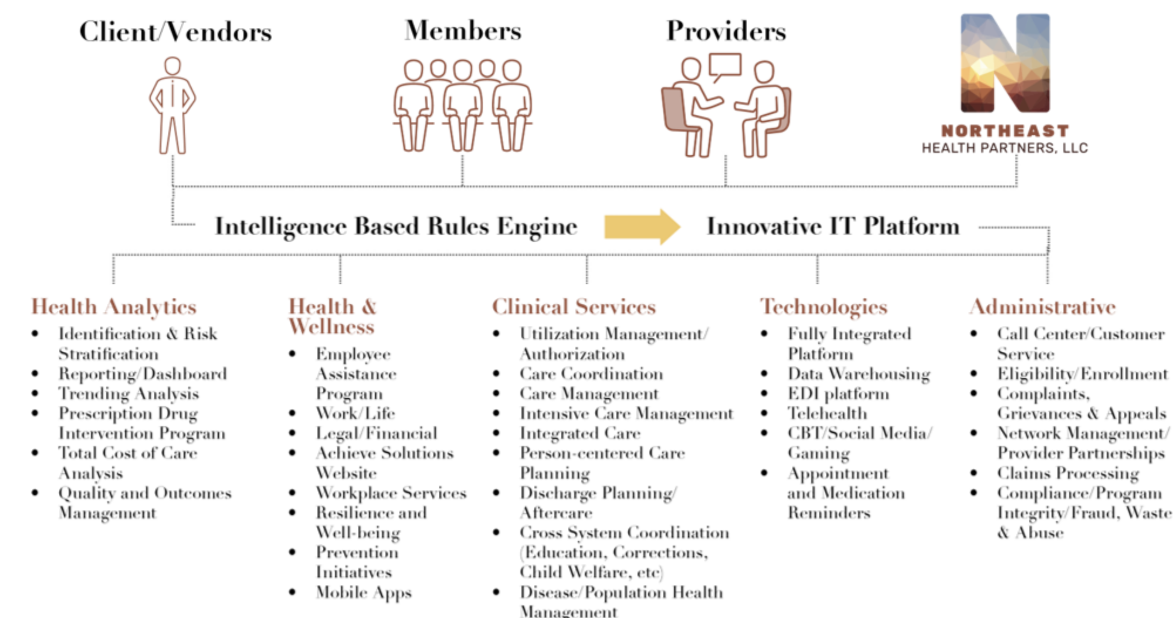
export C-CDA records. These include Avatar/NetSmart used by behavioral health partners, and most major EHR systems available today.

A sample of local, state and national providers that use Carequality/Surescripts services include:

- Animas Surgical Hospital
- Children's Hospital Colorado
- Hampden Medical Group
- Paladina Health (ED)
- Centura Health
- University of Colorado Health
- Kaiser Permanente – Colorado
- Presbyterian Healthcare Services

Using well-established interoperable solutions advances our goals of improving communication and reducing barriers to care across the full Health Neighborhood, and regardless of which technology solution providers use, the information will be uploaded seamlessly to CONNECTS to support region wide analysis, evaluation and Care Coordination.

NHP operates all of our functions using a wholly owned and operated technology infrastructure provided by Beacon to tie resources together across Region 2. This system has been in place to provide both RCCO and BHO functions in other regions in Colorado and is updated and enhanced on a regular basis. In addition to supporting program data management and reporting, CONNECTS, shown below, is a suite of fully integrated applications designed to provide innovative data management and reporting capabilities that support the full Health Neighborhood.



CONNECTS comprises a suite of fully integrated applications built on a single platform. Data can be organized at the Member, provider, population or any other level required by the Department. This means that our platform is truly an enabler of Care Coordination, rather than a barrier.

Because of the integrated nature of CONNECTS, it facilitates collaboration with regional stakeholders such as Health Neighborhood partners, social services agencies, specialty providers, hospitals, Sheriff's departments, etc. We are pleased to report that we expect minimal start-up activity to configure and develop new integrations for the system, as we have already established

working integrations with all of the currently available Department of Health Care Policy & Financing (HCPF) systems defined for the RAE.

From initial eligibility through Care Management, claims administration and reporting, all of our applications reside on one common platform, CONNECTS. This platform is designed to guide daily clinical decision-making, to be the technology solution to support the community-based clinical population health efforts, and support providers who choose to use CONNECTS as their solution to promote interoperability.

Beacon's significant investment in this technology infrastructure is designed to support highly integrated care modules to support Colorado's goals of improving health outcomes. The updated module incorporates standard industry best practice Case Management design with enhanced features for behavioral health-specific condition management, as well as robust inclusion of physical health considerations for a "whole person" needs management and support. This solution allows us to communicate with specialists, hospitals, post-acute settings, and others in the health system to improve coordination. Our goal is to use technology to increase access to care, especially to the number of specialists in the region who are enrolled as Medicaid providers and who are accepting Medicaid Members.

NHP'S EXPERIENCE IN CREATING AND MAINTAINING RELATIONSHIPS WITH THE HEALTH NEIGHBORHOOD

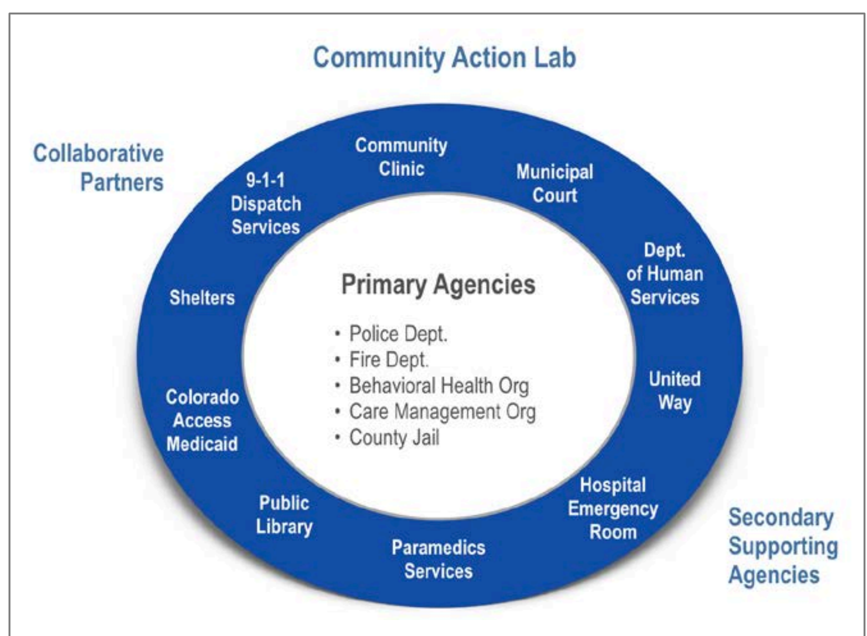
NHP partners have implemented a best practices model for collaboration and coordination that is the basis of Region 2's Health Neighborhood. We already perform these functions successfully throughout Region 2, and will enter into this contract with a smooth implementation. NHP's partners have developed multiple formal and informal approaches to engaging and collaborating with Health Neighborhood partners. Contracts and Memoranda of Understanding (MOUs) are in place with multiple organizations such as hospitals, schools, county health departments and police and sheriff departments. In addition, partners have executed Organized Health Care Arrangements (OHCA) with a variety of sister agencies (e.g., Department of Human Services) and other providers that serve the same Members throughout Region 2. An OHCA is an arrangement of covered providers that enables separate health entities to legally participate in joint activities to support the delivery and management of high quality, cost-effective care. These arrangements enable us to overcome traditional barriers and design and implement collaborative solutions such as:

- Implement a clinical decision support system for treatment purposes
- Support Population Health Management
- Provide a framework for coordination of referrals
- Conduct joint evaluation of operational and clinical activities for quality improvement initiatives
- Support Member navigation services including transitional care
- Jointly engage in utilization review of health care decisions
- Carry out national, state, and regional quality and health reporting
- Identify and coordinate appropriate care for those who utilize higher cost levels of care

These arrangements also allow NHP to conduct joint evaluation of operational and clinical activities for quality improvement activities and conduct financial analysis to determine the cost of care. In the future, as the RAE, we look forward to expanding our relationships and formal contracts both within Region 2 and with other RAEs and providers in other RAEs to further leverage the Health Neighborhood and Community to address Members' social and other health needs.

In late 2016, North Colorado Health Alliance (a consortium of agencies and providers which include Sunrise and North Range, among other community agencies) embarked on a ***community-based Action Lab*** *to create collaborative interventions to improve responses to*

non-emergent 911 calls that result in unnecessary Emergency Department (ED) visits or arrests. In the initial "100-day challenge," there were 45 successful interventions and routings to appropriate, less-costly levels of care. This collaboration is gaining financial support from grants and Greeley city government in order to sustain this impactful program.



North Colorado Health Alliance

Two of NHP's Partners are founding members of the North Colorado Health Alliance (The Alliance). While the alliance movement has grown in Colorado over the last few years, it began with the leadership demonstrated in Weld County 15 years ago. NHP partners continue to support The Alliance as it has expanded over the years. **This extraordinary collaboration between safety net providers, public health department, private hospitals, private providers, and social service agencies and organizations has enabled North Colorado to define and enhance the concept of a Health Neighborhood.** While we acknowledge that barriers still exist, we have worked tirelessly as a community through The Alliance to build the relationships, the technology, and the on-the-ground programs that address issues of access, cost, and quality for all residents of the community.

The Alliance now includes Banner Health, North Colorado Family Medicine, North Colorado Medical Center Foundation, North Range Behavioral Health Services (North Range), North Colorado Medical Center, Sunrise Community Health (Sunrise), Centennial Mental Health Center, Weld County Department of Public Health and Environment, Weld County Commissioners, Weld County Medical Society, United Way of Weld County, and the University of Northern Colorado.

Through The Alliance's extensive community partnerships, they identified that the Weld County area was home to a growing Burmese population having difficulty accessing appropriate health care services. The Alliance worked with the Realizing Our Community organization (ROC), the Burmese community, and Sunrise to facilitate the hiring of a native Burman who is now a full-time Sunrise employee providing interpretation, outreach and engagement services within the community.

Sunrise and Banner Health have contracted with The Alliance to provide specific components of our Care Coordination program. Under the current RCCO program, The Alliance provides delegated care coordination to a subset of Medicaid Members at a variety of provider's sites. We anticipate

continuing to strengthen this work with The Alliance as we build expanded responsibilities under the RAE.

SOCIAL SERVICE AGENCIES

Through our provider partners, NHP partners have strong relationships with all the health and social service agencies in the other primarily rural and frontier counties. The smaller more rural counties in Region 2 are characterized by strong community commitment and collaboration. Where resources are scarcer, these communities have developed a long history of collaboration. NHP, as an organization comprised of local partners who have been working in these communities for decades, commits to supporting local initiatives and collaborations that strengthen the social network. Our leadership has been engaged in community and statewide initiatives to explore solutions to transportation gaps, homelessness, the rural opioid epidemic and higher rates of suicide. We will continue engaging at the local level and use the strength of our organization to establish relationships and communication channels with community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region.

Some of the activities that we have been supporting at the local and state level include:

- Home Care Roundtable
- Assisted Living Roundtable
- Community Action Lab and Ongoing Community Hotspotter/Case Reviews
- Prenatal Outreach Community Meetings
- Weld Child Resource Council
- Regional Health Connector Program
- Community Action Collaborative (CAC)
- Nurse Family Partnership
- Healthy Communities

Use of Primary Care-Specialty Care Compact

The Primary Care-Specialty Care Compact, developed by the Systems of Care/Member-Centered Medical Home Initiative of the Colorado Medical Society, is a mechanism which seeks to improve systems of care by supporting physicians in becoming medical homes and working with specialists to uplink medical homes into integrated medical neighborhoods. The purpose of the Compact is to improve care and build and sustain trusted medical (Health) neighborhoods through a defined communication protocol. It specifies key areas of a mutual care management agreement such as transitions of care, access, collaborative care management and Member communication. As described above, because of our flexible technology infrastructure, NHP will develop solutions that work for the individual provider/PCMP. We commit to supporting the Department's efforts in expanding the use of the Primary Care-Specialty Care Compact. We will include support of the Compact in our primary care contracting and will train care coordinators on the importance of the Compact. In this way, they will encourage specialists to commit to the Compact.

NHP's sub-contractor (Beacon) provides advanced technology solutions that facilitate the type of communications that are addressed in the Primary Care-Specialty Care Compact: smoothing the

referral process, enabling timely communication on Member needs and care plans, and engaging Members in the care process. We will use technology through the Member portal and Member communications and engagement platform to send appointment reminders, check in with Members on upcoming appointments, and identify need for support, e.g., transportation. We believe that the combination of technology, interpersonal relationships and trust, and support of local care coordinators will resolve some of the barriers and result in more appropriate care for Medicaid Members.

Also conducive to appropriate referrals, is the use of the Department-adopted electronic consultation software, through which specialists consult with PCMPs via a telecommunication platform. We concur with the RFP's rationale that electronic consultations increase appropriate access to specialty care, improve both physician satisfaction and Member experience, and improve overall quality of care. To this end, NHP will develop an electronic consultation training program with support materials to educate providers during new provider orientation training, during face-to-face visits with NHP Provider Relations Department staff, in the Provider Newsletter and on the Provider Portal. Training materials will promote the use of electronic consultations and educate providers in the Health Neighborhoods on how this is a method to mitigate incomplete work-ups, reduce inappropriate or unnecessary specialty care visits, and improve timeliness of communication.

In addition to multiple endeavors to improve access in our predominantly rural and urban counties, NHP will continue to use the OHCA and will implement the Primary Care-Specialty Care Compact to strengthen Region 2's Health Neighborhood response to identified needs and meet the requirements of the following Key Performance Indicators (KPIs):

- Improving transitions of care
- Increase the number of specialists
- Track use of electronic consultation

Leveraging the SIM Model to Address Health Neighborhood

NHP is committed to addressing the full needs of every Member throughout their lifecycle and is committed to the Colorado State Innovation Model (SIM) goals of:

1. Providing access to integrated primary care and behavioral health services in coordinated community systems
2. Applying value-based payment structures
3. Expanding information technology efforts, including telehealth
4. Finalizing a statewide plan to improve population health, better care, and improved population health

As an organization, we are committed to an integrated care model that closely partners with the Health Neighborhood in a model that supports population health. Currently, Salud is actively involved as a provider and a leader in the SIM effort in Colorado.

A key piece to the SIM Framework is moving toward an integrated system of care. This movement is well underway throughout Region 2. NHP's goal is to ensure that 80 percent of Members have access to integrated behavioral health providers within the next five (5) years. Currently, in Region 2, there are at least 10 integrated care sites—six in Greeley, one in Fort Lupton, one in Frederick, one in Fort Morgan, and one in Limon. Other providers are developing or planning for implementing integrated care programs.

Region 2 has three basic models for integrated or co-located BH/PH services:

- PCMPs may work with the Community Mental Health Centers (CMHCs) to obtain professional resources for a practice, with the CMHCs each having a turnkey operation and requiring only space within the practice. Examples included BH providers from North Range Behavioral Health Center (North Range) and SummitStone Health Partners (SummitStone) having been integrated into Sunrise Community Health (Sunrise) FQHC clinics and, conversely, Sunrise having placed primary care practitioners in North Range and SummitStone.
- PCMPs may bring private BH resources into the practice, with behavioral health practitioners contracted and reimbursed through the BHO. Examples included Banner Health having contracted with the BHO for behavioral health practitioners located in Banner Health's primary care clinic locations and Salud including resident psychologist and additional behavioral health practitioners from the mental health centers for each of its six clinics in the region.
- Tele-behavioral health is offered to PCMPs to integrate behavioral health consultative services into primary care sites.

NHP partners and the other members of Region 2 Health Neighborhood have excellent working relationships and as the RAE we are committed to expanding diversity of services to the degree possible given the nature of our communities.

Expanding the Health Neighborhood

NHP and its partner organizations participate in numerous community coalitions and learning collaboratives that support local 'neighbors' in identifying and sharing resources, networking, identifying gaps and developing a response for those gaps in service. Further, NHPs care coordination strategy includes all participants in the Health Neighborhood and integrates with our Population Health Management Plan. As integral members of the Region 2 community, we have deep understanding of the social determinants of health affecting our Region and participate actively at the state, regional, and local level in programs and initiatives to support Health Neighborhoods.

The following is a brief highlight of some of the many activities and relationships in which NHP partners engage. Additional examples are provided throughout this response.

Community Coalition or Collaborative	Goals/Activities	Other Participating Community Providers
Pediatric Practice Learning Collaborative	To advance integrated care in pediatric practices. Examined workforce and professional capacity issues as well as billing and coding issues related to behavioral health in primary care practices.	A workgroup of 13 practices, agencies, and practice transformation organizations.
Adult Resource Council	Coordinate and collaborate resources and programs for older adults. One collaborative program developed through this collaboration is the placement of an assistive technology room in the Salud Fort Morgan clinic. Community members with disabilities who rely on assistive technology can receive education and training from volunteers. In addition to adult resources, the council has connected Salud with local school districts to involve Salud Behavioral Health providers and Care Managers in Individualized Education Plans (IEP) in an effort to address social	Area Agency on Aging: Director of SEP, SHARE (Domestic Violence Advocates), Human Services Department (Adult Protective Services), Human Services (Eligibility Technicians), Valley View Villa (Nursing Home): Director of Valley View, Eben Ezer Assisted Living: Social Worker East Morgan Hospital: RN Care Coordinator Fort Morgan Hospital: Hospital Staff

Community Coalition or Collaborative	Goals/Activities	Other Participating Community Providers
	and behavioral concerns that may impact the IEP.	
Carbon Valley Network	Share information and enhances collaboration and coordination between human services groups, faith-based organizations, the school district, municipalities, and nonprofits serving the Carbon Valley. Our vision is to create a comprehensive and coordinated system of care for the residents of the Carbon Valley. These meetings provide presentations about the services that agencies within their services area provide and communicate across a wide variety of agencies. We also maintain ongoing electronic communication across organizations with updates on program/resources.	School districts, Libraries, Human Services Agencies, Probation, Area Agency on Aging, SafeCare North Range Connections for Independent Living, Housing Authority, Hospice, Police Department Child Protection Services, Home Care agencies, Almost Home, Life Choices, Disaster Preparedness, Senior Agencies
MakeTODAYCount! Campaign	Make TODAY Count! is a community health campaign to build a stronger and healthier community. The campaign involves all of Weld County—individuals and families, schools and churches, organizations and businesses. Our goal is to engage people in making simple choices every day that together will make Weld County thrive.	More than 70 agencies including representation from facilities serving child, youth, adults and older adults, disabled, medical care, social supports, faith-based, elementary - college, law enforcement, city agencies, profit and non-profit, health plans, and county agencies.
Thriving Weld - Community Data Dashboard	Thriving Weld partners are building a healthier, better educated, more prosperous community by setting goals and continuously tracking progress.	North Colorado Health Alliance, Weld County Government, Weld County Department of Public Health and Environment, North Range Behavioral Health and United Way of Weld County
Northeast Region HCPF Collaborative	Purpose: To collaborate with health care entities in order to improve the overall health of individuals. Goal: Regional goals are to create and conduct the following—needs assessment; referral roadmap, 211 and pocket resource directory	Lead by a Director from one of the ten county Departments of Human Services. Other participants: Centennial Mental Health Center, Colorado Access, Northeast Colorado Health Department, Northeast Colorado Workforce Centers, Rural Communities Resource Center, Baby Bear Hugs, NECALG – Area Agency on Aging (Northeast Colorado Association of Local Governments

NHP Health Neighborhood Partners

Specialists

As described above, NHP has a well-established network of providers that are the foundation of Region 2's health neighborhood. However, Colorado experiences a general shortage of specialists

for the entire population, and access to specialty providers is a common concern of all payers especially for rural and frontier communities. Counties with small populations spread out over a large area present significant barriers to access. Due to the vast geographic distances in the rural areas of the region, the greatest barrier to accessing specialist care is transportation.

Current gaps in specialty care include: all medical specialties, substance use disorder services, psychiatry, and oral health.

Within Region 2, UCHealth and Children's Hospital Colorado (Children's) specialists are the primary source of "super sub-specialties." The majority of Members in Region 2 access diverse specialists associated with Banner Health in Weld County, Platte Valley Medical Center in Brighton, and UCHealth in Greeley and Fort Collins. Children's is most frequently accessed for pediatric specialty care. While specialist practices are either owned by or closely affiliated with these hospitals, most specialists retain significant autonomy in determining acceptance of referrals. Within Region 2, both Banner Health and UCHealth have extended specialist care to the rural areas by transporting rotating specialists to various communities within the region. North Range and Centennial provide access to behavioral health services across the region and utilize multiple approaches to improve access including tele-psychiatry, tele-therapy, and mobile crisis units (as part of Colorado Crisis Services) that can transport among facilities.

Improving Access to Specialists: NHP has found that existing personal and professional relationships among providers are the primary drivers of access to specialist care. To expand access to specialists in Region 2, NHP will support a variety of approaches including utilizing care coordinators to support Members access transportation services, collaborating with specialists and hospitals serving our region to identify gaps in service and potentially add specialist clinics in underserved areas, and using telehealth to expand access.

Leverage telehealth: Telehealth is an important strategy to increase access to care in rural and frontier areas. We have telehealth programs in place in Region 2 to support tele-psychiatry and tele-therapy. For example, Centennial has been actively using telehealth delivery of psychiatry services since 2009 typically serving approximately 60 percent of psychiatry sessions via interactive videoconferencing to 2000 clients per year. It has proven to be an effective mode of delivery from a Member experience standpoint, and is helping to meet increasing demands for psychiatric sessions in our frontier areas. NHP will promote the use of telehealth to our partners and providers. We will also provide support to providers who contract with us to expand telehealth services in Region 2 areas with little or no specialty care available.

Care Coordination links Members with Specialists

A 57-year-old Medicaid Member had a seizure, fell and hit her head and went to the ED. She was contacted by the Transitions Care Manager based on a CORHIO alert. She does not have transportation and stated she is "always asking family or friends for a ride." The Care Manager resolved a significant barrier by arranging NEMT for her so that she can receive regular care from her neurologist.

The impact to the community is evidenced in the responses clients gave in the Telehealth Client Satisfaction Survey. Responses from clients across the region were positive. Clients from Elizabeth, Holyoke and Julesburg, CO respectively shared:

> *"I am very grateful for the help I am receiving."*
> *"I am thankful to have this service. It gives patients more options for doctors."*

"Much more convenient than driving the 2 hours round trip it would take for me to drive to Sterling."

We will continue to explore ways in which technology can be used to support communication, engage providers, reach our rural and frontier Members, and further the goals of the Health Neighborhood, including:

- Considering tele-psychiatry support for Emergency Departments in the Region
- Adding other evidence based tele-therapy options as appropriate such as CBT for Depression
- Supporting FQHCs and PCMPs to expand their access to telehealth through evidence based programs
- Supporting providers through coordinating technology solutions with other state and federal requirements – in the short run, that includes addressing MACRA requirements in our technology solutions
- Avoiding duplication wherever possible—in reporting, technology requirements, etc.

Tele-behavioral health/tele-psychiatry services have been developed and implemented by NHP in a number of practices throughout the regions. Tele-behavioral health provides behavioral health services, including substance use disorder treatment, consultation and education to PCMPs through contracted behavioral health providers. Tele-behavioral health services are provided through scheduled consults with PCPs or co-located behavioral health practitioners, as well as psychiatric consults directly with Members.

Tele-behavioral health enables PCMPs to manage Members' behavioral health needs within the practice, improves the PCP's efficiency for attending to other Members, improves provider satisfaction with the practice environment, and requires no on-site IT staff expertise for implementation.

To support all PCMPs and especially those in rural and frontier areas, NHP will expand its use of innovative and effective tools that ensure Members have access to care in a timely manner. We will address social barriers and use of translation services, as needed, for Members to ensure they received the treatment they need. Recent innovations in translation services, such as that offered by InDemand Interpreting, the current vendor for several of our partners, has transformed medical interpreting for Deaf and hard-of-hearing Members, those with limited English proficiency. NHP is committed to providing accessible services that engage Members in their care. Through Video Remote Interpreting (VRI), Members are now able to more actively participate with the medical interpreter and providers and engage in a full conversation about their health needs and preferences. InDemand currently offers 25 VRI languages including Spanish and over 200 Voice languages.

Additional telemedicine programs include Ieso Digital Health and Project ECHO. Beacon partners with Ieso Digital Health to outreach Medicaid Members to provide online cognitive behavioral therapy (CBT) for Members with common depressive and anxiety disorders. Ieso uses a secure and HIPAA compliant, web-based platform to deliver real-time typed conversation with licensed and credentialed therapists. The use of written conversation disinhibits Members, making them more likely to disclose thoughts and feelings openly and candidly. Typing also provides an opportunity for more embedded learning than face-to-face CBT due to the method of learning by reading and writing, rather than speaking and listening. Members can read through the transcripts after their sessions, to reinforce their learning. As the session cannot be overheard, therapy is entirely private, unlike video or telephone communications.

Another telemedicine option, Project ECHO® (Extension for Community Healthcare Outcomes), is a movement to de-monopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world. The ECHO model links expert specialist teams at an academic 'hub' with primary care clinicians in local communities—the 'spokes' of the model. Together, they participate in weekly teleECHO™ clinics, which are like virtual grand rounds, combined with mentoring and case presentations. The clinics are supported by basic, widely available teleconferencing technology. Using teleECHO™ clinics, primary care clinicians from multiple sites present cases to the specialist teams and to each other, discuss new developments relating to their Member, and determine treatment. Specialists serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians. Essentially, ECHO creates ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat a particular condition, such as hepatitis C or chronic pain. As a result, they can provide comprehensive, best practice care to Member with complex health conditions, right where they live. ECHO is an evolving model that will continue to grow and expand resources for primary care providers focusing on multiple topics and linking them to specialists or state of the art medicine learning communities.

Hospitals and Admission, Discharge, Transfer Data

NHP acknowledges that hospitals are an essential part of the health care delivery system and Health Neighborhoods, and through our partners has established excellent relationships with hospitals in our region and other hospitals in Colorado that serve Region 2 Members. We will continue to collaborate with hospitals to improve care transitions, implement person-centered planning at hospital discharge, and address complex Member needs. NHP's Data Analytics Department will use and disseminate to appropriate Network Providers admit/discharge/transfer data to track emergency room utilization and improve quality of care transitions in and out of hospitals. These data will be available electronically through a Health Information Exchange for providers and to NHP Care Coordinators who will assess each case and determine the need for further action. Care Coordinators who are co-located in the hospitals will have this information available through real-time access to hospital admission and discharge data. They will assess all cases that are at highest risk or have need for community supports and will follow up as appropriate with hospital discharge staff.

Our Care Managers and Care Coordinators are already engaged with the discharge planning teams at every hospital in the region and have the relationships in place to support Members. They will incorporate new criteria under the RAE and expand their roles with hospitals and discharge planners and focus training especially on supporting LTSS Members and non-institutional discharge options.

For individuals struggling with LTSS decisions at discharge from a hospital, NHP will provide Person-Centered Counseling to guide individuals through a support decision-making process to help them identify personal goals and how services may be delivered. We provide transition support services to help avoid unnecessary placement in nursing homes and other institutional settings. Additionally, NHP aims to support formal partnerships between LTSS providers and acute care entities in order to serve as a bridge for the health system to the community and support the transition of individuals with LTSS needs who are being discharged. During this process, we will also make opportunities to educate hospital discharge planning staff on processes that support LTSS Members and non-institutional discharge options.

NHP fully recognizes hospitals as a critical component to our health neighborhood system, and we work closely with them on an on-going basis. Based on our current relationships with providers in the broader region and our partner contracts with Banner, UCHealth, Medical Center of the Rockies and Platte Valley Medical Center, NHP will execute formal arrangements with hospitals to support Care Coordination, Care Management, and Member access. Our Care Coordination strategy includes all

participants in the Health Neighborhood and integrates with our Population Health Management Plan. We will integrate Care Coordination into our solutions with our providers in the Health Neighborhood.

Sunrise works closely with the three hospitals in their service area providing inpatient care and supporting Care Coordination. During discharge planning, hospital staff directly contact Sunrise clinics to schedule a follow-up appointment for the Member or to request that Sunrise call the Member for follow-up care. Sunrise staff and hospital staff meet on a regular basis to address any administrative or clinical issues. Sunrise, Banner, and NCFM (a Banner Family Medicine residency program) work together to train family medicine physicians (Sunrise has 6 residents for their full three years' outpatient training at all times).

North Range has a close working relationship with the hospitals in Regions 2, and has established an MOU with UCHealth, Medical Center of the Rockies and the West Greeley Emergency Department (WGED). WGED provides medical clearance for Members with an inpatient disposition plan or Acute Treatment Unit (ATU) disposition plan. If placement of the Member is not feasible, the parties work together to evaluate options and identify acceptable placement for the Member. Additionally, North Range has a strong relationship with Banner to provide seamless care to Members with psychiatric health issues. Banner also provides medical consultation and a psychiatric assessment to residents of North Range's Acute Treatment Unit (ATU), and the hospital and ATU provide clinical warm handoffs and clear ED discharge instructions for continued Member care. Banner and North Range also work together on the Crisis Response Team, to provide mobile crisis intervention with Care Coordination outlined by a set of measurable goals that ensure all information shared is complete and accurate; transportation and services are timely; the Member was treated with respect; and that clinicians/hospital staff conduct themselves in a professional manner.

Salud contracts with the Colorado Plains Medical Center in Fort Morgan to provide on-call obstetric services perform deliveries/C-sections for Members and works with Sterling Regional Medical Center to provide obstetric care to Salud Members.

Centennial works closely with all hospitals in the nine rural/frontier counties of Region 2, particularly around Crisis Response, providing assessment and triage during behavioral health crises at Sterling Regional Medical Center, East Morgan Community Hospital (Brush), Colorado Plains Medical Center, Melissa Memorial Hospital (Holyoke), Haxtun District Hospital, Sedgwick County Hospital (Julesburg), Yuma District Hospital, Wray Community District Hospital, Kit Carson County Memorial Hospital (Burlington), and Lincoln Community Hospital (Hugo).

A sample of the many community collaborations that are in place includes:

1. Sunrise co-located PCPs at North Range and therapists from North Range were co-located in the Weld and Larimer County Sunrise locations.
2. Salud implemented a program that provided telehealth services and navigators to coordinate care for foster children and families.
3. Salud implemented an integrated clinical pharmacy program using clinical pharmacists and residency students from UCHealth School of Pharmacy to improve quality related to chronic disease management, enhance management of certain behavioral health conditions that require medications, improve Member/provider education and identify potential drug contraindications.

Hospital Transformation Program

The Hospital Transformation Program connects hospitals to Health Neighborhoods and aligns hospital incentives with the goals of the Accountable Care Collaborative Program. Through the establishment of a delivery system reform incentive payment (DSRIP) program, Medicaid is building

a system in which payment for providers across the continuum are aligned. As this program is being implemented, NHP commits to working with hospitals in our region to determine programs or processes that can be established to support our mutual goals. We will leverage existing relationships and collaborations to work with local hospitals and the Department to help hospitals determine priorities and select projects, interventions, and performance goals for the Hospital Transformation Project. This could include expanded roles for care coordination/care management, new methods of communication, and improved access to specialty services. NHP will incorporate Population Health Management Plan initiatives into our solutions.

NHP is committed to engaging providers in the use of the Colorado Medical Society's Primary Care Specialty Care Compact (Compact) and promoting the use of the department's electronic consultation software.

Develop Holistic Approaches to Assisting LTSS Members
NHP has systems in place through our administrative partner, Beacon, and will provide information and referral services, promotes awareness of services, and maintains timely information about available LTSS regionally. Our work in this area seeks to minimize the otherwise daunting information-gathering task for individuals and families seeking information and counsel, and to provide education and resources to providers, discharge planners, and social services agencies in the Health Neighborhood.

Our staff are trained and successfully:

- Facilitate hospital-to-home, and nursing or rehabilitation facility-to-home transitions
- Transition individuals from nursing facilities back to the community
- Help youth with disabilities to transition from secondary education to postsecondary life that involves options that can keep them integrated in the community
- Facilitate the use of self-directed models

NHP will work collaboratively with local/regional LTSS providers and agencies to effectively reach and serve a broad range of population groups including: older adults, individuals with physical disabilities of all ages, individuals with intellectual and developmental disabilities, and individuals interested in planning for their LTSS needs. Using a Person-Centered approach that respects and responds to individual needs, goals, and values, individuals and providers work in full partnership to guarantee that each individual's values, experiences, and knowledge drive the creation of an individualized plan and delivery of services.

NHP will take a lead role:

- Serving as a highly visible and trusted place for individuals of all ages to turn to for objective and unbiased information and referrals on the full range of long term-care supports and services
- Promoting awareness of the various options available to individuals in their community
- Facilitating access to services and supports, and public programs
- Providing person-centered, culturally and linguistically competent, one-on-one assistance and decision support to individuals
- Partnering with the local No Wrong Door System of Access for all LTSS
- Creating formal relationships between and among the major pathways individuals travel while transitioning from one setting of care to another

The "No Wrong Door" approach is the formal "point of entry" into the State's LTSS system and is used to fundamentally change the experience of consumers who encounter the LTSS system so it becomes more responsive to the preferences and personal goals of its citizens who need, or may at some point need, LTSS.

- Serving all populations, including those under age 60, adults with physical, intellectual, development disability, or mental illness
- Ensuring services adhere to the highest standards and produce measureable outcomes

> *The "No Wrong Door" approach is the formal "point of entry" into the State's LTSS system and is used to fundamentally change the experience of consumers who encounter the LTSS system so it becomes more responsive to the preferences and personal goals of its citizens who need, or may at some point need, LTSS.*

Oral Health
The FQHC members of NHP are the primary oral health providers within Region 2. They are all committed to expanding access to oral health services and support efforts in the Population Health Management Plan to include oral health in the wellness and prevention initiatives.

Sunrise has three dental clinics and directly provides comprehensive primary oral health services to all ages in Larimer and Weld clinics. Offering a comprehensive program, dental Members average 3.4 visits/year. In 2016, Sunrise served nearly 10,000 dental Members.

Salud provides comprehensive dental care to Members of all ages in 4 dental clinics in 3 Region 2 counties. In addition, Salud provides additional services to expand access to oral health:

- Dental screenings in multiple counties
- Dental hygienists visit local schools for medical dental integration (MDI) visits
- Special summer programs in school districts that offer free lunch programs and offer MDI visits
- Participates in the Spanning Miles in Linking Everyone to Services (SMILES) dental home project
- Partners with the public health department and schools in Morgan County to deliver dental services to elementary school children in Ft. Morgan. The program hopes to expand into the six county region of northeast Colorado over time. Dental teams preform services and initiate follow-up for treatment in the local Salud clinic or other dental facilities as necessary.

We will identify all practices currently serving Medicaid populations and, through care coordination, work with them to address any issues or barriers they have in serving Medicaid populations. In addition, we will leverage our existing relationships in the Region to identify new practices and encourage them, with our support, to accept Medicaid Members.

Crisis Services
Centennial and North Range, the two behavioral health partners in NHP, are two of the three providers of the Northeast Region of Colorado Crisis Support Services. As such, they are integral to the implementation of Crisis Services in the Region. NHP will coordinate efforts with Northeast Behavioral Health Crisis System and support efforts to assure access to crisis services. We will educate Providers and Members on the availability of Crisis Services to ensure that Members receive timely access to behavioral health interventions during a crisis.

Managed Service Organizations
North Range is a 1/6 owner of Signal Behavioral Health Network. North Range and Centennial are the two largest providers in the region and are the primary Signal contracted providers. Management Services Organization resources will be very involved when higher level of care needs are identified and are outside the scope of covered services under the RAE. North Range offers both the Withdrawal Management (Detox) and the Residential services for the region.

State & Local Health Departments

All NHP partners have strong working relationships with health departments and will continue to work to strengthen those relationships throughout Region 2. Sunrise works very closely with local health departments and in Weld County has embedded a prenatal clinic within the health department. Additionally, the Weld Health Department and Sunrise have shared an electronic health record since 2004.

Salud works closely with Northeast Colorado Health Department in Sterling and Fort Morgan in the TB program. Salud also works closely with the Weld County Department of Public Health and Environment in multiple programs including SMILES to improve oral health access and also in providing an exam room for no cost birth control and education for students.

Centennial works closely with the Northeast Colorado Health Department's efforts on suicide prevention through the State Innovation Model (SIM) project. Centennial also delivers mental health awareness and suicide prevention gatekeeper trainings and refers individuals as needed to the department. Centennial also works closely with Lincoln and Cheyenne County Public Health Departments providing Mental Health First Aid trainings and referring individuals as needed.

Sunrise manages the WIC contract for Weld County, embedding WIC services at Sunrise's largest family medicine and pediatric clinics in Weld County as well as embedding services at the Health Department. Sunrise works closely with Weld School District 6; our school based health center is permanently located on site at one of the highest need elementary schools in the district. Salud also has WIC services embedded in the Fort Lupton clinic, and WIC staff refer Members to Salud if they are in need of medical or dental services.

Sunrise collaborates with the Board of Cooperative Educational Services, Migrant Head Start to provide medical and dental services to Migrant Head Start children. Sunrise has extensive experience serving migrant and immigrant populations and, for many years, has been the health care home for migrants and immigrants from Central and South America. More recently, they have become the health care home for many of the area's newest refugees from east Africa and Southeast Asia. Effective October 1, 2014, Sunrise began providing Refugee Medical Screening (RMS) Services for the State in northeastern Colorado. We hired a registered nurse to coordinate our RMS services. Sunrise also collaborates with homeless shelters to regularly provide care via our mobile health van.

Role of Pharmacists in Health Neighborhood

Clinical pharmacists provide critical health information and wellness practices to serve the needs of Members, especially those with chronic disease and who fall into the highest BIDM stratification levels. We will engage pharmacists as members of the medical team to support Care Coordination and support the team:

- Review current drug usage
- Assess the Member's understanding of the medication plan and address adherence issues with the team
- Educate the Member about medication issues and provide information about the medication plan

Providers and care coordinators across the region meet regularly with pharmacists either at in-houses pharmacies or through working relationships with local community pharmacies who are serving our Members with complex issues. In addition, we will engage pharmacists and local pharmacists in community efforts to support the population health management plan including immunizations, flu shots, smoking cessation, and other initiatives.

Sunrise directly provides pharmaceutical services in Larimer and Weld clinics. In addition to our sliding fee scale, Sunrise connects Members as appropriate to the pharmaceutical assistance programs. In 2014, this program provided over $2.5 million in low-cost medications to Sunrise Members.

Salud has 340B agreements with a number of Walgreens that allow Members to access low-cost medications. Salud partnered with UCHealth's School of Pharmacy to implement a program whereby clinical pharmacists and pharmacy students assist physicians with medication therapy, Member education, shared medical appointments, and hospital transitions for Members with chronic conditions. Our expectation is that this model can be expanded moving forward.

North Range partners with QOL/Genoa to manage a pharmacy in the North Range central facility. Centennial will also have pharmacy services from QOL/Genoa starting in 2018.

Other Partners

NHP also collaborates with a wide range of community organizations throughout Region 2 in support of the health neighborhood. These partnerships provide a variety of activities, and offer opportunities for dialogue and community-based solutions to local challenges. Some of these relationships include:

Organization	Activity/Purpose
University of Colorado Family Medicine Residency University of Colorado Residency Program (Morgan County Rural Training Program)	Salud is a host site for the Morgan County Rural Training program where Family Medicine residents have the opportunity to work in our clinic and gain valuable rural health experience. Additionally, this provides a valuable added resource to our medical team in Fort Morgan.
Northeastern Colorado Area Agency on Aging	Salud has an MOU in place with the Northeastern Colorado Area Agency on Aging (Fort Morgan) that utilizes space in the clinic and collaborate with Salud on general partnering, etc.
Baby Bear Hugs	Promotes positive parenting, enhances family strengths, and prevent abuse and neglect to infants and children. Baby Bear Hugs leases space in the Fort Morgan Salud clinic; this agreement leads to collaboration and bidirectional referrals.
Office of Emergency Management	Emergency management planning and partnering.
Area Agency on Aging	Care Managers collaborate with agency Case Managers to set up housing in the Guadalupe Apartments in Greeley.
OUR Center	Care Managers interact directly with OUR Center Case Managers and complete bi-directional communication and referrals. For example, they help with medical portion of application for assistance with United Power, or assist Members who are applying for disability.
Community Management Partnerships in Kit Carson, Logan, Morgan, Elbert, Cheyenne, Lincoln Counties	This collaboration promotes coordination and assistance in the planning of service delivery activities including, but not limited to, program collaboration and integration, cross systems training, grant writing support, fund development assistance and identification of community need.
Early Childhood Councils	Early childhood specialists collaborate on resource and referral initiatives surrounding infants and toddlers. Centennial delivers behavioral health treatment.
CO Division of Vocational Rehabilitation	Cross resource and referrals

Organization	Activity/Purpose
Drug Court: Morgan and Logan Counties	A public health approach that uses a special model to help addicted offenders into long-term recovery. Also cross resource and referrals.
Logan County Sheriff's Office	Collaboration: Jail Based Behavioral Health Services, Gun Shop Project Advocate, Crisis Respite and Intervention
County and Prairie Express	Referrals for transportation and purchase of transportation services
Gun Shop Project	Provide education and awareness of suicide prevention to a fire arm retailer, gun range and firearm safety instructors in Logan, Morgan, Phillips, Weld, and Washington Counties

OFFEROR'S RESPONSE 14

Describe the Offeror's plan to support and build Communities in the region to address social determinants of health, including how the Offeror will define Community and address requirements in Sections 5.8.3 and 5.8.4.

BACKGROUND

Northeast Health Partners, LLC (NHP) is a partnership between four deeply embedded Colorado health care organizations: Salud, North Range, Centennial, and Sunrise, with extensive experience delivering physical and behavioral health care services in Regional Accountable Entity (RAE) Region 2. This partnership leverages the complementary experience and expertise of these organizations and blends the best attributes of these local organizations and their many regional colleagues to better serve Colorado's Health First Members.

Through our own experiences and multiple collaborations, we have built an in-depth understanding of the health disparities and inequities in our region. Although we are organized as a new corporation, we have already demonstrated our ability to develop plans and execute them to optimize the physical and behavioral health of Members through our roles as delegated Regional Care Collaborative Organization (RCCO) providers, providers within the Behavioral Health Organization (BHO), and multiple initiatives with regional providers, Members, and community stakeholders.

Recognizing that the conditions in which Members live also impact their health and well-being, each organization has established relationships, independently and collaboratively, with economic, social, educational, justice, vocational, recreational, and other relevant organizations to promote the health of local communities and populations.

Social Determinants of Health

Social determinants of health are not static and intersect on a multitude of fronts. Addressing Members' social needs is critical to improving their health outcomes. However, even when we understand the social issues, we do not always have a clear path to improving those conditions.

> "We intervene often at the individual level in clinics and in the health care system — [but] the social determinants of health are social. The interventions are often collective."[1]

An understanding of the underlying social determinants of health enables us to further engage with the community and leverage combined knowledge and resources across multiple sectors to improve health and well-being of residents. The shared objective of addressing social determinants is to create a more holistic approach that addresses underlying root causes and intervenes earlier, reducing more protracted social and health issues.

Factors such as socioeconomic status, access to transportation, race, education, and class interact with individual habits such as smoking, physical activity, social isolation and alcohol resulting in correlative or connective impacts on overall health (Figure 1). [2]

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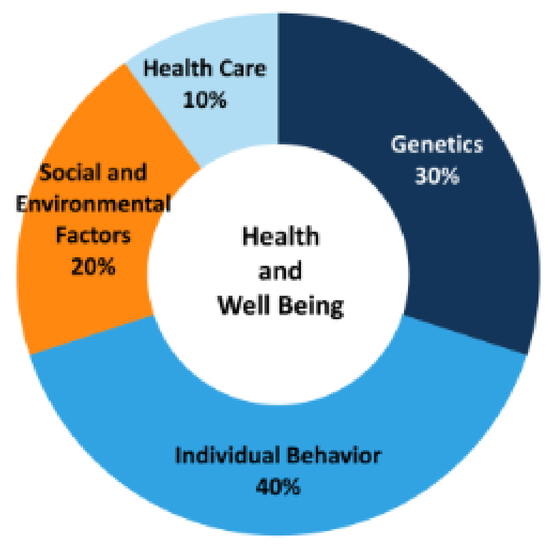
[1] Damon Francis, MD and Namita S. Mohar. MEJM Catalyst, September 27, 2016. Accessed at http://catalyst.nejm.org/interviews/

[2] Giuse, Koonce, Kusnoor, et al. (2017). Institute of Medicine Measures of Social and Behavioral Determinants of Health: A Feasibility Study. *American Journal of Preventive Medicine, 52*(2), 199-206.

Figure 1

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

As local providers we have been involved in this work for decades and we understand the role of social determinants of health and what it takes to build community. We recognize that health equity can become realized when communities address social and environmental determinants through population-based approaches and targeted approaches focused on communities experiencing the greatest disparities.[3] Building on a definition that was developed in a multi-city study to examine community in the context of vaccine prevention activities, NHP will use the following **definition of community**:

> **A *group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.*** [4]

As noted in Healthy People 2020, resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.[5]

[3] Dr. Harry J. Heiman and Dr. Samantha Artiga. Issue Brief. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity (2015)*

[4] What Is Community? An Evidence-Based Definition for Participatory Public Health. Kathleen M. MacQueen, PhD, MPH, et al. Am J Public Health. 2001 Dec;91(12):1929-38.

[5] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care have a significant impact on health outcomes as illustrated below: (Figure 2).[6]

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

As the RAE, we cannot single-handedly impact the social and environmental conditions that impact our Members and their families. As an organization of safety net providers deeply embedded in the region, we understand and have responded to the diverse needs of Region 2, with highly disparate conditions from the urban setting of Greeley, to the rural and frontier counties in the rest of the region.

[6] Dr. Harry J. Heiman and Dr. Samantha Artiga. Issue Brief. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity (2015)*

As the RAE, we strive to engage Members, families, and their communities in a continuing dialogue within and across various environments to support sustainable, actionable solutions that address inequities in social determinants of health in local settings.

First and foremost, community is not a place, a building, or an organization, nor is it an exchange of information over the Internet. Community is both a feeling and a set of relationships among people. People form and maintain communities to meet common needs.

Members of a community have a sense of trust, belonging, safety, and caring for each other. They have an individual and collective sense that they can, as part of their community, influence their environments and each other.

That treasured feeling of community comes from shared experiences and a sense of—not necessarily the actual experience of—shared history. As a result, people know who is and isn't part of their community. This feeling is fundamental to human existence.

Neighborhoods, companies, schools, and places of faith are context and environments for these communities, but they are not communities themselves.[7]

To support and build communities aimed at closing the gap between health disparities and inequities, we must have the trust of the Members we serve, as well as the myriad community organizations that serve them in other aspects of their lives. By delivering on our promises, continuing to support the Health Neighborhood and actively engaging with the broader community—we will return exponential gains in health outcomes and cost savings to our State.

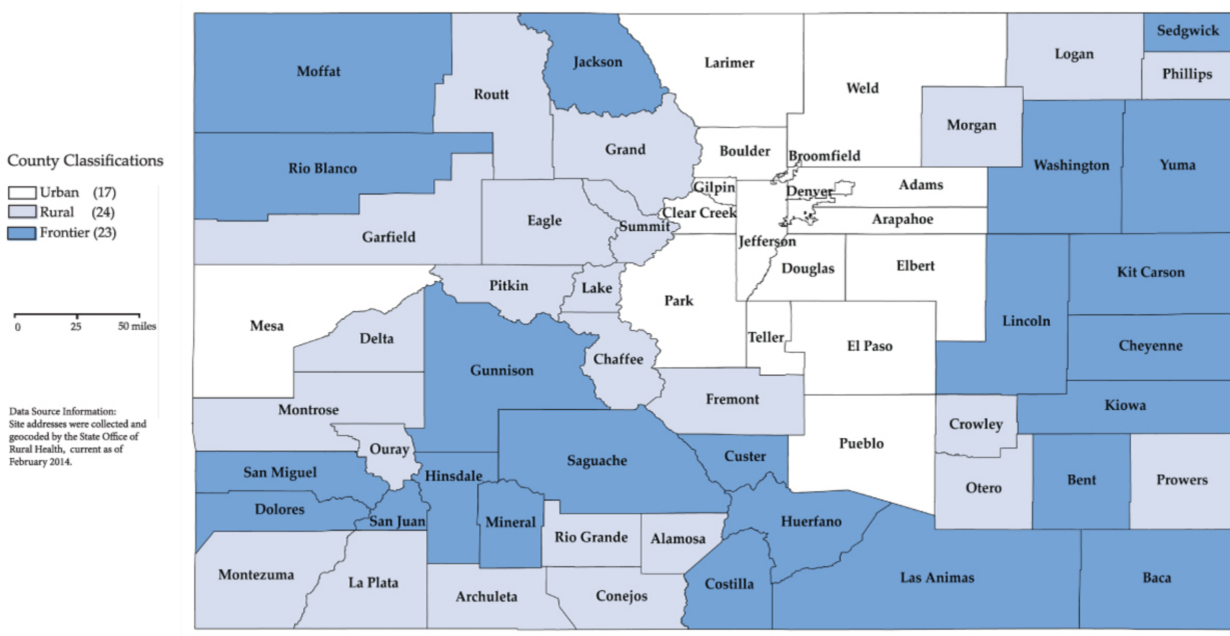
Understanding Our Communities - Social Determinants of Health and Challenges in Region 2

The Northeast Region 2 of Colorado sits close to Nebraska, Kansas, and Wyoming borders. The Region consists of 10 counties: Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma. The total population of region is approximately 372,000. Of that, Weld County has a population of 285,000, representing 75 percent of the population for the Region. Under the RAE program, 24 percent of the Region's population is estimated to be enrolled in Medicaid.

The region is mostly rural, with the exception of Weld County, and has limited access points, with two main highways that provide routes to major metropolitan areas. Within Region 2, most of the counties (Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma Counties) are considered frontier counties with a population density of six or fewer residents per square mile. Three of the counties (Logan, Morgan, and Phillips) are designated as rural. The exception is urban Weld County that was listed as the fourth fastest-growing metropolitan statistical area in the United States, gaining 3.5 percent between July 1, 2015, to July 1, 2016.[8]

[7] Chavis, David and Lee, Kien, "What is Community Anyway?," Stanford Social Innovation Review, https://ssir.org/articles/entry/what_is_community_anyway, May 12, 2015.
[8] http://www.denverpost.com/2017/03/23/greeley-population-oil-and-gas-slump/

Colorado County Calssifications



Most of the Region is characterized by the Health Services Resources Administration of the federal government (HRSA) as Medically Underserved Areas (MUAs)—geographic areas with a lack of access to primary care services. In Region 2, Logan, Sedgwick, Phillips, Yuma, Lincoln, Cheyenne, and most of Weld counties are designated as MUAs for primary care. All of the rural/frontier counties are MUA for mental health.

The disparity between Weld County and other counties in Region 2 is apparent in several health and social indicators. Weld County has the highest median household income at $58,400 annually and the youngest median age at 34 years. At the other end of the continuum is Sedgwick County with a median household income of $39, 980. Fourteen percent of the children in Weld County are reported as living in poverty while 25 percent are living in poverty in Lincoln County and 24 percent in Sedgwick County.

Health and Social Indicators in Region 2

County	Median Household Income	Median Age	% Uninsured	% Some College
Colorado	$58,942	36.5	12%	71%
Weld	$58,404	34	12%	61.9%
Other Counties in Region 2*	$45,487	40	15% (Average across counties)	55.08% (Average across counties)

*Counties in Region 2 include Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma, and Weld.

Indicators of Well-Being in Region 2[9]

Nearly 50% of school age children are enrolled in the Free and Reduced School Lunch program. Morgan County reports the highest rate at 63% and Phillips County reports the lowest at 39%.

Depending on the county, a range of **between 14% and 25% of children in a county are living in poverty.**

Between 2002-2014, **rural Colorado saw a 140% increase in opioid overdose deaths**, compared to a 96% increase in urban areas during the same time frame. Washington County saw the biggest increase in the state, with a 400% increase in opioid overdose deaths between '02-14.

Three counties in Region 2 rely solely on Centennial as the behavioral health provider (Cheyenne, Phillips and Sedgwick). Tele-psychiatry and tele-health are critical initiatives to assure access for all Members.

The rate of smoking across the region is **approximately 16%.**

Cheyenne County **does not have a dentist or a physician.**

Our partners currently offer Medication-Assisted Treatment (MAT) programs across the region. A safe and proven approach to help those addicted to alcohol, opioids, and other substances, MAT helps people stay focused on therapy and recovery goals. It combines behavioral therapy and medications such as SUBOXONE®, Buprenophine, Vivitrol® Naltrexone®, or Campral® to treat substance use disorders. Our programs are a team-based approach to opioid use that involves a medical provider with a DEA-X license prescribing Suboxone and regular therapy by BHPs. This program uses a Member engagement tool called OpiSafe that looks at PDMP data to identify prescription utilization and has a Member facing engagement platform with a smart phone app that Members can use to communicate symptoms, and behavior to their provider team.

Similar to the state population, Region 2 has a predominantly white majority with Hispanic-identified people as the second-largest racial/ethnic population. Hispanics make up the largest part of the minority population across the Region followed by African American. While English is the predominant language spoken at home in Region 2, other languages, specifically Spanish, are represented in the Region. Although these represent a relatively small percentage of the overall population, several other languages are represented in the Region including Polish, Urdu, Punjabi, Pashtu, German, Korean, Somali, Karenni, Burmese, Tai, Kiswahili, and Russian.

As providers, we have developed a range of programs to address the language and cultural needs of Members. We intend to maintain and expand support of programs to respond to the diverse language and cultural needs of Members such as:

- Language training for clinicians and support staff
- Cultural competency training such as Bridging the Gap, Bridges out of Poverty, and cultural modules in Relias
- Recruitment of bilingual clinicians and support staff
- Recruitment of bilingual staff from within new immigrant populations to serve as in-house interpreters
- Use of the Language Line as well as InDemand, a state-of-the art language services solution, that assists limited English proficiency and Deaf Members and provides immediate access to medically qualified interpreters

[9] Snapshot of Rural Health. 2017 Colorado Rural Health Center. State Office of Rural Health.

New immigrant populations continue to grow in the Greeley/Evans service area. East African and Southeast Asian political refugees are settling in the Greeley/Evans area, working at the meat packing plant. When considering the specific needs of refugees and other immigrant populations, a review of literature on social determinants of health shows that refugees and immigrant groups, including temporary migratory workers, experience unique challenges—including trauma, limited English proficiency language acquisition, and housing.[10] Furthermore, refugees and other immigrant populations experience higher levels of segregation into low-income neighborhoods, leading to challenges accessing adequate nutrition as well as an increase in the likelihood of homelessness.[11] Our partners have become the health care homes for many of these families. We have reached out to the population and to support services such as Lutheran Family Health Services and the Global Refugee Center for cultural competency introduction and training. In addition, partners have hired from within the immigrant community.

Transportation

One of the biggest barriers to access in our predominantly rural and frontier region is transportation. Southern Weld is slightly less challenging than eastern Colorado; however, transportation options are minimal. There is little or no mass transportation available. People are dependent on personal vehicles for most transportation, with families and friends often providing the back-up. Some agencies partner with local taxi companies to provide free rides, but the problem is compounded by the shortage of specialty providers, which often necessitates Members needing transportation to the Denver metro area to receive these services.

An extensive network of crisis and alternative services is in place to maximize local resources and prevent the need for travel. School-based treatment and after-school programs, respite homes for adults and children, in-home crisis support, and homeless outreach services all improve access for persons most at risk.

Our partners work to address transportation challenges with multiple local and state agencies and human service organizations. We also have expanded access to care through mobile units in addition to other stationary efforts as noted above. For Example, Salud and Sunrise, members of NHP, each have mobile units to help reach the rural, migrant, and hard-to-reach populations in urban and rural Weld County. North Range provides transportation services for Specialized Women's Services and their Female Offender Program.

We will continue to explore ways in which technology can be used to support Members in their communities especially with access issues. NHP understands the communities in which they live and work and works to ensure the needs of our Members are met with the resources available.

Suicide in our Rural Communities

According to the Colorado Health Foundation Health Report Card: Data Spotlight, Mental Health (2016), the state's suicide rate has increased over the past decade, reaching 19.4 suicide deaths for each 100,000 residents in 2014. More Coloradans die each year by suicide than by car crashes, homicide, flu, or pneumonia, respectively. In 2015, Colorado overall had the seventh highest rate of suicide in the country[12]. For Coloradans 14-24 years of age, suicide is the leading cause of death. There are differences among those who are more likely to consider or die by suicide, with the suicide death rate being higher in Colorado's rural and frontier regions than urban areas. Additionally,

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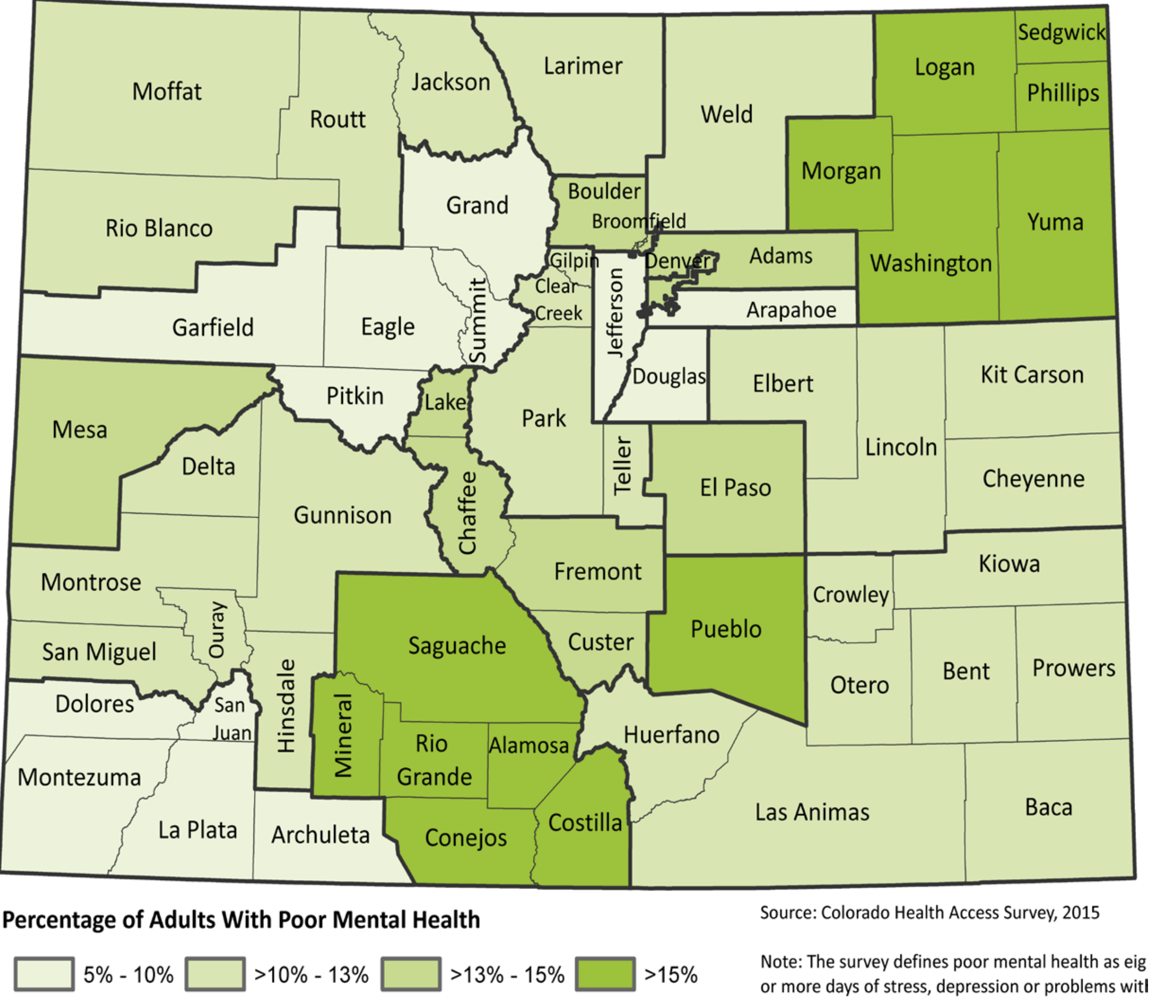
[10] Hiebert, 2011; Hynie, 2014; Krieger & Higgins, 2002; Ley & Smith 2000; Murdie, 2008.
[11] Hynie, M. (2017). *Social Determinants of Refugee Health.* Presentation York University Center for Refugee Studies Summer Course.
[12] David Brendsel (2015) Suicide claims record number of Coloradans. Colorado Department of Public Health and Environment. Retrieved from: https://www.colorado.gov/pacific/cdphe/news/suicide-claims-record-number-coloradans

access to mental health providers in rural counties remains low with a ratio of one provider for every 3,282 people.[13]

We have been engaged in efforts within our communities to identify root causes and implement prevention programs. As the RAE, we have selected suicide prevention as one of our Population Health Management Plan initiatives to work in a focused manner across the Health Neighborhood and with the broader community to address this need. Suicide prevention is described in more detail in *Offeror's Response 15*, and our Population Health Management Plan segmented for Adult Members, as **Attachment 6**.



NHP understands and our community partners have implemented initiatives to address those social determinants that impact Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies. NHP partners have established relationships and communication channels in place to impact change in areas such as food, housing, energy assistance, childcare, education, and job training in the region.

[13] The State Office of Rural Health: Colorado Rural Health Center. Snapshot of Rural Health in Colorado 2017 Edition. http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2013/10/2017.1.4-Snapshot-FINAL-FINAL.pdf

Our Board and staff:

- Are leaders in creating and supporting the North Colorado Health Alliance
- Sit on local, regional, and statewide committees with Departments of Human Service, Departments of Public Health, Regional Health Connector, Centennial Area Health Education Agency, Colorado Department of Public Health and Environment, SIM, Office of the Attorney General (Substance Abuse Trends and Response Task Force) and special task forces to coordinate services and develop new models
- Provide staff and resources to local initiatives to address multiple areas of social need
- Co-sponsor wellness and prevention programs with schools, churches, and Public Health departments to reach people where they live and learn
- Offer technology solutions to address transportation and isolation issues such as tele-psychiatry and tele-therapy

NHP will use the technology and administrative solutions provided by our administrative contractor, Beacon Health Options (Beacon), to support and strengthen these efforts. Their innovative solutions will enhance our ability to provide service, track outcomes, and manage community-based efforts across the region.

Region 2 has areas of strength and growth and recognizes the challenges with lack of transportation options and access to specialized services especially in our frontier areas. We are committed to working across the spectrum to support the individual communities and the Medicaid Members and families who live across this diverse region.

Social Determinants of Health Plan Moving Forward

As the program is initiated, we will convene a series of meetings across the region with providers, Members, and stakeholders to identify social determinant priorities for NHP as we begin this new role as the RAE. It is our intent to understand these issues in light of the RAE responsibilities from a regional perspective and assure that the voices are being heard from each community. We will work with the Member Advisory Council, local hospitals, and local public health agencies to develop their community needs assessments in order to understand the issues being assessed, and identify areas where we can build collaborative strategies to reduce health inequities and disparities.

Our model is committed to broad stakeholder engagement. We fully intend to engage with the designated state agencies, providers, the advocacy groups, and consumers to ensure program design includes input from all stakeholders. We will extensively rely upon the Statewide PIAC (Program Improvement Advisory Committee), Regional PIAC, Member Advisory Council, and relationships with providers in the community to review, assess, and identify new or changing opportunities to impact the social determinants of health in Region 2. We also want to make sure our programs and coalitions work for the population being served. As partners, our organizations have a long history of collaborating with and advocating for communities, with strong Member and community input throughout the process.

The information obtained through these regional and local meetings with representation from the communities, stakeholders, Members, and the Board will be the foundation of **a NHP Social Determinants of Health Plan** that enables us to prioritize our role and engagement with our community partners. This plan will be updated annually and presented to the Board for review and approval at that time. We will also seek input from the Department and other statewide organizations such as CDPHE, SIM, Colorado Coalition for the Homeless, etc.

This effort will be staffed with seasoned professionals who have led similar efforts under high performing BHO and RCCO contracts.

Our Engagement with the Community

NHP collaboration and support of community initiatives impact health and well-being of the community.

Under the auspices of the RAE, we will be able to further enhance the community efforts that have been undertaken by each of our partners. The organized structure of the RAE will enable us to continue our close work with community organizations while building a regional plan and perspective, developing regional metrics and assessments, and sharing information about best practices. The work that we have begun with hospitals, Primary Care Medical Providers, specialists, first-responders, government agencies, and stakeholder groups will be strengthened by developing and maintaining a regional plan and single on-line resource directory. We will also collaborate with school districts to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth.

- We have formal relationships and meet regularly with every **County Department of Human Services** to address joint cases, community needs and resource allocation.
- North Range has case managers **embedded at the local jail** and staff members work closely with the local shelter to provide referrals and linkages to services and supports.
- Centennial providers and case managers provide services to all jails in the remaining nine counties of the region.
- North Range and Centennial Early Childhood teams work closely with caregivers, daycares, and DHS to identify children and families with challenges and provide support and consultation.
- **Care coordinators, case managers, and peer counselors are fully integrated** at Sunrise and Salud, collaborating on cases and developing integrated Care Plans with Members and their families that include direct service, crisis intervention and linkage with referrals for emergency housing, health care, food and mental health services and Identification of and referral to community resources.
- The partners all work with local organizations to **identify and resolve food access issues** including Meals on Wheels (where available), food pantries, WIC, SNAP, local churches, and Departments of Human Services. We support Members in need through the application process if needed to obtain WIC and SNAP benefits and to access food in emergencies through local partner organizations.
- **Rooted in a rural context, partners work collaboratively to reduce roadblocks** between programs including public health, human services, education, Area Agencies on Aging, providers, etc.

Centralized Resource Directory

As part of the system-wide approach, NHP will coordinate with United Way's 211 Resource Directory and determine the best approach to developing and operating one centralized regional resource directory. Currently, United Way maintains this centralized resource directory for Weld County and rural counties have static resource directories. There is no single source of information for Members, providers, or care coordinators across the Region. Through our administrative contract, NHP has the resources to maintain a RAE-level centralized regional resource directory that is cloud based, mobile-capable, and maintained in real time. However, we do not intend to duplicate local efforts. We will work with United Way during implementation and determine the most effective method of meeting this requirement that provides the service, expands its reach, and minimizes duplication.

Building on Our Strengths

Through our partners, NHP has established relationships and communication channels with Community organizations across the entire Region that provide resources such as food, housing, energy assistance, childcare, education, and job training. Using the Social Determinants of Health Plan, we will align, not duplicate, efforts. NHP believes working together as a community accomplishes greater outcomes for our providers, Members, and community.

The following are examples of engagement in the community through our partners. As the RAE, we commit to maintaining and expanding these functions to further support relationships and communication channels that integrate the Health Neighborhood and support the Population Health Management Plan to impact social determinants of health. These programs have been in support of Community Organizations to expand access, improve the overall well-being of the community, and remove roadblocks to Member access to programs and initiatives, particularly evidence-based, promising programs in the regions.

Homelessness

Homelessness is a social determinant of health within Region 2 to consider. Interestingly, the percentage of households who spend 30 percent of their income on mortgages or rent is at or lower than the state average. However, in Region 2 the average percentage of persons living in poverty is higher than the Statewide average (14.5 percent for Region 2 versus 12.9 percent in the state.) The rate of children in poverty is also higher in the region when compared to the state average (19 percent versus 15 percent). The unemployment rate in Region 2 (6.3 percent) is nearly three times the rate in Colorado overall (2.3 percent). These factors impact the rate of homelessness in the region. Within Weld County alone, there were over 1,000 homeless youth during the 2014-2015 school year.

NHP RAE partners in Region 2 have created a number of initiatives to support homeless populations.

- **Weld's Way Home** is a consortium of agencies, including North Range, and community stakeholders who are working together to address homelessness in Weld County.
- **Fourth Street House** located in Sterling is a housing program that is offered in conjunction with treatment as transitional housing for those who need to master the skills necessary for future independent living.
- Providers in NHP RAE also provide administrative support for the **Division of Housing Section 8 Housing Choice Vouchers** to income eligible individuals. The **Office of Behavioral Health and Division of Housing State Housing Voucher Program,** a similar program to the Section 8 Housing Choice Voucher program supports applicants who are considered to be homeless, have a mental health and/or substance use disorder diagnosis, and must be an open or enrolled client with the local mental health center.
- **Colorado Choice Transitions Program (CCT),** a newer program through Centennial, is derived from collaboration between DOLA - Division of Housing and Health Care Policy and Financing; this effort moves persons with disabilities out of nursing homes and other long- term care into the community.
- **Projects for Assistance in Transition from Homelessness (PATH)** Program provides outreach and case management services to hard-to-reach homeless individuals with severe and persistent mental illness. Outreach activities are done to identify those persons in the community who are homeless to connecting them to community mental health and substance use disorder services. Referrals are made as the individual transitions to mainstream services that end their homelessness.

- Initiatives such as **Frontier House**, a program of North Range Behavioral Health, provides Members vocational, educational, and social goals. Often working with Department of Vocational Rehabilitation, the accredited Clubhouse helps Members find and sustain transitional, supported, and independent employment positions. Staff support Members in obtaining housing.

Criminal Justice

On average, Region 2 has a lower violent crime rate of 171 per 100,000 reported instances to the state average of 309. Incarcerated individuals in Region 2 have access to several initiatives in partnership with the Justice Department, local County Correction's offices, and community-based partners. NHP partners have strong jail-based programs throughout the region in collaboration with the Office of Behavioral Health and the County Sheriff's Office. Community-based treatment for offenders suffering from alcoholism and drug abuse and the co-occurring mental health issues associated with these addictions, provides substantial savings to the taxpayer, and increases the safety of the community at large. Research unequivocally finds that treatment for these co-occurring disorders reduces drug use and criminal behavior.

To reduce recidivism, therapeutic intervention rather than incarceration alone is required. To treat alcoholism and illicit drug use disorders, as well as mental illnesses, research demonstrates that to be *successful* treatment must:

1. Occur at the earliest possible opportunity
2. Be based on an individual treatment plan that incorporates natural communities and pro-social supports
3. Include family members when they offer a positive impact on the recovery process
4. Provide a continuum of community-based services

Examples of the NHP partner's programs that support individuals from Incarceration to release are discussed below:

- **Jail-Based Behavioral Services (JBBS)** exist across the Region through the efforts of both North Range and Centennial in conjunction with the County Sheriffs. JBBS provides incarcerated individuals evidence-based behavioral health services, while assuring continuity of care within the community after release from incarceration. This approach is an effective strategy towards reducing the length of incarceration for individuals with behavioral health challenges, and decreasing recidivism and re-incarceration rates. Inmates are equipped with a seamless transition to treatment, opportunities for successful reentry and continued services with their behavioral health provider in the communities to which they are released.

- **SPACKLE (Supportive Probationer and Community Living Environment), collaboration with Weld County Probation.** This program connects those recently released from jail with behavioral health disorders with North Range housing and access to a continuum of programs that can lead to successful living outside the prison system. This program has allowed probationer-clients access to the rest of the North Range recovery-based mental health and substance use programs, including outpatient individual and group therapy and/or psychosocial and vocational rehabilitation (Clubhouse or Individual Placement Services, for example). We are also able to connect them to other community mental health centers or agency services if needed.

- **Female Offender Program (FOP)**: This program, in collaboration with Weld County Probation, supports women struggling with addiction and mental health. A court-ordered program for females, FOP helps these women learn coping strategies and life skills to help them make healthier decisions and build more positive relationships. The overall focus of the program

enables the individual woman to learn about themselves in their recovery and to foster healthy relationships and support in their lives.

- **MOUs with Police, EMTs and other First Responders:** We have formal arrangements with police departments and first responders across the region to enable us to serve Members in crisis. We have close working relationships with all these organizations and work to improve access to care and minimize disruptions during transitions of care. These are critical relationships that support our work in every community.

In addition, NHP Partner's are engaged in a broad range of programs and collaborations with Human Service Departments and other community organizations to address social determinants of health. The following is a sample of the many initiatives and collaborations underway.

- **Mental Health Supported Employment (MHSE)** services are an integral component of the client recovery model. Centennial works through MHSE to identify individuals who need vocational training, job coaching, interview techniques, exploration of workplace skills, and personal career exploration. MHSE assists clients with a behavioral health disorder diagnosis who meet the eligibility criteria through Division of Vocational Rehabilitation (DVR) as a person with the most significant disability or meet indigent qualifications for Office of Behavioral Health employment support.

- **Collaboration between North Range and the Child Welfare Division of Weld County Department of Human Services**. As Heather Walker, Child Welfare Division Director says, "We communicate with North Range on a regular basis and brainstorm well together to solve problems creatively. Most importantly, after many years of working together, our values and purpose are aligned—we are both committed to the idea that each child gets the right intervention at the right time, and the earlier the better."

- For example, North Range works with the DHS child welfare team to help childcare providers and the families of children who get suspended from daycare facilities. We help by creating a wrap-around plan with the daycare and family – a plan that addresses the child's environment as well as educates the provider and family to redirect the child in more positive ways. This approach provides a stronger, family- and child-centered solution that better ensures the child's success long-term.

- Our partners work closely with other regional organizations including **Healthy Communities, WIC, Baby and Me, Tobacco Free, SNAP, Nurse Family Partnership, Colorado Family Planning Initiative (LARCs), Family Resource Center and Temporary Assistance to Needy Families (TANF)**. We work with these agencies collaboratively to obtain services and improve access for Members and their families--and also to build policies that reflect needs at the community level.

NHP engages with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the Community.

Departments of Public Health

Our Care Coordination and Case Management program is well documented in OR 16. It demonstrates our extensive relationships with local hospitals and Departments of Public Health to improve access to services and outcomes for Members and their families. In addition, we have been engaged in community health needs assessments and other public health efforts for many years as

the local Federally Qualified Health Centers (FQHCs) and Community Mental Health Organization (CMHCs) in the Region. We have developed our initial Population Health Management Plan to reflect the priorities of our local Departments of Public Health understanding they are built on an inclusive planning process. This will also allow us to further engage with Departments of Public Health as we implement our initiatives and leverage existing programs in the Region.

Our partners were all active participants in developing and providing input into the **County Community Health Improvement Plans.** We offer a consistent approach to the work being done in the counties by similarly relying on local needs assessments and evidence-based programs such as Colorado's 10 Winnable Battles and the Colorado Opportunity Framework to address health and social determinants of health. We commit to working in our local communities through our partners to collaborate with all the stakeholders engaged in updating and implementing County Community Health Improvement Plans. These coalitions work together to develop plans that are broad-reaching, and include multiple stakeholders across the communities including providers, MSOs, Healthy Communities, first responders and the Crisis System and others. In addition, we have developed collaborative programs with county Departments of Public Health, including:

- One example of our collaborative approach, characteristic of the collaborative nature of this Region, is the development of programs, care coordination, trainings and community engagement brought together by the **North Colorado Health Alliance** (The Alliance). The Alliance is a formal community partnership founded in 2000 by 3 organizations (North Range Behavioral Health, Sunrise Community Health, Centennial and the Weld County Department of Public Health & Environment) to enhance collaboration at a time when access to affordable, quality, integrated care was threatened by an economic recession in Colorado. The Alliance is a formal collaborative joint venture between public and private entities dedicated to treating community health as a single complex phenomenon spanning medical and non-medical determinants of health. This community joint venture has been built upon the four pillars of access to care, workforce, and organizational development, integrating infrastructure, and accountability.

  While this formal model may not be applicable in some of our smaller, rural counties, it demonstrates our commitment to community collaboration and engagement to address the health and social needs of the community. As the RAE, NHP will continue to support the work of The Alliance and the many other community collaborations that are in place across our Region. The responsibilities inherent in the RAE will enable us to further engage with our community partners to address the multiple needs of Members and their families.

- **My Health Connections:** The Alliance serves as a Certified Assistance Site for Weld County providing impartial assistance to consumers seeking health coverage through the health insurance marketplace, Connect for Health Colorado. Trained professionals, known as Health Coverage Guides, assist Weld County residents through the complexities of purchasing health insurance online.

- Salud works closely with Northeast Public Health Department through multiple projects, programs, and initiatives. The **Spanning Miles in Linking Everyone to Services (SMILES)** dental home project partners with the health department and schools in Morgan County to deliver dental services to children in Ft. Morgan. Salud also collaborates with the Northeast Public Health Department to care for TB Members.

Education and Schools

NHP will collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth. As the safety net, we have

extensive experience working with school districts, schools, and employment programs across the region to improve health and also the overall well-being of Medicaid children and youth. Among our achievements:

- **School-Based Health Clinic (Kid's Care Clinic):** The Kids' Care Clinic collaborative team includes a School nurse, Health Clerk, Outreach coordinator, Behavioral Health Consultant, family Nurse Practitioner, Medical assistant, Dentist, and a community outreach technician, which assists with Medicaid and Child Health Plan Plus (CHP+) for children. Community Partners include**:** Sunrise Community Health, North Range Behavioral Health, School District 6, Weld County Department of Human Services, and the North Colorado Health Alliance.

- Salud provides additional services to expand access to oral health:
  - Dental screenings in multiple counties
  - Dental hygienists visit local schools for medical dental integration (MDI) visits
  - Special summer programs in school districts that offer free lunch programs and offer MDI visits
  - Participates in the Spanning Miles in Linking Everyone to Services (SMILES) dental home project

- **Mileage Club Program:** Before-school walking and running clubs to increase children's physical activity levels. The mileage clubs reach nearly 1,000 children, teachers, and families at three different schools.

- **Healthy Food and Beverage Policy Program:** Working with local municipalities and public venues to encourage the adoption of Healthy Food and Beverage policies, The Alliance provides assessments, technical assistance, and implementation support to key venues in the county. To date, nine public venues have adopted healthy food and beverage policies.

- **Community Health Data Dashboard**: Thriving Weld Dashboard is a collaborative effort to facilitate data sharing for collective impact in Weld County. Over 70 partners from a variety of sectors, including Sunrise, Weld County United Way, and North Range, use the dashboard to help Weld County bring about measurable and long-term results. The dashboard provides an online gateway to information about how our community is doing regarding areas of access to care, active living, education, healthy eating, healthy mind and spirit, livelihood, and health equity.

- Centennial supports **a School-based Specialist (SBS)** program utilizing a consultation/training model across 36 school districts, with special focus on those communities with few resources available to youth. The SBS provides training, resources and support using evidence-based practices targeting prevention and early intervention strategies to meet the behavioral health needs of children and youth. The SBS acts in a referral role to assist schools and families in connecting with local behavioral health resources, as well as serving as an internal consultant within Centennial to equip our outpatient providers as they provide direct service to children referred for services.

- **North Range School-Based Services for Weld School District 6** provide screening and assessments, individual, group, and family therapy and crisis intervention, case management for students and their families, referrals, and education/consultation/ support for parents, teachers, and administrators. Therapists are located in thirteen schools across elementary, middle, and high schools. A very successful program that is gaining steam and regard across the county, contracts are pending for RE4 (Windsor) and local charter schools.

- Under our **Family Connects umbrella,** Members have access to Home Instruction for Parents of Preschool Youngers (HIPPY), Parents as Teachers (PAT), SafeCare© Colorado, and Early Childhood Mental Health Consultation. These teams partner with High Plains Library District, Weld School Districts, multiple United Way programs, Nurse-Family Partnership, DHS as well as other smaller organizations. The teams assist families in finding housing resources, help perform health assessments as well as BH assessments to children, provide nutrition education as part of the home visits, and use "I'm moving, I'm Learning" trainings for caregivers to promote child wellness. Family Connects supports 400-500 children annually and their adult care givers.

- North Range **Suicide Education and Support Services** (SESS) provides **SAFE:Teen**, an interactive and powerful presentation designed for middle and high school students with information about suicide risks, warning signs, and available resources. At each presentation, we have identified an average of four students who are struggling or know someone who is struggling with suicidal thoughts. SESS also provides Question-Persuade-Refer (QPR) Gatekeeper training. Between 2015 and 2016, SESS provided DIRECT services to 7,383 youth and 1,593 adults, as well as grief services to 356 community members. Last year SESS:
    - Certified over 400 adults as suicide prevention gatekeepers
    - Provided four mental health nights for parents
    - Had a town hall meeting targeted at veterans and their families
    - Held our annual memorial balloon release, a Glimmer of Hope, for those left behind

As the RAE, we will continue to support increasing development and implementation of programs that address the social determinates of health for children, including Life Skills curriculum for interested school districts, consultation with providers and community members, training, and renewed efforts to implement anti-bullying programs, suicide prevention, and healthy choices in schools where this is an identified need.

Substance Use Prevention and Treatment

Alcohol and substance use and prevention in the region are important social determinates of health. According to the County Health Ranking Colorado, an average of 17 percent of Region 2 adults report excessive drinking. Currently we provide several initiatives that support substance prevention and recovery in Region 2:

- Centennial's **Substance Use Disorder Prevention Specialist(s)** serve youth in grades 3 to 12 and utilize prevention activities aimed at reducing risk, minimizing harm, stopping deaths and increasing or strengthening protective factors related to the individual's specific problem. This could include risk and protective factors that already exist within individuals, communities, and social cultures.

- A Substance Abuse and Mental Health Services Administration grant supports **Weld County Prevention Partners (WCPP)**, a coalition of community leaders, families, and teens who spearhead efforts across Weld County to prevent and reduce underage substance use. WCPP administers the Healthy Kids Colorado survey and executes a multi-strategy marketing campaign to educate teens, parents, leaders, and the community at large. WCPP has partnered with over 700 alcohol retailers (a collaboration called Responsible Alcohol Retailers of Weld County) to reduce the sale of alcohol to minors. Through their Strengthening Families classes, 78 parents and 56 kids improved communication and problem-solving skills—strategies proven to reduce teen substance use and promote healthy lifestyle choices for families.

- We have a number of **smoking cessation efforts** that are implemented through collaborations that incorporate tobacco cessation into the clinical practice of providers. The efforts of provider partners in NHP RAE will assist in assessing current practices, developing a protocol for asking,

advising, referring, and connecting individuals to appropriate resources. We have selected smoking cessation as one of our PHMP initiatives to address this important public health issue.

- Each of our NHP partner agencies is actively involved in Medication Assisted Treatment (MAT) programs, including interventions to address opioid use disorder, and are actively involved in expanding awareness and provider resources in our communities and Health Neighborhood. Whether within our FQHC or CMHC settings, MAT is a safe, proven approach to control symptoms and cravings that helps people stay focused on therapy and recovery goals. MAT combines behavioral therapy and medications such as SUBOXONE®, Buprenophine, Vivitrol® Naltrexone®, or Campral®. Treatment and active care coordination involves a multidisciplinary team of addiction specialists, therapists, and psychiatrists/physicians. Multi-disciplinary teams assess and monitor each individual. Regular outreach and marketing target those in the community with addiction; referrals also come from a variety of sources.

- One example: North Range and Sunrise partner to facilitate two separate Medication Assisted Treatment (MAT) programs. One is housed with the Sunrise Monfort Family Clinic and one is housed within the North Range/Sunrise Clinic within North Range's main facility. These MAT programs are provided through a partnership of North Range Behavioral Health, Sunrise Community Health, the pharmacy at the Monfort Family Clinic and Genoa Pharmacy (a pharmacy located in the North Range main site). **A safe, proven approach to control symptoms and cravings that helps people stay focuse**d on therapy and recovery goals, it is particularly effective for people challenged by opioid addiction. Similar MAT programs exist with interdisciplinary teams providing integrated care by Centennial and Salud.

Managed Service Organizations

NHP is an active participant in Signal Behavioral Health Network, the MSO for Region 2. We are represented currently through a partner organization on the Signal Board of Directors. As such, we are actively engaged with them to create policies and programs that are aligned to serve our Members.

Colorado Crisis System (CCS)

Northeast Behavioral Health (representing North Range Behavioral Health (Weld County), SummitStone Health Partners (Larimer County) and Centennial Mental Health (10 counties in Northeastern Colorado) are the local providers of Crisis Support Services across the northeast region. In addition to the statewide hotlines and text-line, Region 2 residents may access walk-in crisis centers, respite, and crisis stabilization programs around the region. The crisis system works with other regional providers and first-responders so that individuals in mental health or substance use crises get the right care at the right time. As the RAE, we will continue to work with CSS and the regional providers to ensure that programs and solutions are in alignment and meeting the needs of residents.

Colorado Opportunity Project

NHP promotes Member engagement with evidence-based and promising initiatives operating in the region that address the social determinants of health. NHP is aligned with the framework set up through the Colorado Opportunity Project.

The Colorado Opportunity Project (COP) and similar state initiatives like the SIM program have further refined our understanding and awareness of the impact of social determinants of health within our communities. Our Systems Integration Coordinator works as the liaison for the Colorado Opportunity Project as well as designs and implements activities and programs that align with the COP. The COP's emphasis on aligning initiatives across sectors ensures more information sharing across sectors as well as interdisciplinary work centered on trusted practice tools and initiatives.

We have utilized the indicators for the COP to ensure evidence-based practice is considered and we have used the framework from COP in building our Population Health Management Plan.

Other State Initiatives

We commit to participating in and aligning our activities with advisory groups and existing programs and initiatives to strengthen the health system. As noted throughout the proposal, we in the northeast region have a long history of collaboration within our region, across regions, and at the state level. This is part of our DNA and we will continue to engage in community and state efforts to improve the health and well-being of our communities. Some additional examples include:

- **Regional Health Connector Program**: The Alliance, with participation from Sunrise and North Range, hosts the Regional Health Connector (RHC) for Weld County. The role of the RHC is to improve the coordination of local services to advance health and address the social determinants of health. The RHC focuses on connections among clinical care, community organizations, public health, human services, and other partners.

- **Community Action Collaborative**: The Alliance leads a “Community Action Collaborative” (CAC) to create an innovative model to improve responses to non-emergent 911 calls. A collaborative group of partners including North Range and Sunrise, fire, first responders, law enforcement, municipal courts, human services, the local library, and local shelters came together through The Alliance to address a community need. The CAC model is an integrated community approach that can effectively manage and treat complex individuals by providing linkages to primary care and other community-based settings.

- **Make TODAY Count! (MTC) Collaboration**: The Alliance leads a group of 70+ cross-sector agencies and organizations in Weld County, including North Range and Sunrise, which work to coordinate, align, and accelerate efforts of the Weld County Community Health Improvement Plan. The Collaboration meets on a quarterly basis as large group, and then subcommittees from three focus areas (healthy eating, active living, and healthy mind and spirit) meet monthly. One such effort focused on increasing awareness of the sugar in soft drinks and reducing obesity.

Health Neighborhood and Community Report

NHP, utilizing its administrative agent, Beacon, is uniquely experienced and able to meet the Department’s reporting requirements for a Health Neighborhood and Community Report. Beacon has successfully met or exceeded similar requirements under their existing administrative responsibilities for RCCO and BHO contracts, a fact that is well documented by multiple sources, including the Health Services Advisory Group (HSAG) audits. In addition to process reports, they have demonstrated multiple times their ability to support program evaluation reporting that leads to recommendations and substantive changes.

Now, by having access to a unified Web-based platform, Beacon has been able take advantage of technologies that make large-scale reporting and collaboration easy and effective. In addition to the technology solution, our model is quite different from others in that we believe in the strength of local partnerships and will encourage individuals across our organization and region to use the platform to drive deep change. To be effective, reporting needs to:

- Meet regulatory and contractual requirements and collect accurate, timely information on activities
- Encourage individuals at multiple levels of the organization to participate in a meaningful way in data collection document activities and collaborations and break down barriers and roadblocks

- Foster honest and frank discussions of root causes and, in the process, develop a shared view of the thorniest barriers and collaboratively explore solutions within NHP and with the Department
- Be open to exploring multiple potential solutions rather than seeking to coalesce prematurely around a single approach. Our approach to monitoring, evaluation, and change management is to first diverge, then converge
- Focus on generating a portfolio of experiments that can be conducted locally to help prove or disprove the components of a more general solution, as opposed to developing a single grand design
- Report regularly to the Regional PIAC and the Board to report on progress towards corporate objectives and set out policy guidelines within which management will operate
- Report back to all Members of the Health Neighborhood on successes and barriers in a transparent manner to engage them in the conversation and solutions

We believe our technology solutions link to our commitment to transparency, and engagement and local participation will enable us to provide the Department with a Health Neighborhood and Community Report that tracks all requirements in *Section 5.8.5.1.2* and further enhances NHP's and the Department's work towards building sustainable solutions.

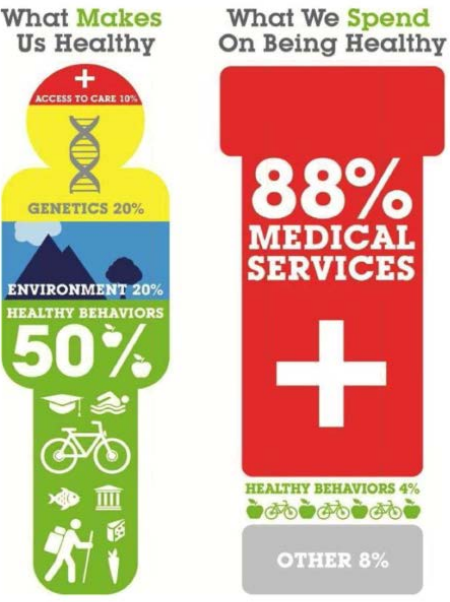
OFFEROR'S RESPONSE 15

Describe in detail the Offeror's proposed population health management strategy and document the specific major interventions the Offeror will implement using the forms in Appendix I Population Health Management Plan. Describe how the Offeror will monitor and track the delivery of interventions defined in the Offeror's Population Health Management Plan.

BACKGROUND

Northeast Health Partners, LLC (NHP) is deeply committed to improving the health of the Medicaid population in Region 2. As a partnership of local, experienced organizations that serve the physical and behavioral health needs of our Members, we have a proven track record of successfully collaborating with community partners, local governments, and the Department to address the population health needs of Region 2. To this end, we have developed an initial Population Health Management Plan (PHMP) in alignment with ongoing health initiatives at the local, state, and national levels. Our PHMP's measures were selected after careful analysis, and our comprehensive approach to population health management uses data to stratify the population and offer a range of interventions to support Members at all life stages and levels of health.

We have undertaken comprehensive analysis of the needs of the community and their congruence with local, state, and national health priorities. Initially, we assessed the priorities that have been identified by each of the public health departments in our region to find consistent issues. Subsequently, we analyzed State level priorities and evidence-based interventions from the Colorado Opportunity Project and Colorado's 10 Winnable Battles. Finally, we reviewed priorities and requirements that impact Federally Qualified Health Centers (FQHCs) and primary care providers (UDS and national quality targets through HEDIS and to a lesser extent MACRA). We also weighed behavioral health priorities and plan to incorporate private practice areas of focus when finalizing our population health plan. Our goals in developing the Population Health Management Plan are to focus on high priority areas and to reduce duplication of effort for PCMPs wherever possible. **Attachment 5** it is a graphic presentation of our analytic framework.



Source: Bipartisan Policy Center, "F as in Fat: How Obesity Threatens America's Future" (TFAH/RWJF, Aug. 2013)

NHP is fully committed to systematically managing the health of the Medicaid population in Region 2. We have presented in **Attachment 6** and **Attachment 7** an initial Population Health Management Plan segmented for Adult Members and Pediatric Members, respectively. After we are awarded the contract, we will refine our Plan with input from the Regional Program Improvement Advisory Committee (PIAC), community stakeholders, and other providers. We will develop and submit a final Plan to the Department within 60 days after the effective date of the contract. This Plan will incorporate feedback from the Department and community input.

Defining Population Health

Population health is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[1] As we work toward reducing health disparities

[1] Kindig, David, Stoddart, Greg, "What is Population Health," American Journal of Public Health, American Public Health Associates, March 2003.

within the Medicaid population in Region 2, we will utilize population health management tools founded on a detailed understanding of the distribution of health conditions and health-related behaviors, and consider the social determinants of health, such as income, culture, race, age, family status, housing status, and education level. We recognize that we must address medical care, but also look and act upon the broad range of other factors and conditions that influence health because ultimately, medical care (or access to care) comprises only 10-20 percent of overall health.[2]

POPULATION HEALTH MANAGEMENT STRATEGY AND PLAN

NHP's Population Health Management Strategy is data-informed, regionally specific and tailored to the specific communities we will serve. It includes a tailored set of interventions to meet the needs of our diverse population and exists for the sole purpose of achieving demonstrable improvement in the Population Health Management goals set forth by the Department. On Day 1, we will begin to impact the Key Performance Measures and other indicators of health and wellness that we know can improve health, control costs and improve the experience of care for our Members.

Our Approach

The NHP Regional Accountable Entity (RAE) approach to population health management is guided by national research, ongoing state initiatives, and especially, by continuous assessment of our local environment and organizational strengths. A joint venture by local experts committed to improving the health of populations in Region 2, NHP is intentional about aligning our work with the health priorities identified by County Health Departments in Region 2, as well as state and national initiatives to support population health management interventions already in progress in our Region.

In addition, close collaboration with community organizations that provide services "in the trenches" day in and day out drives much of our approach. To illustrate this point, in Weld County where the majority of Region 2 residents reside, we work closely with the North Colorado Health Alliance (Alliance), a formal, cross-sector community partnership of public and private community organizations and the county public health department. An example of a current population health management approach that is already underway is 'Thriving Weld Dashboard', a collaborative effort to facilitate data sharing for collective impact in Weld County. Over 70 partners from a variety of sectors use the dashboard to help Weld County bring about measurable and long-term population health results. The dashboard provides an online gateway to information about how our community is doing in terms of access to care, active living, education, healthy eating, healthy mind and spirit, livelihood, and health equity. Through the RAE, NHP will be able to support local efforts across the region and work collaboratively to assess impact and create meaningful change.

The Institute for Healthcare Improvement (IHI) describes characteristics of a successful population health management model as follows:

- An organized system of care
- Established multidisciplinary integrated care teams empaneled within the practices or as close to the provider site as possible
- Continuous care both in and outside of office visits
- An organized approach to patient engagement
- Sophisticated health information technology solution that includes timely access to population health data, stratification and predictive modeling, and communication among providers and patients[3]

[2] Woolf, Steven H., Progress in Achieving Health Equity Requires Attention to Root Causes, Health Affairs 36, no. 6 (2017): 984-991, doi: 10.1377/hlthaff.2017.0197.
[3] Institute for health technology transformation. Population health management. A roadmap for provider– based automation in a new era of healthcare

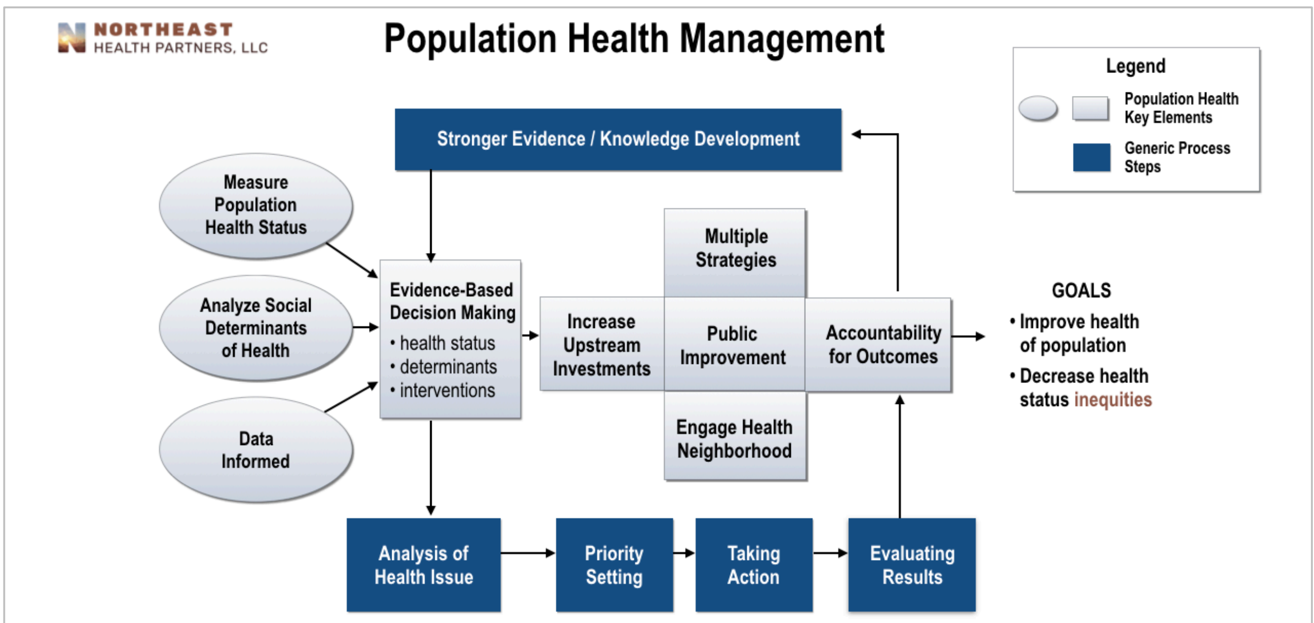
An Organized System of Care

NHP brings to the RAE program a comprehensive understanding of the health status, health-related behaviors and social determinants of health for all the Members across Region 2. We represent the majority of safety net providers in Region 2 and also have contracted with Beacon Health Options (Beacon) to provide proven administrative support. This combination enables us to commit to the Department that we can fully support a Population Health Management Plan through:

- Integrated, empaneled Care Coordination using a person- and family-centered approach supporting Primary Care Medical Providers (PCMPs) and the Health Neighborhood
- Capabilities to build upon the Department's data systems and perform analytics to successfully implement an information-based approach to delivering and coordinating care and services across the continuum
- Highly ranked administrative system based on the national resources of our Administrative Services Organization, Beacon in collaboration with the Department and the Business Intelligence and Data Management (BIDM) System to apply advanced analytics to assess, track, and monitor the health status of all Members, and monitor changes in health needs and stratification as they occur

NHP will utilize a system-wide approach to assess the population and prioritize interventions based on evidence. Importantly, interventions are constructed and implemented at the local level, enabling care delivery that our Members know and trust. All partners and network providers are held accountable for outcomes, which are evaluated regularly. Our organized system of care and approach to Population Health Management encompasses eight key elements:

1. Focus on the health of populations
2. Address the determinants of health and their interactions
3. Base decisions on evidence
4. Increase upstream investments
5. Apply multiple strategies
6. Collaborate across sectors and levels
7. Employ mechanisms for public involvement
8. Demonstrate accountability for health outcomes



Data Informed

NHP analyzed the needs of the communities we serve and congruence with local, state, and national population health priorities in selecting the seven adult and seven pediatric initiatives included in this initial Population Health Management Plan. In aligning our work with the priorities of the County Health Department's in our Region, we intend to enhance our potential for success and strengthen relationships with the Health Neighborhoods. Similarly, our goal is to reinforce population health efforts underway at FQHCs and PCMPs and not to create competing requirements or duplicate efforts. We have also selected seven initiatives which we believe are relevant to adults and selected ages within the pediatric population. Mirroring the approach of the Colorado Opportunity Project, NHPs PHMP coordinates and aligns interventions through a life stage/ indicator-based framework.

Stratification Framework

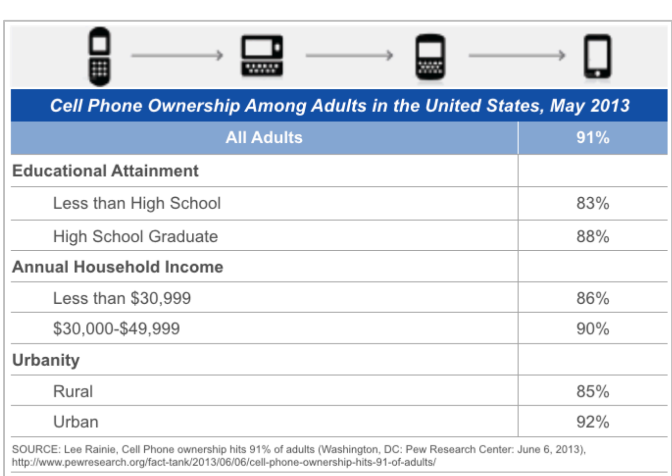
NHP commits to partnering with the Department and stakeholders to develop an Accountable Care Collaborative (ACC) stratification framework that will be used by all RAEs. Our approach aligns with the Colorado Opportunity Project, Colorado's 10 Winnable Battles, County Health Department priorities and national evidence-based priorities for FQHCs and private providers. We also weighed behavioral health priorities and plan to incorporate private practice areas of focus when finalizing our population health plan. We will update our Population Health Management Plan annually. We have built our Population Health Management Plan and related technology ecosystem to align with Department investments such as BIDM with the intent to augment them rather than duplicate them.

Our Population Health Management program meets all requirements established by the Department. The draft Population Health Management Plan uses BIDM, Health Needs Survey, and other available data for stratification. We will explore additional stratification or data points including the BIDM data points (e.g., conditions, risk weights, emergency room visits, well-child status) that are slated for future releases of the system and accessible to providers in the MyClients view. This will enable us to identify Members who change stratification levels, particularly into higher risk categories and offer a range of interventions to support Members through all life stages and levels of health.

We will ensure that all assigned Members receive regular interventions (in excess of the required two interventions) throughout the year in support of population health, such as adult and child prevention and wellness information. These are described in more detail throughout our response; however, it is important to note that by using technology we will be able to provide interventions and messaging that are timely and reflect current issues.

Health Promotions Campaigns and Interventions

Cell phone ownership is widespread across income and demographic groups. As early as 2013, research showed that 88 percent of Hispanics, 93 percent of Blacks, and 90 percent of Whites owned cell phones. In that same study, nine in ten adults (86 percent) with annual income below $30,000 and 83 percent of adults with less than a high school education owned a cell phone. Colorado already uses a mobile application for enrollment into Medicaid through PEAK.



Cell Phone Ownership Among Adults in the United States, May 2013

All Adults	91%
Educational Attainment	
Less than High School	83%
High School Graduate	88%
Annual Household Income	
Less than $30,999	86%
$30,000-$49,999	90%
Urbanity	
Rural	85%
Urban	92%

SOURCE: Lee Rainie, Cell Phone ownership hits 91% of adults (Washington, DC: Pew Research Center: June 6, 2013), http://www.pewresearch.org/fact-tank/2013/06/06/cell-phone-ownership-hits-91-of-adults/

Text-based population health campaigns and tools will be purchased by Beacon for the

RAE and made available for a variety of initiatives linked to community resources and other community-based initiatives. By purchasing at a multi-region level, we will be an aggregator of this common technology. Members moving from one region to another will be able to keep the tools that are working for them. The Wellpass solution includes a number of options for Members such as Text4Health, Text4baby and Text2Quit. These are described in more detail in the Population Health Management Plan, *Appendix I*. While we will leverage technology because of its low cost and wide reach, all of our interventions also include the human component. PCMPs and care coordinators will be engaged in these campaigns so that they can share consistent messages and reinforce the texting information that Members will receive. In addition, they will identify Members who may need more intensive services or care coordination to improve their overall health and wellness.

By using texting technology we will be able to provide interventions and messaging that are timely and reflect current issues, such as:

- Reminders for flu shots during the winter
- Wellness and prevention messaging about childhood injury during the summer
- Responding to data-driven issues such as identifying gaps in immunization coverage or well-baby check-ups by county, sub-region, etc.

The Population Health Management Plan includes a crosswalk of stratification levels and examples of the major interventions we will offer for each level. These will be reviewed and finalized through an open, transparent community-wide process, as well as with the Department during implementation.

CARE COORDINATION

NHP partners have utilized multidisciplinary integrated care teams fully supported by Care Coordination for many years, and will leverage this experience to further develop and encourage its network providers to adopt this concept. Care Coordination has been included as one of the interventions available to Members.

NHP providers have implemented or are closely familiar with a variety of multidisciplinary integrated Care Coordination supported models in Region 2, including:

- For nearly 15 years, North Range and Sunrise have bi-directionally integrated medical and physical services. Currently, North Range has embedded staff in five Sunrise clinics in Northeast Colorado. North Range staff work side-by-side with Sunrise staff, seeing patients in Sunrise exam rooms, documenting in Sunrise's charts, co-creating care plans, jointly facilitating group visits, attending the same staff meetings, and more.
- Sunrise brings its mobile van to North Range's crisis stabilization center on a regular basis.
- Salud FQHC-employed behavioral health therapists are integrated in numerous primary care clinic locations.
- Tele-behavioral health is being utilized across the Region and will be supported through the RAE.

Care coordination at the place of care and/or from existing trusted relationships, is a critical intervention that is available to all Members. NHP will encourage the majority of Member-facing care coordination efforts to occur in the community and will provide a safety net for those Members served by providers with the ability to take on these functions. We will ensure that every Member has suitable services available to them using either face-to-face or remote care coordination engagement strategies. Our fully integrated clinical model will not leave any Member behind, regardless of where they seek care. Through our multidimensional approach, we will support

providers so that they can meet the needs of Members and their families, minimize administrative "hassles" and improve Member and provider satisfaction. Additionally, our program facilitates care across multiple provider settings, as well as diverse geography, by placing the Member at the core of the team. Leveraging existing best practices in our network and coupling those programs with enhanced IT support, analytics and health neighborhoods will provide optimal support and care for Members.

MEMBER ENGAGEMENT

NHP is person- and family-centered. To this end, all of our solutions, whether they are technology-driven or human-driven, are tailored to the Member's preferences. We will develop programs and support our staff and providers to actively engage Members across the entire care continuum. We will develop enhanced communications strategies that foster Member relationships by providing clear, concise information recognizing language, access and cultural differences. We have diverse populations in our Region, both within the Greeley urban environment and dispersed across the remainder of our rural and frontier counties. With this consideration in mind, we have implemented Member engagement strategies such as integrated services as well as telemedicine and telehealth solutions that decrease extensive travel times for Members and improve access. At the same time, we will use data registries, medication and visit alerts, and access to data through provider and Member portals that include crucial information for managing care.

Care Coordination/Population Health Management Plan Enablement Technology

NHP operates all of our functions using a wholly owned and operated technology infrastructure provided by NHP's Administrative Services Organization, Beacon. This system, CONNECTS, is a comprehensive management information platform comprising a suite of fully integrated applications designed to provide innovative data management and reporting capabilities. This integrated computing environment, detailed in our response to *Offerors Response 7*, provides the tools to support population health management including:

- Integrating the Department's selected stratification system at the individual and population level
- Providing current health risk assessment data electronically to the individual PCMP and care coordinators
- Identifying Members whose stratification level changes particularly higher risk categories
- Supporting proactive health promotion programs at the provider, care coordinator, and Member level
- Providing a database of community health and social service programs and activities targeted to population health and our specific interventions
- Supporting self-management interventions aimed at engaging the targeted populations
- Providing one unified database for evaluation and analytics to track progress, identify challenges, and report to providers, stakeholders, management, and the Department

CONNECTS comprises a suite of fully integrated applications built on a single platform. Data can be organized at the Member, provider, population, or any other level required by the Department. This means that our platform is truly an enabler of care coordination, rather than a barrier. Because of the integrated nature of CONNECTS, it facilitates partnering with regional stakeholders, such as Health Community partners, social services agencies, specialty providers, hospitals, and Sheriff's Departments so crucial to successfully managing population health.

MONITORING AND EVALUATION

Managing a successful PHMP requires a formal evaluation strategy to ensure that program objectives are described and measured. NHP has the capabilities through technology as well as seasoned management and analytics staff to assure that the PHMP is reviewed at least annually based on objective, documented outcomes and changes and health status in the community. In

addition, we commit to running the stratification methodology on predetermined intervals, insuring Members are receiving interventions as described based on analysis and evaluation, and submitting revised plans to the Department when there are changes to our strategy.

We will evaluate the process and outcomes of the PHMP. Process evaluation focuses on analyzing how program activities are delivered. On a monthly basis, we will measure, analyze and report on:

- Who delivers the program/intervention and how often?
- To what extent was the program implemented as planned?
- What population was reached through the intervention (e.g., the number of Members targeted, how many Members actually receive the intervention, and characteristics of the Members receiving the intervention by geography, ethnicity, age, etc.)?

Data will be aggregated on a quarterly and annual basis to look for trends. In addition, on a quarterly basis, we will assess the following issues:

- How is the program received by the target group and program staff?
- What are barriers to program delivery?
- How are providers being engaged in the interventions and what additional support do they need?
- What have we learned to make program improvements/refinements? If so, what changes were made?

As demonstrated throughout this response, NHP is committed to a continuous performance improvement process. Especially during the first year of implementation, it will be crucial for us to understand each of the interventions in the PHMP from a process perspective to determine if there is need for additional resources, training, materials, provider support, or other structural changes to assure the most effective outcomes.

These questions enable practitioners to also assess the quality of implementation, which is critical to maximizing the program's intended benefits and demonstrating strategy effectiveness. Process evaluation also provides the information needed to make adjustments to strategy implementation to strengthen effectiveness.

Outcome/Effectiveness Evaluation

On an annual basis, we will measure the PHMP's impact by assessing progress in achieving outcome objectives. Each intervention has a specific measurable outcome that will enable us to assess the impact of our proposed strategy on Member health and well-being. Some interventions such as increasing annual well visits, prenatal visits, dental services, immunizations, flu shots, and seat belt use and decreasing Emergency Department visits for ambulatory sensitive conditions and can be measured objectively in the short and long-term. Other interventions that address general health and wellness such as reducing the incidence of smoking and obesity rates are long-term interventions. We are committed to working in the long term with our community partners such as departments of public health, religious institutions, schools, and other community organizations to address the social determinants of health in our community. With local partner organizations whose longevity in some cases exceeds 50 years, we have demonstrated the commitment to these communities and our intent to be part of the solution for the long-term. In fact, the most recent partner of NHP has been working in the community for 22 years.

Impact Evaluation

We commit to assessing program effectiveness and measuring achievement across the following components:

- To improve the health and well-being of Medicaid Members in Region 2

- To further enhance Member-centered team-based care
- To engage and empower Members
- To strengthen and support community partners, community partnerships and the Health Neighborhood
- To turn data into information and action by collecting and analyzing data that documents program impact per setting and sector across the RAE and in our communities

Results will be shared with the Department, communities and the public through formal reporting, success stories, the Member Advisory Council and Regional PIAC, trainings, and in community partnerships.

STAKEHOLDER INVOLVEMENT

To ensure the success of our population health management plan, all key stakeholders will be involved in the development and revisions of the final PHMP. This includes engaging Members and network providers. Members will be engaged through the Member Advisory Council that holds open, well publicized meetings that are accessible to all Members, through the Member, and through more informal conversations with network providers, Care Coordinators, and Member Services Representatives. Network providers and community stakeholders will be able to participate through the Regional Program Improvement Advisory Committee (Regional PIAC) and through our provider services staff.

NHP's approach as described in this response is oriented towards supporting Members and providers in building a person- and family-centered care system that is coordinated within a practice and has the tools to support providers. The Department and other statewide representatives will be involved through the statewide PIAC. We value input into our processes and will continually work to ensure that our systems are transparent and accessible.

STAFFING AND IMPLEMENTATION

The Population Health Management Department will be led by a Director, Population Health, Care Coordination and Innovation. That position will report to the Chief Clinical Officer. Together, they will develop, refine and execute the Population Health Management Plan and manage the stakeholder feedback loop to refine and enhance this Plan throughout the RAE contract.

Population Health Management Plan

NHP's Population Health Management Plan (PHMP) is included in two separate Attachments:

- **Attachment 6:** Population Health Management Plan - Adult
- **Attachment 7:** Population Health Management Plan - Pediatric

OFFEROR'S RESPONSE 16

Describe in detail how the Offeror will provide the required Care Coordination interventions to support the Offeror's Population Health Management Plan, including how the Offeror will:

a. Design, deliver and track Care Coordination activities across the full continuum of care
b. Align and collaborate with Care Coordinators from different systems to reduce duplication and Member confusion.
c. Outreach, intervene, and monitor Members who meet the criteria for inappropriate overutilization of health care services.

Northeast Health Partners, LLC (NHP) is committed to providing a person- and family-centric approach to Care Coordination including consideration of the preferences and goals of Members and their families and connecting them to the resources required to carry out needed care and follow-up. Central to the design and operation of our program is effective and efficient Member-focused Care Coordination and medical management. We take an integrated comprehensive approach to these key activities, involving not only PCMPs and Members, but the families of Members, specialty and ancillary providers, and community resources appropriate to each Member's needs. This reflects our philosophy that care should be coordinated, Members must have an active decision-making role in their health care, and primary care providers should receive the support and resources they need to treat Members in a holistic manner.

Since inception, Region 2 has experienced three models of Care Coordination – each with their own benefits and challenges. For the purpose of *Offeror's Response 16* we are referring to Care Coordination and Care Management synonymously.

In one model, the RCCO provides Care Coordination services for Members many of whom live in remote, sparsely populated regions that make onsite Care Management difficult. The RCCO also care manages unattributed lives throughout the region.

In another model, the RCCO has delegated Care Coordination functions to select PCMPs across the region through direct delegation agreements. Salud is an example of this model. Members attributed to Salud in the greater Frederick, Fort Lupton, Sterling, and Fort Morgan communities, received Care Coordination directly through Salud staff who are embedded in the integrated interdisciplinary team at all Salud sites.

The third model in our region has aligned Care Coordination services at the community level with staff provided through the North Colorado Health Alliance (The Alliance). In this model Care Managers are neutral to the site of care, but faithful to patients. Their overt goal is to care manage the patient wherever the patient receives care (i.e. the PCMP, mental health agency, hospital, ED, urgent care, specialist, diagnostic facility).

The model described below is based on the highly successful mixed model approach in place in Region 2. Building on the strength of the existing RCCO program, delegated provider partners and community partners will work collaboratively in an integrated care model, supplemented by a central Care Coordination team that supports the Member regardless of where their needs fall on the care continuum.

Integration with the Population Health Management Plan

Our Care Coordination program supports and is integrated with our Population Health Management Plan, and includes a range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being. In addition, Care Coordinators participate in behavioral/physical integrated health teams, coordinating health and

social needs in a manner that promotes Member empowerment, healthy lifestyle choices, and informed decision-making. We are committed to engaging Members to be active decision-makers in their health care. The Population Health Management Plan includes multiple approaches that are designed to engage Members regardless of their needs. This includes:

- Community-wide wellness programs coordinated with schools and Public Health Departments
- Accessible, culturally sensitive wellness and prevention communications available through multiple modalities:
    - From providers and at provider sites
    - Text messaging solutions
    - Member portal
    - Member Services staff
    - From Care Coordinators and care teams

Care Coordination and Care Management engages Members and provides information that enables Members to make the best health care decisions possible in conjunction with their PCMP and/or other providers. In addition, NHP will leverage the work being done by The Alliance and by County Health Departments through their needs assessment and development of high priority issues to address priority areas either within specific counties or region-wide. The Regional Program Improvement Advisory Committee (Regional PIAC) and Member Advisory Council will also identify health and wellness topics that are relevant to the local communities or the region in general.

Transparency and Accountability

We will develop a transparent system that is easy for all those involved to understand and participate in. Our Care Management staff will work with Members, families, providers, and others involved with a Member's care, to identify health care needs, as well as other services that may be required. They will also assist with care through transitional periods, which is critical to ensuring that care proceeds along a path that leads to a good health outcome. Care Management staff will pay particular attention to those with special needs, including identified cultural and/or linguistic needs. We will also engage diverse community resources to respond to the needs of Members, particularly those that may be presenting challenges or barriers to health care access.

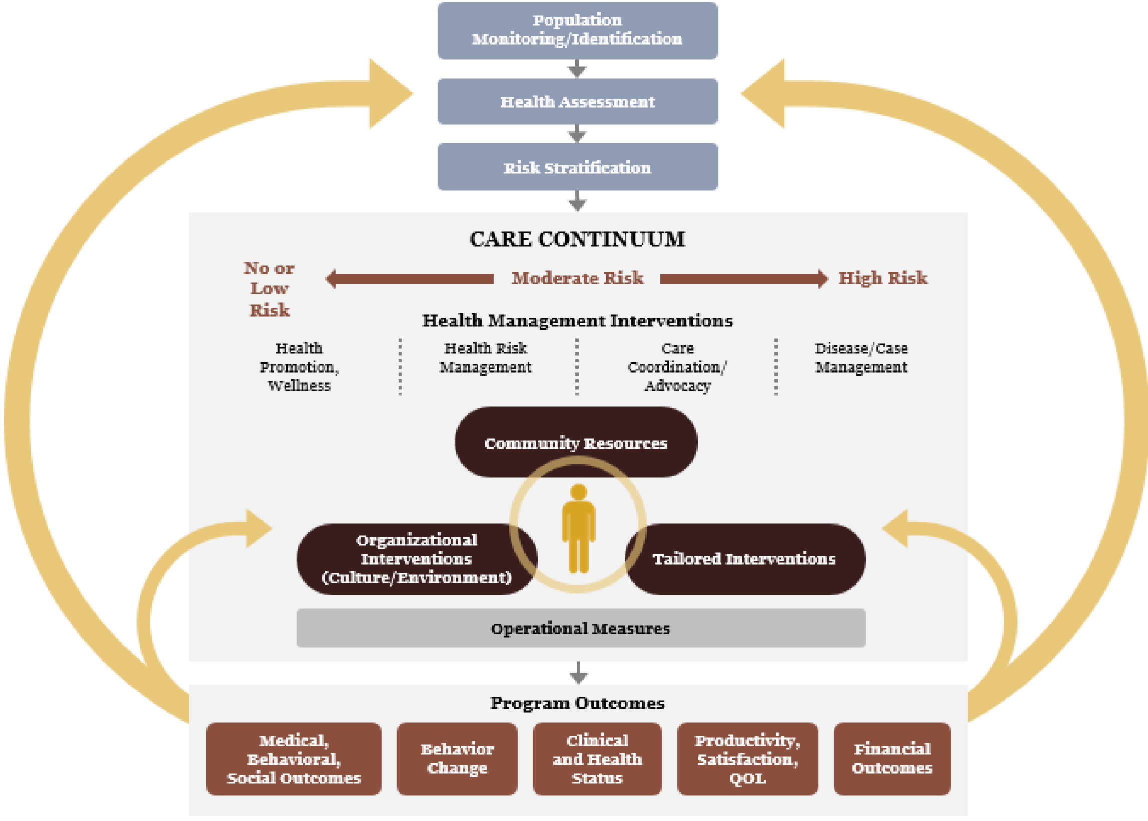
CARE COORDINATION

Region 2 has an established, successful Care Coordination/Care Management program already in place.

We are proud of the successes we have accomplished working over the last five years collaboratively with the RCCO. The delegated model established throughout much of our region has been in the forefront of building integrated care teams. Care Coordination is provided at the point of care whenever possible, and is fully coordinated within and between practices including other providers and organizations serving the Member. The delegated provider model is working effectively and is in place for over 60 percent of the Members in our region. However, in our smaller rural and frontier counties, this model is not economically feasible. For that reason, NHP will support Care Coordination utilizing all available resources, including telephonic outreach and on-site assessments, assuring that Care Coordination is available to all Members regardless of where they live in the community. Care Coordination across the system will be supported by the advanced technology tools provided by Beacon Health Options, our administrative contractor. Care Coordination information will be maintained for case tracking, monitoring, and evaluation reporting in Beacon CONNECTS. This will enable us to track patients across the system as well as to ensure accountability.

The following graphic represents the Care Coordination model that we will support as the RAE.

Conceptual PHM Framework



Source: Care Continuum Alliance, *Outcomes Guidelines* | *Report, Vol. 5,* 2010

As the RAE, we will support Care Coordination at the delegated sites and across the region. This includes leveraging the existing resources at Beacon and The Alliance to provide a Care Manager learning community.

We will identify and provide an environment to share Care Management best practices.

NHP will also offer training for providers, Care Coordinators, Care Managers, and anyone involved in supporting the Member through the Care Coordination process, and will support the one Central Regional Resource Directory (to be developed in conjunction with community partners such as United Way's 211 system). This resource directory will be available to Members, providers, and everyone involved in Care Coordination/Case Management.

Delegation Process

NHP will utilize a delegation process that is consistent with NCQA guidelines to assess compliance with program requirements and NHP policies.

During Year 1, NHP will contract for an objective, independent evaluation of delegated provider sites to:

- Determine overall effectiveness in meeting program requirements and objectives
- Identify strengths and weaknesses in program effectiveness

We will incorporate findings from evaluations and Department performance audits to assess individual delegated provider capabilities and guide program design, trainings, and delegation contracting.

We will re-contract with each delegated provider specifying the requirements under the RAE. We understand that while we may delegate Care Coordination functions, we are responsible for ensuring that the function is performed appropriately, and contracts with each delegated provider will include:

1. Required elements for compliance with accreditation entity, federal and state laws including maintenance of PHI and compliance with all Medicaid requirements
2. Responsibilities of the organization and the delegated entity
3. NHPs assessment process
4. Remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement

Annually, we will conduct a full delegation audit of each site to review responsibilities stated in the mutually agreed-upon delegation document compliant with Department and Medicaid regulations and requirements. We will leverage the audit and evaluation experience of our administrative agent, Beacon, to guide our process. Beacon has extensive experience conducting audits and evaluations of Care Coordination and Care Management under the auspices of the RCCO and BHO. NHP will utilize the established processes to conduct objective assessments of delegated Care Coordination providers on an annual basis (or sooner, if issues arise), and develop corrective action plans to address any identified issues.

NHP will conduct regular mandatory group meetings with delegated Care Managers to discuss issues and solutions for improving Care Coordination performance and more effectively implement solutions that result in improved health and outcomes for Members. We will leverage relationships and systems already in place and expand them to other practices to support peer-to-peer consultation and promote Care Coordination best practices. In addition, the CONNECTS system will include extensive community information and learning tools for Care Coordinators, patient navigators, peer counselors, PCPs, and all members on the care team.

Staffing

The Chief Clinical Officer will be responsible for Care Coordination strategic oversight and ensuring that the Care Coordination process, regardless of where it is located, meets requirements. NHP will manage training, communication, reporting and the multiple responsibilities of the positions. Care Coordinators and Case Managers will work to the extent possible in integrated teams in one of the three models referenced above. A centralized staff will be available to provide Care Coordination for those providers that do not have this capability.

High-intensity Care Management meetings are held regularly with Sunrise, North Range, The Alliance, and other PCMPs to best manage high-utilizers of all services (BH, PC, hospital, ED).

Through CONNECTS, Care Coordinators across the system will have electronic access to the Members' case files, identify cases for review, monitor implementation of the population health management plan, and address all components of the Care Coordination process including case identification, assessment, care plans, outreach, and community engagement. NHP will also be able to assist Care Coordinators at delegated sites bridge multiple delivery systems and state agencies. Similarly, NHP's team will intervene when the systems and providers engaged with a Member's complex care require leadership and direction. NHP understands and commits to providing Care

Coordination tools, processes, and methods to be available and used by network providers as described in this RFP.

The Chief Clinical Officer and NHP staff will meet on a regular basis with delegated entities and providers to review reports, progress toward meeting goals, the Population Health Management Plan and case outcomes. They will also meet regularly with the Department, participate in all related departmental and statewide meetings related to Care Coordination, special workgroups created by the Department or other state agencies to improve services and coordination of activities for populations served by multiple systems. They will be responsible for providing the interface between the Department and other statewide committees and local Care Coordinators, primary care providers and medical directors. They will communicate through a variety of mechanisms including the provider newsletter, the provider portal and direct face-to-face meetings held within the Region.

CARE COORDINATION PROCESS

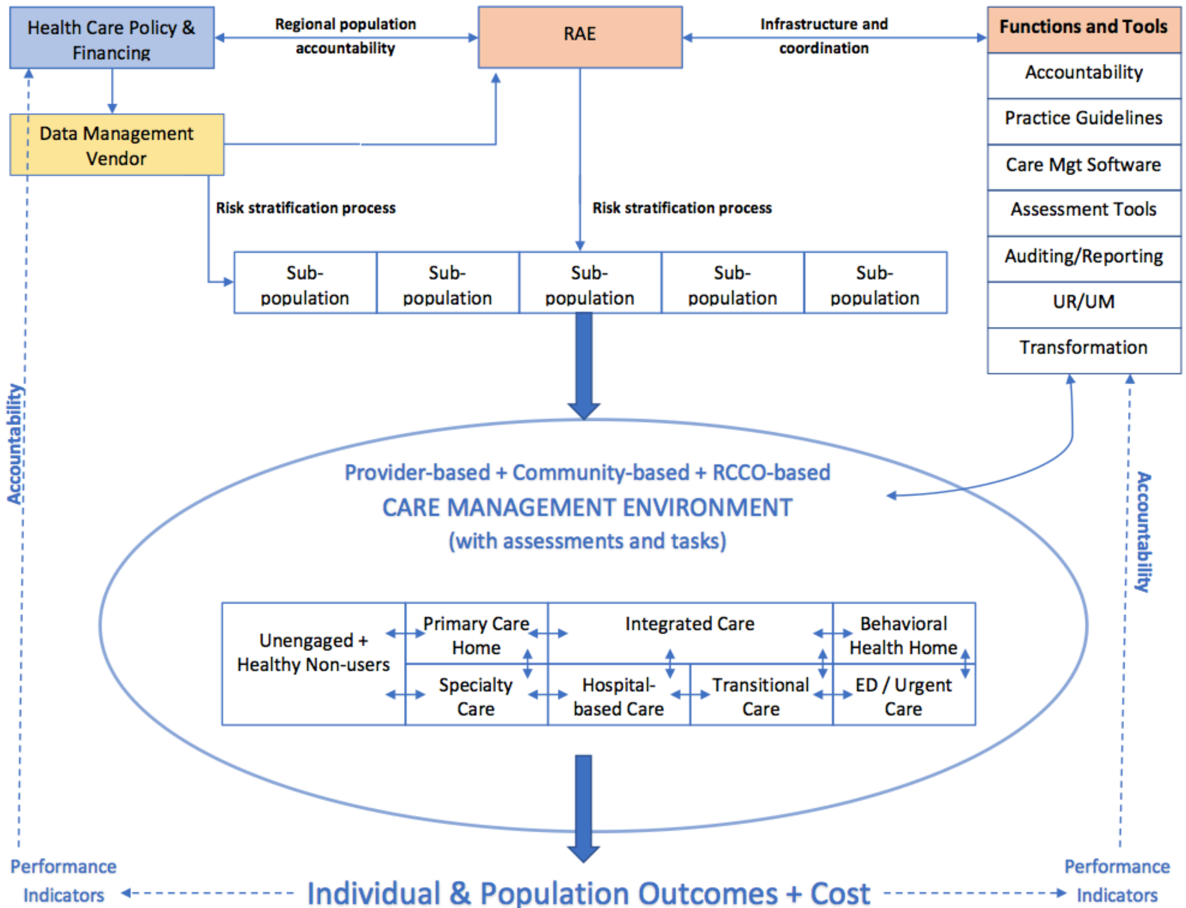
NHP will continue the successful Care Coordination approach that is currently in place in Region 2 that combines best practices of delegated community-based Care Coordination with a strong central resource for specialized services, transitions of care, program management, training and evaluation.

The Community Model of Care Coordination connects with the Member beyond traditional boundaries and helps the Member navigate between health care and community services.

Our Care Coordination program includes a range of activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being. The model includes community health workers, RN Care Coordinators and behavioral health specialists across the region. Care Coordination services include face-to-face assessment, coordination, and navigation activities with clients and families, (including in their homes and inpatient care locations), care planning with clinical care teams (physical, behavioral, and oral health), telephonic engagement of Members, inter-organizational care planning via community Hotspotters Meetings and non-medical determinant work as necessary to ensure transportation to needed health care services.

Our partners have a long history of working closely with all related programs in the Region, and Care Coordinators interface with other programs such as First Steps (prenatal), Healthy Communities, Health Care Program for Children with Special Needs, Nurse Home Visitor Program, Title X Family Planning, and substance use/addiction services to enhance the outcomes for Medicaid Members. As the RAE, we will continue these relationships and develop formal agreements to support the Care Coordination process.

Our Approach to Care Coordination



Our program is:

- ✓ **Accessible to all Members**
- ✓ **Provided at the point of care whenever possible through a model that integrates with care teams and includes PCPs throughout the process**
- ✓ **Data driven**
- ✓ **Addresses both short- and long-term health needs**
- ✓ **Culturally responsive**
- ✓ **Respects Member preferences and is designed using a person- and family-centric model**

Our Care Coordination model places the Member at the center of care in his/her Health Neighborhood. The model is neutral to the location of care or agency – e.g., we provide Care Coordination at whatever site is appropriate for the Member and the care team including PCMH, behavioral health setting, or other, such as long-term care. The model allows the Care Coordinator to connect with the Member beyond the traditional limiting boundaries created by alignment with a single provider organization.

SYSTEM APPROACH

To support the entire primary care community in Region 2, our provider partners made a commitment to implement a system-wide approach that incents PCMPs to offer Care Coordination at the site of care. At the same time, we will have the systems and staff in place to support Members who seek care from primary care providers with smaller Medicaid panels who do not have the resources to support in-house Care Coordination. All Members will have access to comprehensive, responsive Care Coordination. Through the RAE contract, all of these providers will have access through one data repository, in addition to Business Intelligence and Data Management (BIDM), to Care Coordination data on Members who might move across providers or across regions.

We intend to develop three types of PCMP provider contracts to align with the Department's payment reform goals and distribute rewards in harmony with provider performance and outcomes in Region 2. Depicted on the following page, this contracting model is distinguished between ***Contributing, Collaborative, and Accountable Providers***.

- **Contributing Providers** are fee-for-service Medicaid providers who will receive the support of NHP and will receive a supplemental payment to encourage and reward their participation in the Medicaid program. These providers contribute the overall Medicaid network, provide access in areas of the region that are underserved, and give our Members additional choice in where to seek care.

- **Collaborative Providers** are more advanced practices that will receive a larger Care Coordination payment from NHP to reward them for increased collaboration that will lead to better coordination across the entire Health Neighborhood and system of care for their Members.

- **Accountable Providers** are our most advanced Medicaid providers in the region. These providers not only serve Medicaid at scale, but they do so efficiently, and have a demonstrated track record of embracing integration and other innovations. The Accountable Providers take ownership for their attributed Members' Care Coordination and are focused on our core KPI metrics to drive increased quality of care, health of the local population, and clinical outcomes, while decreasing total cost of care.

NHP has designed a provider financial support methodology to support Member-centered Care Coordination offered at or close to the practice site. We believe our financial support plan will give providers adequate payment to support the Care Coordination and Care Management activities they provide. We have established a new model, illustrated in the following graphic, that classifies providers into groups based on their scope, scale, needs, and ability to influence the greater provider community in the region. NHP will drive accountability not only as the organizing body, but by engaging and empowering the highest volume and most influential providers to establish regional norms that align with the quality measures (KPIs) defined by the Department to steer regional performance. Providers will be incented to co-locate Care Coordinators in their practices and leverage the data, tools and actionable analytics available through NHP and the Department. NHP will fill any regional gaps and provide Care Coordination for those providers who are unable to manage PCMP functions internally, thereby ensuring Members of Region 2 have Care Coordination services available to meet their needs.

Value-Based Contracting Model

Contract Type	Scope of Service	Earning Potential	
Accountable	Attributed memberships drive a significant proportion of regional membership and Providers possess the greatest level of capability to impact the regional KPIs.	Maximum PMPM payment by the RAE.	Eligible for share of $4 PMPM bonus earnings.
Collaborative	Provides enhanced services and may be on a path to Alternative Payment Model with HCPF. Delegates Care Coordination and Population Health activities to the RAE.	Premium PMPM payment by the RAE.	
Contributing	Meets minimum Medicaid PMPM requirements & provides basic services. Small Medicaid panel size. Not enough volume to drive regional performance outcomes.	Meaningful payment by the RAE.	

CASE IDENTIFICATION

NHP will support a data driven, population-based strategy utilizing BIDM stratification, Beacon analytic capabilities, our PHMP, and input from providers and referral sources to identify Members for inclusion in Care Coordination. Our data capabilities enable us to accept electronic case identification from BIDM stratification, hospital ADT data, and information from the CONNECTS data system. This is a multi-modal approach that espouses “no wrong door.” Members will be assessed for Care Coordination if they meet one or more of the following criteria:

- Results of BIDM stratification identifying Members in the highest risk quadrant recognizing their significant behavioral health and physical health needs and also coordinating with the Population Health Management Plan
- Results of stratification for Members who may demonstrate high risk in either physical health or behavioral health, but not necessarily in both (coordinating with the PHMP)
- Enhanced predictive modeling through CONNECTS via our machine learning and natural language processing technology
- Cases that support Population Health Management Plan interventions requiring Care Coordination across the spectrum of services from wellness and prevention through high-risk Care Coordination
- Adults with two or more chronic conditions
- Members with multiple admissions, readmissions, Emergency Department visits
- Members with chronic behavioral or physical health conditions with Emergency Room visit, related inpatient admission, or medication adherence gaps
- Members in the Client Overutilization Program (COUP)
- Polypharmacy
- Referrals from the UM vendor including information on hospital admissions and the Department’s Nurse Advice Line calls
- Pregnant women who have presented late in their pregnancy, are high-risk, or have been identified as needing further support
- Transitions of Care identified through referrals from hospitals and Department ADT data, post-acute settings, CORHIO, criminal justice system, and other sources.

- Members who have been identified with difficulties accessing care across the spectrum (e.g., primary care, behavioral health care, specialists, dentists) due to transportation, child care, LTSS service needs, and other agency involvement
- At-risk Members whose status is identified through changes in the “wrong direction” through the stratification system or whose Health Risk Assessment suggests need for Care Coordination services
- Children with chronic conditions and included in high physical health risk or high behavioral health risk and/or enrolled through special aid categories
- Physician referral
- Self-referral

Providers also will have access to the Department’s Health Risk Assessments, BIDM stratification scores and other methods of assessing Members to enable them to identify Members in need. NHP will provide electronic case lists to Care Coordinators to identify cases and prioritize Members for Care Coordination services.

ASSESSMENT PROCESS

Care Coordination is designed to support the Member along the care pathway to improve coordination of care and ensure access to needed services. The first step in the process is a comprehensive person- and family-centered assessment. Care Coordinators across NHP will utilize a uniform set of assessment tools to determine appropriate Care Coordination services and develop a personalized whole-person care plan for each assessed Member.

Care Coordinators will be able to utilize the assessment tools within their EHR systems or directly into Beacon’s CONNECTS systems (if selected by the provider). Regardless of the method of data entry and collection, a uniform data set that supports reporting, supervision and auditing will be uploaded into CONNECTS to create one central database.

Members and family members are integral to the assessment process to engage them early in the process and consider Member and family preferences and goals. We can identify resources in a collaborative manner to connect them to the resources required to obtain needed health or social services or link to community resources. Core elements of the assessment include:

- Evaluation of the presenting medical and psychosocial/behavioral problems
- The Member’s readiness to change disease states, cognitive status, safety level, language requirements, transportation needs and other related factors, if applicable
- Medications, family support, psychosocial barriers, lifestyle factors, behavioral health needs, transitions of care, and prior medical history
- Cultural and linguistic family characteristics
- Sources of referral services and supports to identify needs and assure that the plan supports connections and communication with multiple agencies, health care partners and other agencies
- Desired outcomes from the Member and the family

Summary Assessment Process and Resources

Acuity Assessment/ Stratification	Health Care Benefit/ Resource Availability	Psychosocial Resources/ Barriers to Care
Behavioral Health Utilization: Inpatient and Emergency Room admits in the past 6 months	Health Status	Safety – Danger to self/others
CANS	Housing/Stable Living Arrangement	SF-12
Clinical History	Legal Issues	Social Support
Cultural/Linguistic Support	Medical Conditions/Health Status	Transportation Issues
Disabilities (Hearing, Vision, Mobility, Intellectual)	Medication Safety, Knowledge, Adherence, Reconciliation Need	Treatment Participation
Engagement	Mental Health/Substance Use	Opioid Risk
Financial Barriers	PHQ-9	
GAD-7	Presentation	

Our assessment process is based on state and nationally accepted assessment tools.

IMPLEMENTING THE CARE COORDINATION PROCESS

NHP Care Coordinators will develop individualized care plans for Members who are participating in Care Coordination/Care Management that include a proactive sequence of health care interventions and interaction. Care plans are individualized and reflect the needs, preferences, and are culturally sensitive of the Member. Informed or shared decision making—in which Members, families, and clinicians work together to balance scientific evidence and patient preferences to make optimal medical decisions with the Member—also can be an important part of a highly functional Health Neighborhood.

An elderly Member received a new and much needed mobility chair when a Care Manager worked with National Mobility, the provider, and Member Services to make the request, and facilitate the entire process until the patient received her mobility chair. It was the focused time and attention provided by the Care Manager that made all the difference.

To support Care Coordination with the Member's providers across medical, specialty or behavioral health practices, Care Coordinators conduct regular clinical team meetings with providers to review the progress of each Member and makes adjustments as needed to the plan of care. We have developed fully integrated practices and our team meetings promote communication by including physical health and behavioral health providers, as appropriate. PCMPs may sit in on these meetings with behavioral health specialists, Care Coordinators, and other members of the care team to participate fully in developing the person- and family-centered care plans including Care Coordination or Care Management. Within this context, Care Coordination plans address the Member's short and long-term health needs, Member and family goals, and reflects their cultural preferences.

Care Coordinators support the client where there is need, including but not limited to assisting with medical care, providing education and materials on wellness and prevention, coordinate with interventions in the Population Health Management Plan, family issues, transportation or educational needs, legal or financial issues, behavioral health counseling, clinical groups, medication management, and coordinate across agencies and programs.

The role of Care Coordinators is multi-faceted and can address a continuum of issues depending on the Member's requirements. Inclusive functions are applicable for all acuity levels. Specialized functions are applicable for Members who may have chronic conditions or demonstrate higher levels of acuity.

Inclusive Functions

- Population risk stratification
- Facilitate the coordination of care
- Follow up with transitions of care
- Review medication lists
- Encourage evidence-based practice for members
- Provide individual lifestyle coaching and wellness groups

Specialized Functions

- Identify gaps in care for patients with chronic illness
- Review and reconcile medication lists
- Outreach to current clients
- Screening/Assessments
- Follow-up with transitions of care
- Connection to Community Resources

Domain	Care Management Functions
Informed Choice	Supporting specific care plan goals, Power of Attorney, living will, palliative care, and hospice conversations
Function and Safety	Provide support for transportation, home safety, fall prevention, functional deficit, cognitive, and caregiver supports
Condition Management	Identify gaps in care, support self-management plan, identify red alerts, focus on pain management
Medication Management	Provide medication reconciliation, identify polypharmacy and side effects, identify barriers for medication adherence, conduct medication review
Prevention/Lifestyle	Education and support on issues such as nutrition, weight, smoking, screenings, immunizations, alcohol/drugs, depression screen, stress management education and support
Barriers	Identify cultural/language barriers, needs of community resources and social supports, needs for transportation, financial barriers, and environmental barriers
Transitions	Support transition planning, coordinate provider network involvement, identify optimal site and provider

Member Engagement

We are committed to Member engagement and ensuring transparency and communications across the system. Members and PCMPs have enhanced resources for Care Coordination and population management through empaneled Care Coordinators within or as close to the point of care as

possible and easily accessible technology support. This includes data registries, medication, text wellness updates, and visit alerts.

Role of the Member Services Team as a Help Desk and Onboarding

Our Member Services Representatives will be critical components in the Care Coordination team. Using our administrative agent, Beacon, we have a fully staffed unit of highly trained Member Services personnel who have worked with Medicaid and understand the needs of the Medicaid Member. They will have access to the **Centralized Registry of Community Resources for Region 2** that will be developed with our community partners within the Health Neighborhood and the broader social service community. The Member Services team has been providing first line service for many years and has hands-on experience working with the broad range of community resources across Colorado.

Member Services Representatives (our "Help Desk") have multiple opportunities to help Members and also to integrate with Care Coordination. Members may not know how to access a specific service or find a provider like a dentist or a pharmacy. Our Member Services team is trained and has experience in referring cases immediately to Care Coordination that require that level of service and communicating Member needs to the Care Coordinator completely and with a fully written case note.

From the Call Center

Our call center staff connected a Member with Low Energy Assistance Program (LEAP) for help paying her utility bill.

Our call center staff helped a Member find a dialysis treatment facility closer to home that significantly cut the time and cost of the transportation.

There are also cases in which the Member Services Coordinator is able to quickly resolve the issue by providing information to the Member on a requested community service (e.g., where is the nearest WIC office), identify their PCMP and help them make an appointment, identify the nearest Medicaid dentist or dental clinic. In this way, the Member Services Representative works as an integral component of the team supporting Members and improving access to the health system. All Member Services calls are monitored and tracked and supervisors are able to intervene at any time to obtain emergency services for a case that requires more immediate attention.

Sometimes, Medicaid Members are difficult to reach. Member Services staff will support this effort by making outbound Member welcome calls including verification/assignment of a PCMP or changing a PCMP. The team will provide education about the program, perform a brief assessment of immediate needs, identifying potential high risk Members and facilitating enrollment into Care Management for timely intervention. During a call with a Member, the onboarding staff member can accomplish a "warm transfer" to a Care Coordinator if necessary, to address an urgent issue. In addition, we will use our text messaging capabilities described in *Offeror's Response 15* to reach Members to support wellness and prevention education including information on how to access a PCMP, obtain a wellness visit, alternatives to Emergency Department use, advertise the Department's Nurse Line, inform Members of the availability of the state behavioral health Crisis Support Services, nutritional information and seasonal information such as flu shots, preventing spread of the flu, etc.

Transitions of Care

Because of our experience working with Members and their families through transitions of care and across social services, we understand the impact a transition can have on a Member's well-being. Moving from hospital-based care to home or post-acute settings may result in disruptions in the Member's pharmacy management that can result in readmissions. Members who have been

institutionalized or incarcerated need to have support within the health and social service systems as well as establishing Medicaid eligibility quickly to engage them into the community.

In addition, in Region 2, we face some specific challenges because of our rural and frontier characteristics and gaps in services. Members in our most rural and frontier communities do not have access to many specialty services. Members may have to travel a distance within Region 2, for example, to access Banner services, or leave the region altogether to receive specialty services from providers such as Banner, UC Health, North Suburban Medical Center, Children's Hospital Colorado, and Platte Valley Medical Center.

NHP will maintain a team of Transition Specialist Care Coordinators to support those Members and their PCP practices through transitions of care. Delegated provider practices with Care Coordination will be able to manage many types of transitions and will be encouraged to do so to maintain continuity. For specialized services and/or those practices in need of additional support, NHP will provide specially trained staff to address transitions.

We have excellent working relationships with all of the hospitals in our Region and contiguous regions. We will formalize these relationships as the RAE and also develop formal relationships with other RAEs, especially Regions 1, 3, and 5, to assure continuity of care for our Members who:

- Seek care in another RAE Region or
- Are attributed to another RAE but obtain care in Region 2

Our Region 2 Transitions Team will focus on active engagement with PCMPs and other providers during the transition process by sharing information about the hospitalization, the medication reconciliation process, and perceived gaps in the treatment plan that may create barriers to recovery. It will coordinate with the Member's Care Managers and support community recovery by providing or coordinating the following activities:

- Helping the Member or family access needed community resources via provider web portal, email, fax, or phone
- Managing non-hospital transitions through home visits by a nurse practitioner, who will assess and arrange to address the Members' medication, living skills, and behavioral needs
- Work with Members to coordinate care across RAE Regions

Health Promotion and Education

Care Coordinators support the client where there is need, including but not limited to assisting Members obtain medical care; providing education and materials on wellness and prevention; coordinating with interventions in the Population Health Management Plan to address family issues, social needs, educational needs; facilitating legal, financial, and behavioral health counseling as well as transportation, clinical groups, and medication management; and coordinating across agencies and programs. Care Coordinators are on the front-line with Members and families and have the opportunity to address general health and wellness issues in the context of care planning. This can include the importance of developing a relationship with a PCMP, following up on wellness appointments, flu shots, nutrition, and opportunities for encouraging physical activity.

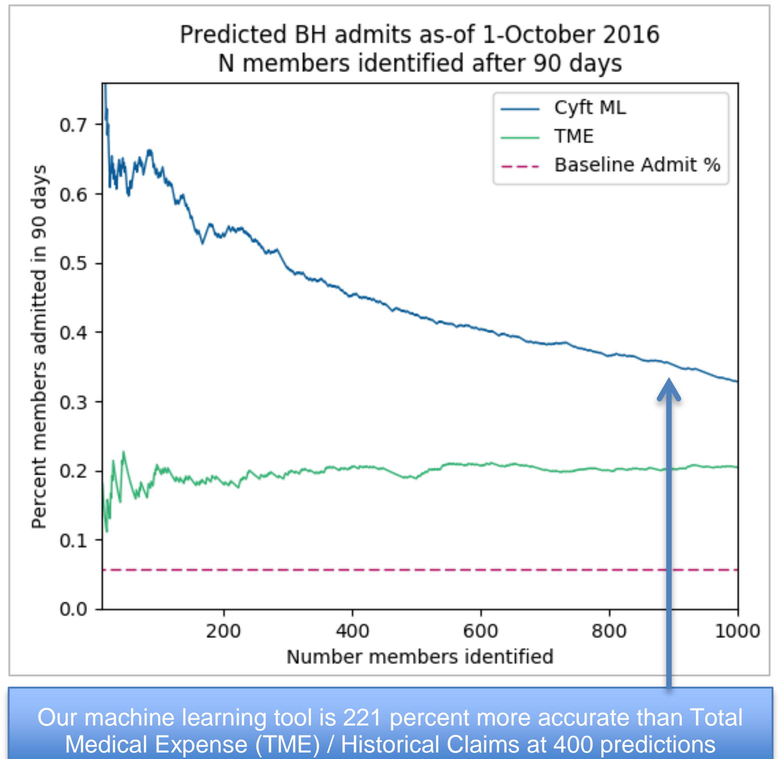
NHP will also maximize the use of technology and other information mechanisms to reinforce messages on health, wellness, and prevention. This will include working with providers to have current information on community wellness activities as well as information on maintaining good health—from nutrition and physical activity to signs of a heart attack and oral health care. We will include information on the Member Portal, our individual provider websites, Facebook, and community sites. We will coordinate health promotion and education with our flexible Texting

platform that lets us stay in touch with Members about flu shots, health fairs, nutrition, and many other related wellness initiatives.

Emergency Department Utilization

For some Members, especially those without a strong PCMP relationship, the Emergency Department becomes the de facto health provider. Other Members may use the Emergency Department to obtain medications. Hospital discharge can lead to inappropriate ED utilization if the Member does not understand discharge instructions or cannot implement them.

The unification of physical and behavioral health data, shared at the Region 2 level, creates windows of opportunity for NHP to have a timely impact on our Member's care before they are at risk of being admitted into higher (and costlier) levels of care. NHP will use its exemplary data management systems to take advantage of these opportunities to improve care and reduce costs. Our machine learning tool, for example, has been used in other markets to predict inpatient admissions with an accuracy that is 221 percent better than tools that rely on Total Medical Expense or historical claims.



Our machine learning tool is 221 percent more accurate than Total Medical Expense (TME) / Historical Claims at 400 predictions

NHP will conduct ongoing analyses to determine when Members are overusing health resources, are hospitalized using the Emergency Department for inappropriate or non-emergent purposes, or are ready for a transition of care. Care Managers can then intervene with the Member to address overuse, educate Members about appropriate use of the Emergency Department, or help Members implement their hospital discharge plan. NHP also will work with long-term care facilities to proactively address health and behavioral health issues. In this way, NHP can help ensure Emergency Department use by those residents is appropriate.

Aligning and Collaborating with Care Coordinators from Different Systems

NHP Members can be involved with multiple service agencies (for example, the criminal justice system, LTSS, programs for individuals with developmental disability, and youth and family services). It is easy for Members to become confused about whom to turn to for help, and it is easy for agencies to assume someone else is conducting Care Management activities or to provide duplicative services. NHP will work closely with our Members and other Care Coordination and Case Management entities to develop a Care Coordination plan that makes sense for the Member and is integrated with all services and systems involved in their care. We are committed to reducing duplication and promoting continuity by collaborating with the Member and the full Member's care team including sister agencies to identify a lead Coordinator for Members receiving Care Coordination from multiple systems. The relationships and pathways of communication exist and do

not have to be created with County Departments of Human Service, Managed Service Organizations, Area Agencies on Aging, local law enforcement and other organizations serving the needs of Members. We will maintain and enhance these relationships as we move into the RAE contract to promote physical and behavioral well-being for all of our Members.

For cases in which there are multiple agencies involved and potentially multiple Care Coordinators, we will designate a staff person to serve as NHP's single point of contact with the different systems and settings. Staff persons, whether at delegated providers or internal to NHP, are all provided extensive training including the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population.

When another agency is designated as the lead agency, we will work with them throughout the process to assure access to health services and coordinate activities. We also remain in contact with Members to make sure their health needs are being met and identify ways in which we can support them in the context of a multi-agency team approach. We ensure that the care plan identifies the lead organization, defines services, roles and responsibilities of each Care Manager, and then ensure the Member understands the roles and responsibilities of each Care Manager. As noted, we are already embedded in the community and have MOUs with a number of agencies to define roles and reduce duplication of services.

Tying it all together: Integrating traditional and innovative medical management strategies with broader Care Coordination activities

To ensure that all Members receive the level of Care Coordination they need, our plan for Region 2 includes the innovations described above, which build on and integrate traditional medical management activities such as utilization management and high-risk Case Management. We believe that this combination of strategies will not only improve Members' quality of care, but also realize efficiencies in the ways this care is delivered. Our innovative programs, such as on-boarding and transitions of care, add to clinical effectiveness by ensuring that Members needs and preferences are central to everything we do, care is appropriate and administrative "hassles" are minimized.

MONITORING, EVALUATION AND CARE COORDINATION ACTIVITY REPORT

Documentation

The care plan is fully documented in either the provider's EHR or into CONNECTS, depending on the provider's preference. In either case, information to support reporting, monitoring, auditing, and evaluation will be uploaded into CONNECTS so that NHP has a Care Coordination activity record for all services performed in the Region under the oversight of the RAE. Consistent data sharing, reporting, transparency, and integrations will be a key to our success in managing Accountable and Collaborative providers and their Care Coordination activities against our expectations. This tracking will enable us to measure effectiveness against the key performance indicators and refine our programs to achieve incremental successes throughout the term of the RAE program.

The CONNECTS platform supports documentation of assessment, care planning, outreach, face-to-face encounters and referrals, and communication by each user as well as providing the underpinning for a continuous performance improvement process.

Addressing the fourth component of the Quadruple Aim—improving provider experience—CONNECTS provides state-of-the-art transaction capabilities for network providers. The user-friendly provider web portal, ProviderConnect, along with the support and educational tools we offer, ensures optimal use of online systems, resulting in increased use of web-based technology, a decrease in administrative burden for providers, and enhances our ability to monitor performance.

Beacon's Care Management platform within CONNECTS provides a dedicated place for clinicians and Care Coordinators to document and manage care plans in an efficient, standardized, and comprehensive manner. This module accommodates multiple levels of treatment plans, including intensive Case Management and integrated Care Management, while achieving the following objectives:

- Streamlining workflows and incorporates efficiencies, producing sequential and cohesive documentation in line with the program
- Incorporating industry best practices, meeting contract and market expectations for intensive Case Management and integrated Care Coordination programs
- Including a case stratification process to inform resource allocation
- Supporting Care Coordination functions from assessments, care planning, coordination between providers/specialists, transitions of care, outreach, reporting
- Supporting outcome and operation management reporting

NHP's partnership model allows data management systems to be compared, contrasted, and leveraged to the advantage of the partnership. Each partner has their own expertise, experience, and sophistication. By sharing these, NHP is able to normalize the quality and consistency of the data that is used in reporting to the state.

Protecting Member Confidentiality

NHP is committed to protecting each Member's right to privacy and ensuring HIPAA requirements are enforced. All coordination of care is performed only with the Member's consent and a current release of information to the Medical Home, to the behavioral health provider, or to other providers.

Consent procedures have been streamlined and woven into the workflows to reduce administrative burdens as much as possible. NHP's robust grievance procedure will enable us to identify any weaknesses in our safeguarding process and opportunities to better inform Members regarding confidentiality and information sharing among Care Coordinators and providers.

NHP partners have already established Organized Health Care Arrangements (OHCA) with a variety of sister agencies (e.g., Department of Human Services) and other providers that serve the same patients throughout Region 2. An OHCA is an arrangement of covered providers that enables separate health entities to legally participate in joint activities to support the delivery and management of high quality, cost-effective care and processes such as Care Coordination. Associated with these arrangements, they also have established processes for Joint Privacy Statements that informs the Member of these clinical relationships and uses of HIPAA protected information for medical services.

Outcomes

Our evaluation framework is designed to measure our success at meeting program goals, to ensure that NHP's Care Coordination program:

- Meets the needs of all Members in the Region, as defined above
- Is compliant with state and federal regulations and program requirements
- Supports and enhances the implementation of our Population Health Management Plan
- Reduces duplication
- Supports the establishment connectivity of the Health Neighborhood
- Further enhances the provider's ability to meet the Department's stated KPIs

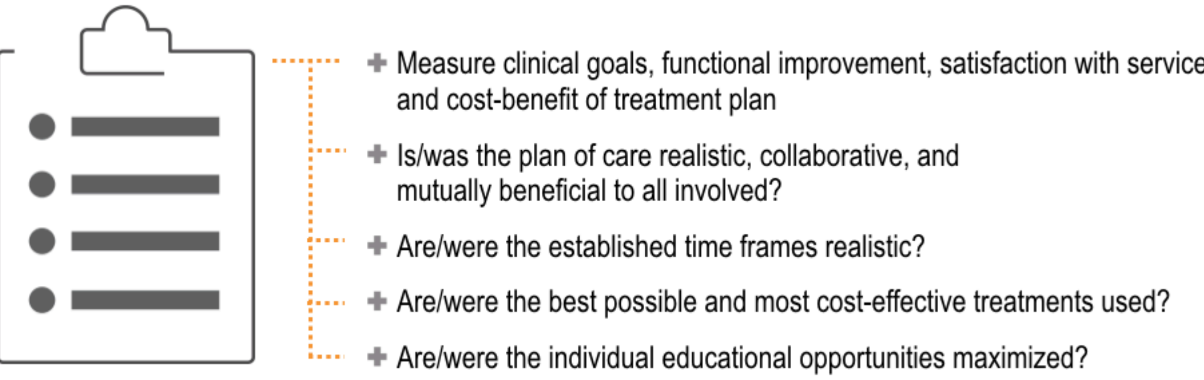
We have built effective systems that meet program requirements and deliver meaningful Care Coordination in the Region.

In a review of Care Coordination records from 2015-16, Region 2 partners scored 100 percent in overall compliance with Care Coordination requirements.

Quality Improvement

At the administrative level and at the partner level, our quality improvement system is based on a continuous performance improvement model. We have developed and will continue to support a robust evaluation process at the provider level, working with Care Coordinators and supervisors to regularly assess the effectiveness of Care Coordination plans for individual Members. As part of our commitment to Continuous Quality Improvement, case assessments are regularly scheduled and focus on the following:

Components of Case Assessments



NHP is also engaged in Continuous Quality Improvement that:

- Collects and analyzes quantitative data measuring outcomes
- Collects and analyzes qualitative data including (CAHPS) surveys of Members, family members, community partners, and providers to assess satisfaction with program elements and implementation
- Based on data outcomes, addresses clinical programming processes
- Provides training, new programs, and corrective actions to address findings
- Establishes alliances with community partners, including aligning transition support services to fill gaps
- Collaborates with families, providers, the Department, other state agencies and community agencies to improve systems of care

Quality improvement is more than using data to improve current practice. NHP partners are well-known innovators and early adopters. NHP will stay current in emerging best practices to determine if and how new initiatives or pilots should be tested. Further, NHP's Quality Director will participate in all State and Department meetings to stay up to date on the latest State and Federal initiatives so we can coordinate with practices, Care Coordinators, stakeholders and other agencies and implement improvement projects for the Region 2 Members.

Care Coordination Program Oversight and Management

The Quality Improvement Director at NHP will be responsible for providing ongoing training, advisories, and support to Care Coordinator supervisors across the region. He or she will provide ongoing updates from state-level meetings about initiatives to help us keep Care Coordinators advised about working with multiple delivery systems and state agencies.

Further, the CONNECTS system is an electronic interface that enables NHP to communicate with providers, medical directors, Care Coordinators and other team members across the Region. Through this mechanism, we can add new policies and procedures, memos, information about community resources or programs, and any necessary material to support the system.

In addition, NHP will provide regular training as described above, meetings on community programming, update staff on state policies and initiatives, and review the results of the population health management plan and reporting and evaluations. NHP will develop and provide all staff procedure manuals and other guidance materials in order to ensure a common understanding of terms, procedures, and policies.

The Medical Management Committee will address system-level barriers to effective Care Coordination. Furthermore, demographic analyses of the community within the identified service areas will be conducted to assess how cultural, geographic, and economic factors impact Members' health care utilization and overall health.

Dashboards

An added benefit for the Department, NHP's providers, and other qualified stakeholders is access to Beacon's real-time, online dashboard reporting. The secure, password-protected online portal enables access to our web-based reporting and analytics in real-time from a desktop.

The Department and other dashboard users will be able to create personalized dashboards and conduct a variety of analyses across a full range of inpatient and outpatient utilization features, including data regarding Member enrollment, Care Coordination, encounters, and authorizations. Drill downs on individual sub-group and clinical trends—including division, level of care, and diagnosis—will also be available to users. Using dashboards, the Department can monitor key metrics on a regular basis. Our evaluation and outcome measurement are supported by the BIDM system, State audit findings, as well as Beacon's CONNECTS platform.

As described within our response to *Offerors Response 7*, NHP operates all of our functions using a wholly-owned and operated technology infrastructure provided by Beacon. The CONNECTS system, which has been in place to provide both RCCO and BHO functions in Colorado, is owned by Beacon and is updated on a regular basis. Graphically depicted on the following page, CONNECTS is specifically designed to meet the Department's data management and reporting requirements.

NHP Health Analytics

From initial eligibility through Care Management, claims administration, and reporting, all of our applications reside on one common platform. It is designed to guide daily clinical decision-making and support utilization of treating providers, facilities, and clinical staff. This integrated computing environment has significantly enhanced our ability to improve the coordination of care and service delivery for the Members we serve. It also has allowed us to customize our system to support the varying requirements of our partnerships across the nation.

CARE COORDINATION ACTIVITY REPORT AND MONITORING

NHP understands our reporting responsibilities and takes them seriously. Our administrative agent, Beacon, has well-established resources in Colorado and has been producing reports for multiple BHOs and a RCCO for many years. They will bring this seasoned team to support NHPs reporting requirements. We commit to fulfilling each of the specified RFP reporting requirements and attest that we will have trained, dedicated staff to meet each of the reporting requirements. These reports are also critical to our internal management and quality improvement processes. These required reports will be reviewed and monitored on a regular basis by the Clinical Director and Quality Director.

We will provide reports that meet the Department's timelines and requirements listed in *Section 5.9.4.1 through 5.9.4.1.5*. Through Beacon, we will create a **Care Coordination Activity Report** in a format agreed to by the Department and NHP and will meet the prescribed submission dates. The report will include Care Coordination activities performed by network providers and subcontractors. The Care Coordination Activity report will include narrative descriptions of how NHP and our network providers provided Care Coordination for enrolled Members, including basic, one-time activities and long-term interventions. These descriptions will demonstrate how network providers are using team-based care approaches to deliver Care Coordination, activities we have undertaken with its Network

Providers to increase and improve Care Coordination at the point of care, and examples of Care Coordination activities performed during the previous quarter.
***The report will contain, at a minimum, narrative and statistics that include the number of unique Members for whom Care Coordination was provided by NHP and PCMPs during the reporting period by the following categories*:**

- Transitions of Members from one RAE to another RAE when Members are actively engaged in Care Coordination and/or receiving covered services through the Capitated Behavioral Health Benefit
- Transitions of Members from institutional settings to community-based services
- Transitions of Members from inpatient hospital stays to the community
- Medicaid-eligible Members transitioning out of the criminal justice system
- Children involved with Child Welfare

Finally, NHP will work with the Department to provide other information requested during our contract.

OFFEROR'S RESPONSE 17

Describe in detail how the Offeror will support Network Providers in accordance with the requirements in Section 5.10, including descriptions of the types of payment arrangements the Offeror will make available to PCMPs and Health Neighborhood providers to support achievement of the Accountable Care Collaborative goals.

Northeast Health Partners, LLC (NHP) will serve as the central point of contact for network providers regarding Health First Colorado services and programs, regional resources, clinical tools, and general administrative information. Our Regional Accountable Entity (RAE) network support strategy provides a comprehensive suite of tools, services, and opportunities for communication and education for providers, all of which will adhere to Health First Colorado's brand standards.

Our strategy is mindful of the different types and specialties of providers, as well as transformational needs, as we assist providers move along the integration continuum, particularly in rural and frontier counties. As such, we will provide needed support for providers that are interested in integrating primary care and behavioral health services. NHP staff will continue to enhance the delivery of team-based care, as our staff has done for the last 20 years in the counties of Region 2, by leveraging our staff and by incorporating Member navigators, peers, promoters, and other lay health workers into our network strategy. Our network management strategy is underscored by state-of-the-art health technologies that are designed to advance the providers' business practices while maintaining our focus on improving Members' health and experience of care.

As we discuss in detail throughout our response to this section, our network support strategy will be documented in our practice support plan, which will be submitted to the Department of Health Care Policy and Financing (the Department) within 30 days of the effective date, for review and approval. This plan will outline the:

- Types of information and administrative support, provider trainings, and data and technology support that NHP makes available to network providers
- Practice transformation strategies we offer to help practices progress along the integrated care continuum via the State Innovation Model (SIM) framework for integrated, whole-person care
- Administrative payment strategies NHP will use to financially support providers

This practice support plan will be updated annually and submitted to the Department by July 31 of each year by NHP's Program Officer on behalf of the Director of Provider Relations or their designee. Our Director of Provider Relations will also serve as the liaison between the Department and our partners, network providers, and subcontractors to ensure that all provider support is coordinated, does not duplicate existing service, and keeps the Department informed of our support activities.

GENERAL INFORMATION AND ADMINISTRATIVE SUPPORT

In addition to the Provider Relations Director, NHP will use a team approach to manage activities for network provider support within the Region. We will empower providers to use self-service tools and connect directly to the appropriate departments for assistance on Member-specific cases by offering contacts for key services, such as Medicaid Member attribution, authorizations, a list of contract responsibilities, quality audit descriptions, or care coordination services. In the event of service issues, or if the provider encounters challenges in achieving a resolution or a trend arises, our provider relations representatives will be available to serve as liaison between the provider and the applicable NHP department for a timely and comprehensive resolution of any issues that the provider was unable to resolve using self-service tools. Our practice support plan will reflect how we intend to communicate to network providers to link them to any existing resources and communication materials for the following topics:

- General information about Medicaid, the Accountable Care Collaborative (ACC) Program, and NHP's role and purpose as the RAE
- The Department's process for handling appeals of physical health adverse determinations
- Our process for handling appeals of behavioral health adverse determinations
- Available Member resources, including the Member provider directory that will be available 24/7 via our website and hardcopy on request
- Clinical resources, including, but not limited to screening tools, clinical guidelines, practice improvement activities, templates, trainings, and other resources
- Community-based resources, such as child care, food assistance, elder support, housing and utility assistance, and other non-medical supports
- Our Population Health Plan
- Our Social Determinants of Health Plan
- Quality Corner – Updates and reminder on quality and performance projects

Our provider support call center, which is currently open from 8:00 a.m. to 5:00 p.m. during regular business days, is staffed by representatives who understand and have been a part of the transformation of the Health First Colorado Medicaid program that has taken place over the last 20 years. Our staff, which are the same staff that have supported providers in the Regional Care Collaborative Organization (RCCO) Region 2, are fully trained to answer questions or requests for administrative and technical support from physical, behavioral, and oral health providers. Additionally, representatives have access to subject matter experts at key departments who they can consult with regarding specific, in-depth questions and provide a response in a timely and comprehensive manner. As the RAE, we will ensure that network providers are aware of, and have access to a wide array of informational services and supports as the Community Behavioral Health Services Program, Primary Care Case Management, and Long Term Services and Supports (LTSS) programs are transitioned to the RAE.

Our provider support services are tailored to the needs of the entire network, including the essential community providers (i.e., Federally Qualified Health Plans [FQHCs], Community Mental Health Centers [CMHCs], rural health clinics) and individual practitioners. We will ensure that any information gaps that exist are identified, researched, and tracked so that the provider can be linked to the existing resource or so that training can be developed. By tracking each identified gap, we will be able to determine the training needs of the network while not duplicating existing materials or services.

NHP's general information and administrative support communication tools include, but are not limited to:

- Provider newsletters, handbook, and email alerts
- Automated texting system for providers who subscribe
- An informational website that includes screening tools, clinical guidelines, proactive improvement activities, templates, Member educational materials, and trainings
- Achieve Solutions, our award-winning, online library of health and wellness information
- Health First Colorado Medicaid information
- Annual trainings
- Informational training on roles and responsibilities
- Medicaid updates
- Live WebEx trainings on technical applications, which are available in printed form when needed
- Recorded WebEx trainings posted to website
- Training in the BIDM system and data access portals

Provider relations representatives will communicate with providers and office staff regularly and will ensure providers are adhering to program requirements. Staff will also provide any necessary information, training, or other feedback as part of their outreach. Provider support staff will be responsible for the initial recruiting in their territory of the region, but also ongoing recruiting to fill gaps that develop in their area, education and trainings, and managing provider inquiries that are routed from the call center. The teams will use traditional methods of network management, but also introduce new ideas to maximize efficiency, including:

- **Point of Contact:** Provider relations staff will begin by requesting each provider office designate a representative as a liaison. The liaison will be the point person for each office and will handle all program-related activities with our Provider Relations Department. This method will minimize miscommunication and increase overall efficiency.

- **Practice Assessments:** Provider relations staff will conduct periodic assessments of the physical and behavioral health provider offices to identify training needs or additional supports based on the level of care and services they provide. We will use Beacon's proprietary Network Assessment and Action Communication (NAAC) Tool to document the assessment results and provider transformation plan, as well as communicate between the interdisciplinary team. Using this proprietary tool, our provider relations staff may submit and track providers or practice staff referrals to subject matter experts to conduct tailored training, technical support, or implementation. The NAAC tool will also track the outcome of conducted interventions and progress of the provider transformation plan.

- **Provider Service Line:** NHP's Provider Relations Department will manage provider calls coming into the toll-free number. Staff is available from 8:00 a.m. through 5:00 p.m., Monday thru Friday, except on observed holidays. Trained staff is able to assist with general questions, offer guidance on how to access the suite of clinical and operational tools and systems (e.g., BIDM, CCAR, MMIS, ProviderConnect, NHP website) that promote quality care. Staff will have access to the CONNECTS system, our fully integrated care manage system, which will enable them to address inquiries related to Medicaid provider enrollment, eligibility, obtain a list of attributed Members, authorization and referrals, Member assignments, and questions related to Medicaid benefits such as EPSDT. They will have contacts and resources at the Department, developed by NHP, to assist providers with questions or concerns, as appropriate.

  In addition, representatives will spend much of their time in the field meeting with providers. A representative can be dispatched to conduct in-person, personalized provider support for complex provider needs.

- **In-Person Connection:** Staff will use continuous contact with provider offices to build strong relationships to maximize communication and efficiency. This, in turn, should help reduce the number of providers terminating from the network while also providing increased dialogue to encourage providers to remain in network. Staff will also be equipped with laptops and smartphones to access the system remotely so they have real time access to provider information and communication while in the field. This process will also alleviate the need for duplicative field and office staff; however, the office will continue to have support staff to manage administrative tasks. Effectively, our provider relations representative will be an "office on wheels," able to meet provider and program service goals in real time, with strong customer orientation.

- **Network Assessment and Action Communication (NAAC) Tool:** The NAAC tool is Beacon's proprietary electronic tool that will be used to ensure communication between the interdisciplinary team. The NAAC tool allows individuals and departments to document and share key interactions with providers, track transformation assessments, and view completed

activities such as visits or trainings. It allows for support of previous and ongoing practice activities in a coordinated manner between staff and the provider. Provider relations staff will be able to pull information when speaking with a provider and be aware of transformation activities that are occurring throughout the Region across the various departments that assist in the practice transformation efforts. They will be able to use the tool to reinforce information delivered, provide additional support or request additional interventions to assist provider in their practice transformation.

- **Communication Tools:** Staff will have a variety of communication tools at their disposal to facilitate relationship building and interaction with providers. Provider relations staff will use well-established methods such as the website, provider manual, and newsletters to inform providers of Medicaid program information, their roles and responsibilities, available resources, and communication materials available through NHP and state and federal resources. We have established a marketing policy to ensure all provider communications meet Health First Colorado's standards.

  Our staff also has the capacity to send network providers email communications when there is actionable information that benefits their practice from NHP, the Department, or CMS, such as system disruptions or updates, operational process changes, and upcoming trainings.

When a provider is new, transitioning, or had key staff turnover, our provider support team works with them in person, on the phone, or online via WebEx. Once a provider is contracted and credentialed, we initially focus on annual trainings, resolving any communication barriers, and communicating the availability of ongoing supports. Information on initial trainings and the availability of materials will be communicated to all network providers to ensure that providers are aware, at a minimum, of the following Colorado Medicaid program information:

- Eligibility and covered benefits
- State Plan services, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Home- and community-based waiver services
- Capitated behavioral health benefit
- Claims and billing procedures

Our initial training will also ensure that all network providers are well informed of the Department's key contractors, their roles and responsibilities, including:

- Business intelligence and data management
- Enrollment broker
- Utilization management
- Non-emergent medical transportation administrators
- Case management agencies
- Single entry points
- Colorado Medicaid's fiscal agent
- Pharmacy Benefit Management (PBM) system
- Oral health contractor
- Healthy communities
- Community center boards
- Nurse advice line
- Colorado Crisis Services (CSS)

In addition to the above training, NHP will outreach to and educate specialty and other Medicaid providers regarding the ACC Program, its structure, NHP's role as the RAE, and the support we will offer. Our provider support staff will assist providers in resolving barriers and other issues that may arise while navigating the Health First Colorado system, including, but not limited to Medicaid provider enrollment, eligibility and coverage policies, services authorization and referrals, Member and primary care medical provider (PCMP) attribution, and EPDST benefits.

The team system will allocate a manageable number of providers for each team and allow for an effective flow of information between the RAE and network providers. This will also allow our staff to work with network providers not in Region 2 who need assistance and to determine which Members are attributed to their practice.

Strategic Partnership with Network Providers

Network providers identified as strategic providers will work directly with a Provider Relations Manager. They may be identified as strategic providers due to their membership volume, impact to quality metrics for the region, unique specialty or geographic service location, and/or participation in innovative or pilot programs. The Provider Relations Manager's focus is on building highly collaborative relationships with providers to drive provider performance improvement year-over-year through education and data. They serve as primary point of contact for assigned strategic providers who may need help working with NHP, including receiving inbound questions from the provider and filtering those questions to proper internal departments as appropriate. Additionally, the Provider Relations Manager will collaborate with the Quality Department to monitor and interpret provider utilization data, oversee data analysis, develop provider profiles to understand root cause of outlier utilization, and engage providers to discuss and help remedy outlier utilization. The Provider Relations Manager will communicate these clinical issues to NHP's clinical teams and participate in addressing concerns.

Our Provider Relations Manager will have a range of expertise, available tools, and access to other subject matter experts to support network providers to enhance the delivery of care. The partnership between the Provider Relations Manager and network providers allows this dedicated team to consult with the providers over the life of the contract. Each team will contact their assigned provider offices regularly to obtain demographic updates, determine if any problems exist, assess any training needs, and share any relevant information or data such as the number of Members each provider has on their active roster. Should any needs be identified, our Provider Relations Manager will provide the necessary training or refer the provider to an expert through the NAAC tool.

Administrative Support for Clinical Management

As the RAE, NHP uses and recommends to our network providers several medical management, clinical, and operational tools that are designed to ensure optimal health outcomes and control costs for Members. Our suite of tools, resources, and evidence-based practices offer a continuum of support for providers, specialists, and ancillary Medicaid providers. Through our comprehensive training program, we will ensure providers are aware of evidence-based practices to use while treating Members. We will promote fidelity to those evidence-based practices to ensure that services provided are effective, in both health outcomes and cost.

For those evidence-based practices identified as our "core" evidence-based practices, annual fidelity reviews will be conducted to determine whether the program is being implemented as designed. For programs that have fidelity scales readily available, we will use those measures. If fidelity tools are not readily available, we will develop a Problem/Fidelity Custom Assessment that will delineate each program's core components. We will also use the Colorado Client Assessment Record (CCAR) measures to promote fidelity.

Implementing evidence-based practices with full fidelity in rural areas can be problematic due to limitations in personnel, vast geographic areas, and resource shortages. According to the Western Interstate Commission for Higher Education – Mental Health Program, several approaches can help either improve the quality of care offered or demonstrate scientifically that an innovative treatment approach developed in rural regions can be successful. These approaches include:

- Applying to rural programs “core components” of existing evidence-based practices that show the most clinical effectiveness
- Developing hybrid models that comprise core components of multiple existing evidence-based practices as appropriate to a given rural setting, its resources, and the relationships among various physical and behavioral health care providers (or other community agencies) that exist and
- Identifying rural-specific promising approaches that can be developed into evidence-based practices

Through our partners’ extensive experience in northeast Colorado, our staff has assisted providers to adapt existing evidence-based practices into practical applications using these approaches wherever full fidelity has not been feasible. If a program is adapted for specific needs, a fidelity review will be conducted to ensure maintenance of the core components to ensure success.

PROVIDER TRAINING

NHP will establish self-service tools and multiple interactive training platforms to enhance communication with the provider offices. This will allow providers to select a modality that best fits their practice and ensure all providers receive an appropriate level of training. This approach will especially benefit smaller practices or those located in rural and frontier areas, which may not be able to travel or leave their offices to complete training. We describe each modality in detail in the following paragraphs.

Webinars

Our Administrative Service Organization (ASO) Beacon’s Provider Relations staff will continue to use webinars to educate network providers on Health First Colorado program information and inform them of their roles and responsibilities as part of the network. A webinar can be taped and a separate podcast may be recorded and placed on the NHP website. These training videos can then be used by providers as self-service training modules or shared with staff new to the practice. The added benefit is that anyone in their practice can take the trainings on their own schedule and pace, as well as revisit them should they need refresher training.

Webinar trainings may focus on general information and administrative supports and may include Medicaid program information on eligibility, covered benefits and services, operational procedures, and their roles and responsibilities. Special attention will be placed on ensuring providers access to available tools and resources to support provider quality care, such as clinical and operational tools and systems (e.g., BIDM, CCAR, MMIS, ProviderConnect, and the NHP website).

Webinars will also be used to provide annual trainings to update or remind the network providers of their contract responsibilities or changes that impact their practice including, but not limited to:

- Colorado Medicaid eligibility and application processes
- Medicaid benefits
- Access to care standards
- EPSDT program information, including assessment, treatment, and resources
- Quality improvement initiatives
- Population Health Management Plan
- CCAR and use of the CCAR mobile application
- Cultural responsiveness
- Member rights, grievances, and appeals
- Principles of recovery and psychiatric rehabilitation
- Trauma-informed care
- Other trainings identified in consultation with the Department

We will ensure that trainings on the topics above are made available for network providers at least every six months.

We will also offer training via webinars to cover the Disability-Competent Assessment Tool. This tool is used to help ACC PCMPs provide optimum care for Members with disabilities and to help Members with disabilities locate providers that are best able to meet their needs. The need to support practices in disability-competent care is especially important now that the ACC is serving Medicare-Medicaid Members. The tool allows PCMPs to be assessed in the following areas:

- **Communication Access:** To what extent do providers offer varying methods of communication to accommodate Members' needs? Are providers able to adjust communication methods for those who are hard of hearing or those with intellectual disabilities? To what extent do providers give Members information about the accommodations available for those with disabilities?
- **Programmatic Access:** Are there policies or procedures in place to ensure Members with disabilities receive the same quality of care as others? Are extended appointment times available? Can Members bring service animals with them?
- **Physical Access:** Are there access physical barriers on site that limits the ability to care for Members with a disability?

Provider Online Services

Beacon currently has an online provider self-service application that contains an interdisciplinary, curated library of practice support tools based on contract requirements, provider feedback, and identified needs. It currently houses an array of information and tools, including:

- Provider resources with overview information on Medicaid, the RCCO and ACC Program key performance indicators (KPIs), PCMP choice, and available support
- Member materials to assist providers to educate Members on coverage options and immunizations
- An exhaustive resource of clinical tools for providers treating Members of all ages with physical and behavioral health needs, including screening tools and guidelines, resources and helpful pamphlets, and referral and release forms (many available in English and Spanish)
- Operational practice support forms and procedures
- Educational materials for specific conditions that can be downloaded in English and Spanish (e.g., depression, diabetes, teen smoking)
- The provider directory and handbook
- A link to Achieve Solutions, our online library of health and wellness information

This existing website will be leveraged, enhanced, and updated to incorporate required content per the RAE contract. It will link providers to state and local resources, where appropriate, to streamline communication of content. Types of covered content may include:

- First Health Colorado eligibility
- State Plan services, including EPSDT
- Capitated Behavioral Health Benefit
- Business Intelligence Data Management
- Enrollment broker
- Utilization Management
- Non-emergent Medical Transportation administrators
- Case Management Agencies
- Single Entry Points
- Medicaid covered benefits
- HCBS waiver services
- Claims and billing Procedures
- Colorado Medicaid's fiscal agent
- Pharmacy Benefit Management System
- Oral health Contractor
- Healthy Communities
- Community Center Boards
- Nurse Advise Line

- Crisis Services System
- Community-based resources
- Appeals and grievances for physical and behavioral health adverse benefit determinations

Town Halls

NHP will establish travelling, training-specific Town Halls that will be conducted regularly. The topics for training will be driven from provider assessments for practice transformation, quality and utilization data, Learning Collaborative feedback, and identified trends or provider requested training topics. Examples of topics include:

- Quality Improvement Initiative, including developing a Population Health Management Plan
- Cultural Responsiveness
- Member Rights, Grievances, and Appeals
- Principles of Recovery and Psychiatric Rehabilitation
- Trauma-Informed Care and Working with Individuals with Brain Injuries (for example, recently Beacon conducted two training sessions on the implications of trauma on people with traumatic brain injuries)
- Other trainings based on best practices and promising modalities include Motivational Interviewing for Behavior Change and Better Health, the Value of Peer Specialists in Recovery Support, and the Zero Suicide Initiative

These sessions will be managed by our Chief Clinical Officer and NHP will invite experts and diverse presenters who can offer unique perspective, testimonials, innovative best practices and first-hand experience. This may include physical or behavioral health providers who can provide peer-to-peer training and share experience in adopting new tools or processes.

Through experience obtained adopting the RCCO and Behavioral Health Organization (BHO) models, we recognize the importance of encouraging the providers and their practice staff to determine the best way to interact with us.

In order to engage with providers in a meaningful way via the Town Halls, we plan to travel to different parts of the region to maximize in person attendance. The Town Hall will also be available via a live-broadcast where participants can interact with the presenter through question or comments. Additionally, a recording of the event will be posted on the website for providers to view or revisit at their own schedule.

NHP has multiple subject matter experts that are tuned-in to best practices in practice transformation, as well as our regional needs. Their expertise will ensure that providers are trained to offer quality care and services. All training materials will be developed in collaboration with other departments including, but not limited to Quality, Care Coordination, Clinical, and Provider Relations to create new training materials or gather existing materials and deliver training. We will leverage existing materials and guide providers to existing resources available through reputable entities, whenever possible, to avoid duplication and streamline communication.

Annual Seminars

NHP sees the benefits of having seminars with providers of physical and behavioral health care to focus on the successes and challenges in serving the Medicaid population in the contract region based on quality outcomes. The forum will allow the open discussion of ideas on how to build on the lessons learned and develop regional plans for overcoming the barriers to improve quality of care outcomes and customer service experiences for the Medicaid population. The results of these conversations will carry over to our efforts to strengthen Health Neighborhoods, increase active participation of providers in committees, and strategies to improve KPIs.

Learning Collaborative

NHP's Quality Department will lead a regular provider forum on topics selected through KPIs, performance measures, Member satisfaction survey findings, and/or provider feedback. In this forum, we will partner with providers to focus on subjects and develop joint solutions to resolve problems. This forum will be attended by highly motivated providers who will share experiences that spotlight the regional challenges and offer opportunities to troubleshoot the issues. In turn, NHP will present information on local, state, and national best practices. Together, we will develop regional solutions and best practices to impact these challenges or topics that will include tools, training materials, and other supports that we will then include in our training platforms. Provider Relations staff will participate in these forums to inform future provider trainings, communications, and Town Halls.

Continuing Education Units (CEUs)

NHP understands the multiple priorities and demands that our network providers face to provide quality care to our Members. We will use an array of communication tools to promote the trainings and encourage participation including the website, newsletter, provider email alerts, and during routing interactions. Additionally, we aim to make the trainings and presentations meaningful and offer providers a tangible benefit they can take with them after they spend time on a training, Town Hall or seminar. Through consultation with Beacon, we will work to create training content that meets CEU criteria whenever possible. This will enhance the experience of the providers and attract them to engage and participate more readily through one or more of the platforms that will be available.

Monitoring our Training Effectiveness

The training program's goal is to provide superior service to Members in the region. All of these communication and training tools will provide a streamlined process to improve communication, while providing a more transparent system for working with providers. This system will promote cooperative work between the network and providers, enhancing value to Members.

To ensure that our training is delivering on its intended goals, we will ask all training participants to complete a sign-in sheet and evaluation after the training. We will use our SharePoint system to track all the trainings delivered, topics presented including the materials used, and number and type of participants who attend. In addition, our webinar system has the capacity to download a report of the demographics of the participants in the training. Information can be made available to the Department on request. We will collect the data in a report to review with the Provide Network Committee (PNC) quarterly. This process will assist us in assessing the effectiveness of our training topics and methods, and inform future trainings.

We will also maintain a record of training activities we offer and will submit this information to the Department on request. This includes all NHP-developed provider materials and trainings related to the ACC Program or Colorado Medicaid. We will submit this information 10 business days after the date the materials or plans are requested by the Department, and 10 business days after the request by the Department to update documents.

DATA SYSTEMS AND TECHNOLOGY SUPPORT

Our Provider Relations Department will also use the team approach described earlier to manage data systems and technical support for providers within the region. Staff is assigned to territories to be in contact with providers over the life of the contract. Each team will contact their assigned practices regularly to obtain demographic updates, determine if any problems exist, and assess any training needs, including use of the data systems and technology provided by NHP.

Provider relations staff will inquire about the assigned practice's use of data systems and technology that show the use and adoption rate of the technology. This includes ensuring the practice staff has access to the available systems or technology, measuring level of comfort in navigating the system, gauging ability to pull data reports, and the ways in which data are used in practice to inform Member care. Based on this information, they will identify opportunities to overcome barriers so the practice successfully adopts the system. Our provider relations staff will also be knowledgeable on how to use the system so they can support practice staff in navigating the system and increasing the staff comfort level in using it. Provider relations staff will have direct access to our Information Technology Department staff who have the expertise to address more complex issues related to the NHP CONNECTS systems, including ProviderConnect and the CareConnect care coordination module.

Staff will have resources and tools available to educate providers on the data reports and systems available, as well as being prepared to walk practice staff through how to use the data and system to improve Member care. NHP will ensure that our staff develop expertise in the systems and recognize the technological investments from the Department, such as the BIDM system, so that they can counsel and support providers in the adoption and use of these assets.

Providers will also have access to staff through our toll-free number to answer questions and troubleshoot issues with the systems and technology. This may include sharing the desktop screen so together they can navigate the systems and conduct real-time training. Providers will have self-service provider online services via the NHP website, which will have links to training modules for state-supported Health Information Technology (HIT) systems. Additionally, staff may schedule additional onsite meetings for one-on-one training for those that require more attention to adopt the technology.

Actionable Provider Analytics

Health care is highly localized and practice patterns reflect that. For example, in Region 2, we see a difference in Crisis Response between urban (Greeley/Weld) and rural (all other counties). Similarly, SUD treatment between Greeley (Weld) and the rural counties are different (e.g., drug of choice, treatments available such as residential or detox). The graphic that follows depicts the components of our actionable analytics. By focusing the providers on clinical targets with a goal of a specific outcome, we are putting in place a solution for the result, versus the process by which we get that result. PCMPs know their Members and each individual and community needs a different approach. We are not here to show providers how to practice medicine, but rather to align with tangible, objective outcome targets, reward their performance for achieving excellence, and update them on the new tools available to make their jobs easier.

Actionable Analytics

Predictive Modeling & Stratification

Through our partners' experience via the current BHO and RCCO contracts that cover Region 2, we have learned that all providers need access to real-time actionable data and a library of tools and practice support assets. However, provider use of such assets depends heavily on their current performance, Medicaid panel size, and their focus. To this end, we have considered the technical needs of all types of providers and established personas, graphically depicted on the following page, that align with the tools, services, and supports we will make available to them. Our model supports all types of providers regardless of their scope, scale, or needs, so that we can influence the greater provider community in the region and align them with the quality measures (KPIs) defined by the Department to steer regional performance.

Persona 1 Providers describes the most technically advanced providers who have made significant investments in their electronic medical record (EMR) infrastructure and business processes. Their workflows have been designed and implemented for consistency and efficiency, and their EMR is their single system for all clinical operations. These providers are not interested in accessing another system from one payer and often serve multiple payers and lines of business such as Medicaid and Medicare, and commercial health plans. For this type of provider, seamless integration with their EMR system is a must. In fact, most of these providers have already established system integration with other partners to share clinical information. They also publish data for subscribers in standard formats like HL7. For Persona 1 Providers, NHP will offer our CareConnect platform and standard HL7 data interchanges using our scalable EDI infrastructure.

Persona 2 Providers describes providers who are interested in using an external system. Many of these providers have had access to systems in the past by other local partners, but have chosen not to make the investment on their own. NHP will offer these providers access to the CareConnect platform with a single, unified Member record with the appropriate role-based security and access to allow the provider to see and enter information and share data with other users. These providers may serve a single payer, like Medicaid, and conduct care coordination functions above and beyond the basic provider expectations, whereby a care management system will assist them with consistent delivery of assessments, use of standardized screening tools and development of a Member-centric care plan. These providers will receive alerts from the CONNECTS system when a clinical or coordination need presents itself for one of their Members. These email alerts will direct the provider to access the system via a link and review alerts for any of their Members. Actions are documented directly in the system.

Provider Support Scenarios

Persona 1	Persona 2	Persona 3
"We recently implemented an expansive EMR system such as Epic or Cerner and have built care coordination modules and workflows into this system. We do not want to access another system."	"We primarily serve Medicaid members and could benefit from access to a Care Coordination system and integrated health record that feeds us the viewing actionable analytics and alerts we should respond to."	"Our attention right now if focused on areas other than technology upgrades. We have some home-grown systems in place but these have been in use for many years are not up date on all of the HL7 standards."
CareConnects Platform HL7 Data Interchanges	**CareConnects Platform and Spectrum unified patient record and actionable alerts**	**CareConnects Platform and FileConnect custom EDI data transfers**
Users access RAE information in their EMR system via existing worflows. RAE sends and receives all information to the EMR via HL7 standards	Users access the CareConnects Platform and Spectrum Unified Patient Record and Alerts for those patients in which they have access to view	Users have access to information via a custom data load to their system and RAE receives information from user via custom file exchanges

Persona 3 Providers describes providers who are comfortable with the system they have in place whether a custom software solution, older or more basic non-meaningful use level 3 conforming platform or some other tool, and either are not interested or do not have the capacity to make a change. In this case, NHP will still pursue integration with the provider and will offer the third potential option to send and receive actionable health information about their Members. For these providers, we will evaluate their IT capabilities and develop custom data transfer programs to send and receive information. These files will likely be CSV or Pipe delimited flat files and transferred on a regularly scheduled basis. While these are not real-time data exchanges, they offer an integration path for all providers, not just those that prefer a specific type of tool.

The personas and models described above ensure that no provider is left behind or unable to accrue value from the RAE. This supports our commitment to the quadruple aim, allowing all providers to acquire the information they need from us to improve performance, without creating a new distraction from the delivery of care such as the required adoption of new technology and workflow systems from NHP.

Prescription Drug Intervention Program

In addition, we will activate our Prescription Drug Intervention Program (PDIP) for all PCMP providers to give them real-time actionable alerts adherence to guideline medications, sub-optimal dosing, gaps in care, excessive dosing, and, if applicable, Suboxone treatment or medication assisted therapy (MAT). For the populations in which each algorithm is applicable, PDIP has generated significant positive clinical and financial outcomes, including:

ACTUAL PER MEMBER PER MONTH (PMPM) SAVINGS

Medication Adherence Interventions

Inpatient Admissions	Emergency Department Visits
$4 PMPM	$1 PMPM

Polypharmacy Interventions

Emergency Department Visits	Prescription Medications
$7 PMPM	$111 PMPM

- Adherence algorithms:
  - 16 percent increase in Medication Possession Ratio (MPR)
  - Savings of $4 per member per month (PMPM) on inpatient admissions
  - Savings of $1 PMPM on emergency department visits
- Polypharmacy algorithms:
  - 55 percent success rate
  - Savings of $111 PMPM on prescription changes
  - Savings of $7 PMPM on emergency department visits
- Sub-optimal dosing algorithms:
  - 51 percent success rate
  - Savings of $23 PMPM on prescription changes

Successful network management is not only accomplished through managed care functions like contracting with the best clinically performing and cost-effective providers and utilization management discipline, but also through partnership with providers to allow them to focus on the activities that matter most in the delivery of care to Members.

To further assist providers in the use and adoption of the health care technology offered by NHP, as well as state-provided technology systems, our Provider Relations Managers in Region 2 will directly support provider relationships with ***Accountable, Collaborative, and Contributing Providers***, whom we described in greater detail in the financial support section of this response. These staff will conduct practice performance management activities and auditing to ensure that the provider continues to meet all of the delegated activities they have agreed to provide to their attributed Members or other local Members. In addition, our staff will also train providers and guide them through practice performance assessment information and improvement activities. This direct interaction between our provider relations staff and local providers is essential to assist providers in collaborating with NHP as the RAE, leverage all of the actionable analytics and data available to them, and help them focus on the areas of their practice that can have the greatest community impact. Population health battles are won one Member at a time, but practice transformation activities that tackle problems within cohorts allow providers to make quick, but significant improvements.

To prevent duplication, the team will be fully aware of the Department's training and guidelines. We have a certified NCQA Patient-Centered Medical Home™ (PCMH™) Content Expert as part of the team who will be working with providers with a variety of educational activities to support practice transformation into a medical home and will work to maintain the certification. Additionally, the PCMH Content Expert will train other staff to build capacity and program expertise to partner and support providers in their practice transformation.

We will support the practice's transformation activities and supplement the University of Colorado Medical Center practice transformation experts when working with one of the 400 SIM practices, or provide similar support to any practice not part of the SIM program that wants to implement this model. Our Practice Transformation alignment and support activities will give providers support for each of the 10 building blocks. These activities are defined in detail throughout our proposal and summarized in the table below.

	Building Block	NHP Support
1	Engaged Leadership	Our Chief Clinical Officer, Director of Provider Networks, and NCQA PCMH Content Expert are available to leadership at practices wishing to transform. In addition, NHP's provider partners have deep experience in Practice Transformation with Salud being one of the state's SIM providers.
2	Data-Driven Improvement	NHP will provide training, support and expert guidance on the adoption and use of population analytics from the Department (BIDM) and NHP's supplemental machine learning and natural language processing investment.
3	Empanelment	In addition to supporting the adoption and use of BIDM, which is expected to allow providers to view and understand their patient panels, NHP will handle attribution, assignment and re-assignment activities, and work directly with providers to identify additional resources for Members.
4	Team-Based Care	NHP promotes team-based care and providers working at the top of their ability by delivering state of the art tools and technology that allow providers to take action on information and interface with the RAE in a seamless and simple manner. Our Three Persona Provider Integration and Support Model allows all providers to accrue value from the RAE without the need to reinvent their workflows or reinvest in technology assets.
5	Member-Team Partnership	NHP has invested in technology assets that can be used by all providers across the regions. Our digital health solutions, like Ieso that allows access in a virtual manner to cognitive behavioral therapy, allow rural and frontier providers to serve their patients complex needs in real-time and increase the likelihood of follow-up care occurring. For example, our virtual health improvement tools like our texting (care4life) programs can help Members manage their diabetes.
6	Population Management	NHP offers the provider community and Members of Region 2 unlimited access to population health tools and technology such as educational content and behavior change programs that can be accessed anytime and anywhere from the Member's mobile phone. Our Wellpass solutions such as Text4baby, Text4kids, Text4Health, and Text2Quit have been highly successful in helping Members manage their care and change behaviors. These programs will be supplemented by a wide range of population health interventions that address social determinants of health and local risk factors.
7	Continuity of Care	NHP will promote, support and protect the PCMP, Member relationship, and continuity of care. We will also provide PCMPs with actionable alerts and notifications when transitions of care occur that could result in the Member's clinical care plan being altered by another professional (such as discharge plans and prescriptions). Our Care Coordination program will offer care transitions interventions to smooth these transitions, and reduce fragmentation in care for Members whose providers do not perform these duties.

	Building Block	NHP Support
8	Prompt Access to Care	NHP's large and diverse competitive network will attract, recruit and retain multiple providers per zip code and providers with extended hours so that Members can access care when and how they need to.
9	Comprehensive Care Coordination	NHP will provide the provider community with multiple care coordination options that are aligned with our provider financial support models. A provider may be compensated by NHP to perform these functions, may perform these functions using software provided by NHP or may delegate these activities to NHP. In any case, all Members will have someone in the system looking out for them, monitoring their utilization and needs, and interacting with them when appropriate.
10	Integration and Compensation Reform	NHP will support the Department's transition to more comprehensive value-based payment models. NHP has designed its own provider financial support model to align with the direction of the Department. More importantly perhaps, NHP is built upon a flexible and dynamic nationally-tested infrastructure that can adapt to new models of payment with traceability to outcomes.

This effort allows providers to gain experience with practice transformation and see the impact that adopting medical home standards can have on Member care and customer service.

Region 2 Integration of Primary and Behavioral Health Care Activities

For over 10 years, NHP providers, North Range, Sunrise, Centennial, and Salud have worked to integrate physical and behavioral health in Region 2 in order to serve Medicaid and indigent populations in rural communities.

- **Comprehensive Maternity Care**
  Comprehensive maternity care including prenatal care, patient education, behavioral health screening/intervention; oral health education/assessment/intervention; delivery care; post-partum management. Members can choose to receive individual prenatal care from our integrated care team or participate in Centering Pregnancy group. Components include oral health, co-management by Primary Care Provider and OB/GYN, delivery care for both low risk and high risk babies, home visits for high-risk mom/baby pairs, post-partum care and outreach to ensure post-partum visit between 21-56 days of delivery, Pregnancy Related Depression Screening. Comprehensive maternity care is provided through Salud in four rural communities: Fort Morgan, Sterling, Fort Lupton, and Frederick.

- **Integrated Behavioral Health in Federally Qualified Health Centers**
  Individuals with behavioral health needs are served in a primary care setting. The program provides fully integrated behavioral health services in a primary care environment to all patients. We strive to have contact with each Member regarding behavioral health concerns and offer a full scope of behavioral health interventions including psychotherapy, group visits and psychological testing. Salud provides integrated care in four rural communities: Fort Morgan, Sterling, Fort Lupton, and Frederick.

Salud and Centennial Mental Health Center partnered together to provide quality integrated health care to Medicaid Members in Fort Morgan and Sterling. Programs include services provided to special populations such as adults with disabilities, older adults, and foster children. Salud and Centennial developed and implemented a Primary Care Practice Medical Home that incorporated behavioral health consultations into physician practices. This aided transitions of care, collaboration, cross referrals, care coordination and included co-location of psychiatric and behavioral health

services. Co-located services included screenings, assessments, individual and group therapy, case management and physician consultations.

Oral Health

- All Salud Members have access to dental services that are integrated into the primary care environment. Dental services are provided to Members at all ages and include general cleanings and exams, diagnostic imaging, surgery procedures and extractions. For Members ages 0-20 and pregnant women of any age, Salud offers medical dental integration (MDI) where a dental hygienist participates in the medical appointment and provides oral hygiene education and fluoride varnish to lower risk of dental caries among children and pregnant women.

Care Management

- All Salud clinics have Care Managers who are essential members of the interdisciplinary team and identify high risk ACC Members based on claims utilization data (e.g., ER utilization, hospitalizations, and other events), referrals from internal team members or external community resources. Care Managers complete a Health Needs Assessment (HNA) to identify needs within multiple domains including but not limited to: medical, behavioral health, dental and social determinants of health. When appropriate Care Managers create Member-centered care plans designed to identify goals that leverage Member strengths and assets (i.e., family members, local resources, and others). Care Plans help close the loop in overall coordination of care both within and outside the primary care setting and aim to ensure Member access the right care at the right time in the right setting.

Sunrise Community Health Projects

- *Sunrise serves northeastern Colorado, primarily Weld and Larimer*
  The Sunrise Community Health care model provides integrated medical, dental, and behavioral health through co-location of physical and behavioral health practitioners in multiple clinic settings. Integrated care teams develop multi-disciplinary plans for driving Member treatment. Sunrise offers comprehensive, quality services including on-site laboratory, radiology, pharmacy, and Member education. Sunrise is a recognized leader in integrated care, advanced Health Information Technology (HIT), safety net collaborations, and professional health education. In addition, Sunrise co-founded the North Colorado Health Alliance, a community collaboration focusing on low-income, under and uninsured people within our service area. Partners include community health, public health, hospital, behavioral health, specialists, local foundations, education, county commissioners, managed care organization, and county social services. Collaborations focus on integrated service expansion; shared HIT infrastructure; community health improvement; regional accountable care activities; and system accountability and efficiencies.

Other Sunrise Community Health programs include:

- **Shared Electronic Health Record**
  Sunrise and the Weld County Department of Public Health and Environment implemented a shared electronic health record in 2002. A Member's chart is available to clinicians at Sunrise and Health Department clinics thus ensuring safer and more cost effective care.

- **Sunrise Weld Prenatal Clinic**
  Since 2001, Sunrise has embedded primary care clinicians in Public Health clinics for the purpose of providing prenatal care in a community setting. This model facilitates integration and ensures prenatal patients are linked to needed community and public health programs.

- **School Based Health Clinic**
  Beginning in 2004, Sunrise brought primary care medical and dental services to a socio-economically disadvantaged school located in Evans where 95 percent of the children receive free or reduced lunches. These are primarily underserved children and families with limited access to affordable health care. Initially, Sunrise offered services from our mobile health van, and in 2006 a permanent clinic was established on-site. Today, the clinic is open year round, staffed by a nurse practitioner. Medical, dental and behavioral health services are provided on site as is eligibility screening and care management. Members have access to pharmacy, lab, x-ray, at the larger Sunrise clinics. NRBH provides the on-site behavioral health services.

- **Mental Health/Substance Use Disorder Services**
  Sunrise partners with the local mental health and substance use disorder agencies in our service area to bring co-located and integrated care to our community. Behavioral health team members work within Sunrise clinic primary care teams, jointly creating treatment plans and providing care to patients. Sunrise clinicians are also embedded in the behavioral health setting, jointly creating treatment plans and providing care to Members. Sunrise will continue to focus on fully integrated health care and improving care plans and Member outcomes as well as improving referrals to/from medical and to/from behavioral health.

- **Oral Health Services**
  Sunrise directly provides comprehensive primary oral health services to all ages in our Larimer and Weld clinics. We continue offering one of the most comprehensive programs in the state. Our dental patients average 3.4 visits/year.

Provider Assessment

Willing practices will be assessed based on the level of care and services they provide. Staff will discuss opportunities to improve their practice for a more integrated medical home using their strengths and the practice's overall operational strategy and goals with the provider. NHP will use the Integrated Practice Assessment Too (IPAT) developed by the SAMHSA-HRSA Center for Integrated Health Solutions.

Practice Transformation Plan

As the Region 2 RAE, NHP will use the results of the assessment, along with the provider discussion and in consultation with the interdisciplinary team under Provider Network Committee to develop a practice transformation plan that will connect the provider to:

- Educational materials on the principles of practice transformation and its benefits
- Available resources, tools and data systems and technology to advance practice transformation goals
- Trainings on best practices, clinical tools, utilization of data systems and technology, and technical assistance to access when needed or requested

The practice transformation plan will be in alignment with the practice goals, medical home standards, and NHP's focused social determinants. The interdisciplinary team will track the provider's progress in achieving their practice transformation plan using available data and population analysis. We will consider developing visual representation of the practice's progress or opportunities for improvement, which will assist the team in identifying practice needs for targeted trainings or supports, changes to provider transformation plan, or other interventions to ensure the practice is successful in achieving practice transformation. The team will work in collaboration with other parts of the Provider Network Committee (PNC) to leverage webinars, town halls and seminars to deliver best practices on practice transformation into a medical home and drive the goals of the ACC. Providers will receive

training and support on how to use team-based care, strategies for behavioral health integration in a physical health practice, techniques to leverage peer specialists and patient navigators for care coordination and improve quality measures. They will also receive coaching on how to reduce utilization or delivery of low-value services through the emergency room.

In the past, provider relations leadership has actively participated in regional and statewide forums such as “Transforming the Primary Care Practice” conference presented by the Institute for Healthcare Improvement, Introduction to Patient Centered Medical Home (PCMH) 2017-NCQA, Advanced PCMH 2017-NCQA, and Introduction to Patient Centered Specialty Practice-NCQA. They also attend the statewide forums such as the Medical Home Community Forum and Colorado Children Healthcare Access Program (CCHAP) meetings. CCHAP’s mission is “To support primary care medical homes to improve health outcomes for children and advance health equity.” The Medical Home Community Forum promotes the Medical Home Initiative and serves as a resource to those organizations committed to the medical home model. The information obtained through these regional, state and national forums is disseminated to practices through the various established communication structures and training forums to ensure practices have the actionable and timely information and tools. Below we provide examples of provider support and practice transformation information provided in past forums:

- Practice Transformation Toolkit Demonstration
- Zero Suicide Presentation
- Strategies to Access Care Standards and Appointment Availability
- Member Enrollment, Attribution and Disenrollment process
- Updates and Changes to State-run Systems
- Cultural Competency in Health Care

Provider Relations will encourage providers to participate in state funded initiatives such as SIM, CPC+, and enhanced primary care factors. They educate providers on the available incentives using Incentive Factsheets and other state developed materials and work with the providers to support them to identify areas where they meet the incentive, as well as offer strategies, tools and training they can implement to achieve them.

Network Assessment and Action Communication (NAAC) Tool: As providers engage with the multidisciplinary team in their practice transformation, NHP will need a centralized communication tool that allows individuals and departments to coordinate efforts and avoid duplication. The NAAC tool is an electronic system that allows individuals and departments to document key interactions with providers, including track transformation assessments, review the practice transformation plan, and document other related activities such as visits or trainings. It allows for support of previous and ongoing practice activities in a coordinated manner documenting the communication between the department and the provider. Provider Support staff will be able to review and pull information when speaking with a provider and share information on transformation activities that are occurring throughout the region across the various departments that assist in the practice transformation efforts. They will be able to use the tool to reinforce information delivered, provide additional support or request additional interventions to assist providers in their practice transformation.

Colorado Children Healthcare Access Program (CCHAP): CCHAP is a statewide recognized non-profit organization established in 2006 to support pediatric and family practices integration of behavioral health, care coordination, and preventive care. CCHAP has an established relationship and dedicated expertise with pediatric practices where the organization provides coaching to impact Member care at the pediatric medical home; advocacy at the local, regional and state level to influence health care policy; and promote innovative models of care. Our ASO, Beacon, has

partnered with CCHAP to inform and coach pediatric practices on Medicaid programs and integrated behavioral health. This included assisting them on transitioning to the RCCO and instruction on how to use data to improve their practice activities. They initiated training materials and tools targeted for pediatric medical homes, which was then incorporated in practice transformation materials.

Practice Support Plan

NHP will develop a report that describes the plan for practice support for providers in Region 2. This plan will align with the Department's goals in promoting the ACC program and educate both providers and staff members about needs of Medicaid Members. This plan may be updated throughout the year based on program needs, progress made towards meeting plan goals, and educational opportunities. The plan will target items related to operational support, clinical tools, client materials and data systems and technology that support and enhance provider capacity to impact quality KPI outcomes, improve care coordination and system integration, and target social determinants. Examples of activities in previous Practice Support Plans include:

- Selection and dissemination of clinical screening tools such as depression and substance use based on identified need and practice patterns.
- Monitoring and aggregation of data regarding use of Achieve Solutions website
- Registry for adults with diabetes and adults with chronic pain management issues
- Creation and implementation of strategic package of training and education for non-medical staff within PCMP practice to contribute in the practice transformation efforts.

The NHP partners have experience in this region and its rural and frontier areas and will continue to invest in building local community capacity to provide appropriate physical and behavioral health care to the Medicaid membership. We are fully aware that the region lacks an adequate number of oral health providers and high demand specialists and will implement strategies to recruit these providers. The specialists and oral health providers will be an essential part of our network and Health Neighborhood. These relationships will allow our established provider network to better coordinate care with specialists, oral health providers and community supports. This will help create continuous and coordinated care for Members to impact utilization, overall costs and increase health outcome.

Transformation Performance Improvement Activities

All quality/performance improvement activities are data-driven, iterative processes that use all available data and reporting sources including BIDM, our internal data warehouses, and behavioral health claims to guide program development, track progress, evaluate outcomes, and inform decisions about targeted interventions that will positively impact Member care. Quality and performance improvement activities are based on a review of relevant data that is combined with anecdotal information from providers and care coordinators, knowledge of regional and sub-regional characteristics, as well as feedback from Members and other stakeholders.

Quality/performance improvement staff analyzes data regularly including State generated reports, internal reports and ad hoc reports to identify opportunities for improvement as well as areas that are excelling where best practice principles can be shared across the region to help improve other partners' performance. Data is reviewed regularly within the Performance Improvement Activity Committee (PIAC) and Quality committee structures including the Member/ stakeholder KPI sub-committee where Members, providers, outside agencies and other stakeholders have an opportunity to provide feedback on performance, assist in troubleshooting problems identified in the data and devise creative interventions to improve performance. Data is shared monthly with Care Coordinators to assist them with population health management tasks. KPIs are used as a starting point for identifying performance issues. Key performance indicators currently in place include:

- **Total Cost of Care:** Beacon Health Options developed and implemented interventions to address Total Cost of Care using a multi-systemic approach, including Care Coordination, patient outreach and education, utilization of data systems to identify high utilizers, provision of appropriate referrals and special population outreach including prevention for specific populations. Care coordinators outreach Members identified as high utilizers of services, particularly emergency department, and provide Member education and referrals to steer Members towards more appropriate types of services through their PCMP. Member Services outreaches special populations such as Members who need breast/cervical cancer screenings, colo-rectal cancer screenings, and well-child checks to ensure Members are getting proper preventative care. Referral protocols are in place to ensure proper utilization of specialty services. Population health management strategies identify groups that could benefit from additional care coordination support, such as those with one or more chronic conditions or Members with co-morbid behavioral/physical health issues. NHP has implemented many strategies for addressing Total Cost of Care from a Population Health perspective, including: Care Coordination, managing transitions, utilizing Community Health Workers, telemedicine, behavioral health and substance use disorder interventions, preventative screening and disease management programs.
- **Emergency department visits for ambulatory sensitive conditions:** Admit/ Discharge/Transfer (ADT) data is used by care coordinators to identify Members who have had an emergency department visit or transitioned from one level of care to another. ADT data is real time, so outreach is accomplished in a timely manner to assess Member needs and identify barriers. We have had a positive impact over the past two years working on this KPI, resulting in a decrease from .6 percent in FY14 to -11.1 percent in FY16. Within the NHP region, decreasing ED utilization is approached through efforts focusing on interventions such as disease management programs and behavioral health outreach.
- **Wellness Visits:** There has been a strong focus on well-child checks for the past five years including a successful Quality Integration Project that leverages both behavioral and physical health resources to engage Members. Member services provides outreach to those who need preventative screenings such as breast/cervical and colo-rectal. Claims data is used to identify Members who have not had a PCMP visit in the previous 12 months so that Care Coordinators can outreach those Members and engage them in their health neighborhood. NHP have demonstrated successes in providing quality wellness care for their Members as evidenced by: a 79.37 percent Depression Screening rate, hypertension control rate that is higher than both the national and state averages as well as pap test rates that have consistently outperformed national and state rates.
- **Behavioral Health Engagement:** Member engagement in behavioral health care services is an important metric that can link service delivery to the efficacy of outcomes. NHP tracks service engagement using Care Coordinators to actively outreach to Members in an effort to ensure full participation in services. Engagement is defined as a Member attending four services in 45 days. This is a current BHO Incentive Program Measure; intervention strategies are shared across programs. Education and monitoring occur at regular intervals.
- **Prenatal Care:** The Colorado Opportunity Project is being piloted and is currently focused on impacting healthy birth weight in babies born to our Members through referrals to appropriate providers, engagement with their health neighborhood, as well as providing education to OB/GYN providers about engaging with care coordinators to ensure Members receive proper support and referrals. NHP has implemented a successful initiative that resulted in an increase in prenatal visits for their Members. As of 2017, the partners increased the prenatal visit rate to 82.81 percent well above the state and national averages for previous years.
- **Dental Visit:** NHP will use data reports from the BIDM system, as available, to assess the rate of annual dental visits; outreach efforts will be implemented regionally to targeted populations such as youth and families to determine the most effective means of assuring regular visits. NHP will create a dental registry and notify providers on a monthly basis of Members who are due for

a dental visit as a part of our approach to ensuring overall wellness for children. NHP has significantly increased the number of children with dental exam at high risk for caries who received sealants from 17.14 percent in 2015 to 36.21 percent in 2017 (YTD).

- **Obesity:** Body Mass Index (BMI) will be used in measuring rates of overweight and obesity unless the KPI specifications differ. In order to align with the Colorado Winnable battle addressing Healthy Eating, Active Living, and Obesity Prevention, NHP will implement evidence based practices that focus on increasing physical activity, dietary education and behavior therapy. In doing so, Members will learn how to lose weight as well as maintain a healthy weight and lifestyle. NHP is evaluating programs that support Members in increasing physical activity through a rewards based system, and the creation community wellness committees. Community wellness committees will spotlight creating connections to healthy food resources and creating community wellness walking/exercise programs. A diabetes prevention program, using pre-diabetes monitoring through BMI measurement will also be considered.
- **Health Neighborhood:** Quality staff support our provider relations staff in implementing the Specialist Physician COMPACT through monitoring and providing feedback on the performance of participating providers. Quality staff will conduct quarterly audits to determine the extent to which providers are using the COMPACT. The results of the quarterly audits will be submitted to the Board of Directors for review. The audit findings will determine if Accountable practices receive all the quarterly incentive dollars or if some will be withheld until performance improves

Additionally, NHP will develop a ninth KPI in collaboration with the Department, other RAEs and stakeholders. We will track and extract performance data monthly through the BIDM System or our proprietary data management and analytics systems with results vetted through our Regional PIAC and published for public viewing on our website.

Quality staff provides ongoing training for care coordinators and other applicable staff regarding best use of data supplied to them by NHP. Quality staff also provides onsite training for partners/providers/care coordination staff in accessing and using data to improve efficiency and performance. In addition to training topics related to BIDM, KPIs, and use of data and reporting, quality staff also provide trainings for care coordinators on integration, population health management, and external quality review organization (EQRO) audit requirements.

Whole Person Care

Our model for helping practices promote whole person care is through our health neighborhoods. Whole person care focuses on the coordination of physical and behavioral health and social services. Our Practice Transformation Coordinators focus on building on provider strengths to achieve better health outcomes. We will use registries to help practices target populations, share data with the health team, and coordinate care within our health neighborhoods in real time. Continual evaluation of the populations and individual outcomes will be essential.

Real time data and information are essential to effective and timely care coordination, particularly when addressing transitions of care. Claims based indicators, such as KPIs, are by necessity at least three months old due to claims lag. Claims data is useful for overall trending, identifying performance issues at the RAE and practice level, and even drilling down to the Member level when identifying population health elements. However, there are Member needs that require immediate attention, such as transitions related to emergency department visits, inpatient admissions/discharges and transfers. Care Coordination outreach to Members experiencing these types of transitions must be immediate in order to be effective.

NHP will be able to support our Care Coordinators with the information they need by using Beacon's reportable, mobile "Action Alert" tool. Building on existing data available from daily Colorado Regional Health Information Organization (CORHIO) feeds, Beacon has developed a tool that extracts CORHIO ADT data and electronically delivers an alert to the appropriate Care Coordinator

via a secure cell phone. Within 24 hours of a Member being admitted, discharged, or transferred, the Care Coordinator receives an alert that contains a link using a secure login. Once logged in, the Care Coordinator can view the ADT information, including Member identifying information and the location where the admission, discharge, or transfer occurred. Care Coordinators can then provide appropriate and timely outreach and support to the identified Member. Once the initial follow-up contact has occurred, the Care Coordinator will go into the alert system and select the "completed" indicator that confirms the follow-up was accomplished. Documentation of specific follow up information including action steps and plan will be entered into the care coordination tool. There will be reporting capabilities built into the technology that allows NHP quality and care coordination staff to monitor the tool's utilization and effectiveness.

KPIs that would be positively impacted using Action Alerts include:

- **Total cost of care:** The ability to engage Members at the time of transitions is vital to ensuring all needed supports and services are in place. A timely needs assessment and linking individuals with services increases the likelihood of a successful transfer and decreases the likelihood of a readmission or emergency department visit.

  Often, readmissions result from not having necessary supports in place. For example, Members with COPD who do not receive needed durable medical equipment for their breathing condition often are either re-admitted or present to the emergency department within a few days of discharge. Other considerations that can lead to a readmission include not having a timely follow-up appointment with a PCMP or specialist, not having transportation to follow-up appointments, not having enough medication to last until their appointment, and not having home health in place upon discharge. These are all avoidable circumstances that drive up the total cost of care and negatively impact Member care and experience. Immediate intervention by a care coordinator who can provide a timely needs assessment and link Members to needed supports will have a significant impact on this KPI.

- **Emergency department utilization:** High emergency department utilization is driven by several factors including poor health literacy, not understanding the appropriate setting for their care, not having a relationship with a health neighborhood/PCMP or care coordinator, drug seeking, and behavioral health conditions. Care coordinators who are able to engage Members at the time of their emergency department visit, or within 24 hours, are able to perform an assessment to determine the underlying cause of the emergency department visit(s) and provide appropriate education, referral and follow-up that will decrease future emergency department utilization.

- **Behavioral health engagement:** Timely linkage to services promotes recovery. Facilitating engagement as transition occurs means the Member will have the support needed to address immediate needs, such as housing, food or medication. This support allows the Member to focus on recovery and aftercare services with less stress and reduces the likelihood of readmission.

Provider Network Committee (PNC)

NHP's PNC, which reports to Quality Committee, will, in addition to network development functions, oversee the network management activities to ensure that providers receive appropriate technical support and training, as well as, support for practice transformation. The PNC will include representation from NHP's partners, Provider Relations, Quality, Care Coordination, and Member Services Departments. The PNC will meet on a monthly basis and, in order to ensure that sufficient deliberation is allowed for the various components of compliance with access to care standards, each month during the quarter will have a different agenda. For example:

- **First Month:** Assess network Development needs and opportunities. Information resulting from monitoring efforts will be analyzed by the Provider Network Committee to address network

weaknesses, as well as development opportunities, and assess availability and access to care to ensure network adequacy based on Medicaid standards.
- **Second Month:** Assess provider support programs for network providers and identify training opportunities based on best practices, data driven needs or regional trends.
- **Third Month:** Develop and evaluate activities to engage new providers or improve existing practice transformation organizations.

Agenda	Meeting Month
Network Development	January, April, July, October
Provider Support Programs	February, May, August, November
Practice Transformation Plan	March, June, September, December

Provider Support Programs

NHP views the engagement and development of the Network Providers as an essential component to ensure providers have the support, tools and resources to provide quality physical and behavioral health care to Medicaid beneficiaries. The PNC will use the meeting of the second month of every quarter to assess the provider support programs underway to ensure we meet and exceed requirements from contract with the Department. Specific activities will include:

- Review reports of completed trainings of providers through the various training platforms such as webinars, on-site visits, Town Halls and annual seminars; additional trainings may be considered in this review, such as invitations from the State or other entities to speak at their events or seminars
- Analyze results of the training evaluations to monitor the effectiveness of the materials and training platforms; the PNC may provide guidance on the training modality, content, or delivery system to improve the participation, information retention and implementation
- Staff regularly review and monitor provider inquiries to identify technical support or training needs such as credentialing, Medicaid revalidation, complaints data regarding timeliness of claims and authorization processing
- Review available data on provider inquiries, compliance audits, KPI and other health outcomes, systems and data utilization, to discover opportunities for enhanced or targeted training, development of new tools or training topics, and innovative platforms or collaborations
- Provider concerns for any provider level

Evaluate and Develop Strategies on Practice Transformation

NHP will work closely with physical health and behavioral health providers in our Health First Colorado program to support their practices to improve performance as a Medical Home and in their participation in alternative payment models. The PNC will use the meeting of the third month of every quarter to develop and evaluate practice transformation activities to ensure we meet and exceed requirements from contract with the Department. Core components of our provider partnership approach include:

- Periodic review of the Practice Support Strategy in the Practice Support Plan to evaluate efforts and strategies to address provider support needs including:
    - Administrative concerns for authorization and claims processes or understanding of Medicaid and Accountable Care Collaborative programs
    - Identified training needs based on best practices or data driven needs
    - Patterns in requests for system and technical support
    - Engagement in the Practice Transformation and incentive programs

- Analyze provider data related to KPI's, trending reports, or special requests to identify outliers and improvement opportunities and communicating results to individual providers to improve performance
- Develop program/provider initiatives that expand and promote integration; bring innovative thinking and approaches to the provider community by identifying high-performing providers who may be interested in new and innovative payment or program models and helping those providers implement the new concepts
- Take best practices and high quality program ideas/designs about practice transformation and incorporate them into the training platforms and provider visits to drive high levels of value
- Present provider assessments and practice transformation goals established in collaboration with the practice, based on their overall operational strategy; the representatives with varied expertise will provide recommendations to develop a comprehensive, multidisciplinary practice transformation plan; they will dispatch their department experts to provide the training
- Review reports depicting findings and recommendations for corrective action and/or concerns; the data can then be compiled and reviewed in order to track changes and trends; and identify providers who are not meeting program requirements, as well as provide an opportunity to share information about providers who are exceeding performance expectations

NHP has an array of subject matter experts that are always available to meet directly with providers and to serve on local boards and professional organizations, all of which builds strong ties with the provider community and local agencies. Further, our physical presence in the regions we serve promotes our role as a local partner in helping to improve health care systems.

FINANCIAL SUPPORT

As a national managed care organization, NHP's administrative agent, Beacon, brings deep experience in the creation and management of value-based program and payments with providers that goes far beyond our Colorado experience. In total, Beacon manages over $275 million in value-based payments across the US and, as depicted in the table below, performs this work in nine separate states.

State	Value-Based Model	Description
Colorado	Shared savings	Sub-capitation to providers through partnerships with behavioral health plans
New Hampshire	Full risk capitation	Capitated payment arrangements with 10 CMHCs
Kansas	Full risk capitation	County block grants for indigent care
Florida	Full risk capitation with reward payments	Currently with three providers, this arrangement focuses on clinical operations and reporting.
New York	Full risk capitation	Case rate for an inpatient facility
Kentucky	Full risk capitation	Pilot project with health plan partner for foster care youth
Illinois	Full risk capitation	Case rate for Members with SMI: Pilot with Thresholds
Massachusetts	Full risk capitation	REACH program
Virginia	Full risk capitation	Case rate for Members with SMI: Pilot with the Community Service Boards in Virginia

This demonstrated experience means that NHP is well positioned to support the Department's progress towards value-based payment models in all places of service. We have studied the Department's plans and have designed our payment arrangements with PCMPs and Health Neighborhood Providers to align with each stage of the Department's payment transformation

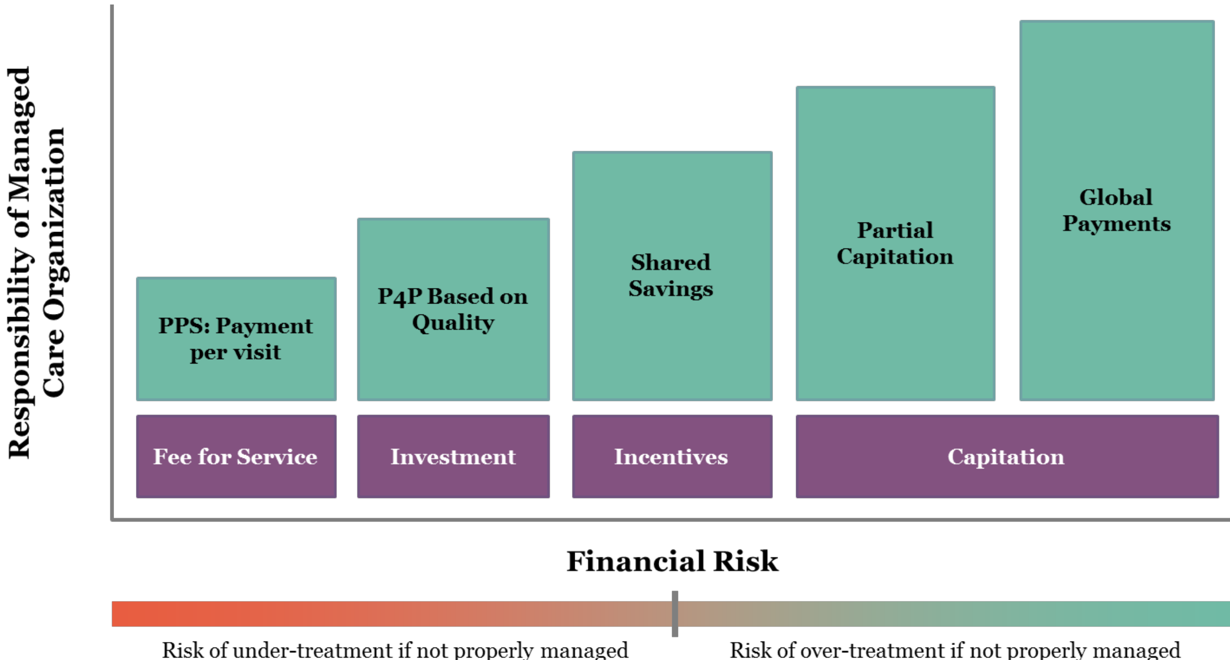
strategy. We created and used the following diagram as our guide to understanding the Department's future for Health First Colorado providers across all services and for consideration in the design of our own financial support models.

Our Interpretation of the State's Value-based Payment Roadmap

Regional Accountable Entity (RAE)		Primary Care - Physician		Primary Care - Clinics		Hospitals	
Physical Health/Social Determinants of Health	Behavioral Health	Primary Care APM	Primary Care APM Track 2 (Risk)	FQHC APM	FQHC APM Track 2 (Risk)	Services	Population Based Supplemental Payments
Incentives	5% Incentives	Higher Reimbursement Tied to Quality	PMPM Tied to Quality	Earned APM Quality Incentives	PMPM	Quality Incentives	Supplemental Payments Tied to Quality / Coordination with Regional Accountable Entity (DSRIP)
PMPM	Full Risk Capitation	Base Payment	Reduced FFS	FQHC Encounter Rate		Grouper Based Payments for Inpt./Outpt.	Volume Based Supplemental Payments

In each place of service, a volume-based fee-for-service model is graduated, where one part of the total payment is set aside for services rendered, and the remaining payment is based on the achievement of value-based performance metrics.

Through Beacon's experience with value-based payment models and payment reform, we have learned that any changes in a complex and interdependent system leads to expected and unexpected consequences that must be understood and managed appropriately. Our managed care approach to financial support for PCMP and Health Neighborhood providers builds on the lessons learned. Across the continuum of payment models, we understand that there is a risk of over or under treatment depending on where the payment model falls. As graphically depicted below, in cases of fee-for-service only payment models, the risk exists for over treatment, as all services are compensated. These risks are mitigated through benefit design and utilization management. At the other end of the spectrum (e.g., Global Payments), there lies the risk in under-treatment because the difference between the payment and services delivered represents profit.



With the Department's strategic direction, current progress and lessons from other markets in mind, we built our payment model based on four core concepts so that we could avoid these pitfalls and accelerate progress towards improvement in the Quadruple Aim:

1. NHP PCMP contracting and payment strategy is aligned with the Department's Alternative Payment Model methodology
2. NHP will align the care coordination payment structure with high standards of care to achieve Quadruple Aim for the Department
3. Providers will earn more as they provide more and achieve more, within an environment that is transitioning from fee-for-service to value-based
4. Our provider contracts will include objective, traceable, and measurable metrics, which providers will report and be used to measure performance so that, as the RAE, we are accountable to the Department, and providers are accountable in the provision of their services to the RAE.

We intend to develop three types of PCMP provider contracts to align with the Department's payment reform goals and distribute rewards in harmony with provider performance and outcomes in Region 2. Depicted on the following page, this contracting model is distinguished between ***Contributing, Collaborative, and Accountable Providers***.

Contributing Providers are fee-for-service Medicaid providers who will receive the support of NHP and will receive a supplemental payment to encourage and reward their participation in the Medicaid program. These providers contribute to the overall Medicaid network, provide access in areas of the region that are underserved, and give our Members additional choice in where to seek care. Collaborative Providers are more advanced practices that will receive a larger care coordination payment from NHP to reward them for increased collaboration that will lead to better coordination across the entire Health Neighborhood and system of care for their Members. Accountable Providers are our most advanced Medicaid providers in the region. These providers not only serve Medicaid at scale, but they do so efficiently, and have a demonstrated track record of embracing integration and other innovations.

These Accountable Providers take ownership for their attributed Members' care coordination and are focused on our core KPI metrics to drive increased quality of care, health of the local population, and clinical outcomes, while decreasing total cost of care. Accountable Providers not only receive the largest payment from NHP, but they are also eligible for a share of the $4 PMPM KPI Bonus Pools when achieved and earned by NHP.

PMCP Value-based Contracting Model

Contract Type	Scope of Service	Earning Potential	
Accountable	Attributed memberships drive a significant proportion of regional membership and Providers possess the greatest level of capability to impact the regional KPIs.	Maximum PMPM payment by the RAE.	Eligible for share of $4 PMPM bonus earnings.
Collaborative	Provides enhanced services and may be on a path to Alternative Payment Model with HCPF. Delegates Care Coordination and Population Health activities to the RAE.	Premium PMPM payment by the RAE.	
Contributing	Meets minimum Medicaid PMPM requirements & provides basic services. Small Medicaid panel size. Not enough volume to drive regional performance outcomes.	Meaningful payment by the RAE.	

Our provider-contracting model distinguishes between Contributing, Collaborative, and Accountable Providers, and sets the level of total reimbursement based on the provider's ability to meet service expectations and quality metrics.

A summary of our PCMP contracting model is detailed below, and describes the requirements and expectations of each type of provider contract.

Contributing Providers

Contributing Providers meet all the requirements to serve Medicaid Members as defined in *Section 5.7.2* of this RFP, including:

- Enrolled as Colorado Medicaid Provider
- Licensed and able to practice in State of Colorado
- Practitioner holds an MD, DO, or NP provider license
- Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics, or is a qualified CMHC or HIV/infectious disease practitioner and all other criteria is met
- The practice, agency, or individual provider, as applicable, renders services using one of the following Medicaid Provider types: Physician (code 05), Osteopath (Code 26), FQHC (Code 32), Rural Health Clinic (Code 45), School Health Clinic (Code 51), Clinic-Practitioner Group (Code 16), Non-physician Practitioner Group (Code 25)
- Provides 24/7 phone coverage with access to a clinician that can triage the Member's health need
- Has adopted and regularly uses universal screening tools including behavioral health screenings, uniform protocols, and guidelines/decision trees/algorithms to support Members in accessing necessary treatments

- Tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information
- Has weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (i.e., Monday to Friday, 7:30 a.m. to 5:30 p.m.) or school hours for school health clinics
- Uses an electronic health record or are working with NHP to share data with the Department
- Uses available data (e.g., Department claims data, clinical information) to identify special patient populations who may require extra services and support for health or social reasons. The practice must also have procedures to proactively address the identified health needs.
- Provider delegates the following required criteria to NHP:
  - Delegates all care coordination activities and some Population Health activities and interventions to NHP.
  - Delegates certain data analytics functions such as the identification of specialty populations not identified by the BIDM system, until time at which the BIDM system does identify and related interventions to proactively address the identified health needs of this sub-population to the RAE
- Other expected attributes:
  - Provider is not a APM Level 1 or Level 2 certified provider or SIM provider
  - Provider may only serve a small number of Medicaid Members and does not wish to engage in a larger relationship with NHP

Payment Model

Contributing Providers receive a meaningful PMPM rate from NHP that is commensurate with their current RCCO experience, but benefits from additional innovations, provider support services, and analytics from NHP.

Collaborative Providers

Collaborative Providers meet all of the requirements to serve Medicaid Members as defined in *Section 5.7.2* of this RFP, as well as the attributes associated with Contributing Providers detailed above. In addition, Collaborative Providers are willing to participate in defined referral process with NHP and other key providers using the Care Compact or similar uniformly accepted method and practice. Collaborative Providers:

- Delegate care coordination, care management, and population health to NHP for their attributed Members, or use care coordination technology provided by NHP
- Share care coordination data with NHP in a prescribed format (i.e., HL7, CCD/CCDA, or mutually agreed upon flat file) to demonstrate their care coordination activity and interventions delivered in support of NHP's performance objectives and KPI measures
- May be a APM Level 1 or Level 2 certified provider or a SIM provider

Payment Model

Collaborative Providers receive a premium payment from NHP for their care coordination activity and ability to meet supplemental requirements as defined by NHP.

Accountable Providers

Accountable Providers meet all of the requirements to serve Medicaid Members as defined in *Section 5.7.2* of this RFP, as well as meet the attributes of Contributing Providers as previously described. In addition, Accountable Providers:

- Accept and use Care Compact for referrals to other NHP network providers
- Perform all care coordination functions for their attributed Members

- Have acquired and implemented their own care coordination tool, either from a previous RCCO, an EMR vendor, or another sources, and chooses to continue to use that product for the delivery of care coordination
- Share care coordination data with NHP in prescribed format (i.e., HL7, CCD/CCDA, or mutually agreed upon flat file) to demonstrate their care coordination activity and interventions delivered in support of NHP's performance objectives and KPI measures
- Follow standard care coordination guidelines established by NHP for quality, and are subject to audit and inspection
- May be a APM Level 1 or Level 2 certified provider or a SIM provider

Payment Model

Accountable Providers receive the most generous payment of all providers from NHP. These providers are also eligible to receive additional earnings from the $4 PMPM KPI bonus pool.

Identification of Accountable and Collaborative Provider Relationships

Using our local experience and knowledge of the provider community and our Colorado-specific analytics tools, we have identified the following providers as initial candidates for Accountable or Collaborative Provider relationships.

Our primary target list for Accountable and Collaborative Provider relationships includes 26 PCMP sites who serve more than 80 percent of Region 2's attributed Members. These sites represent 26 distinct providers. Each one of these PCMP sites serves over 400 Members, with the largest PCMP site serving nearly 17,000 Members. The median number of Members at these PCMP sites is 1,019, with an average of 1,642 Members.

Region 2 Members are served by over 450 PCMP sites.

- **The top 5 PCMP sites by volume serve 53 percent of the Members**
- **The top 15 PCMP sites by volume serve 70 percent of the Members**
- **The top 26 PCMP sites by volume serve 80 percent of the Members**

Over 40 percent of Region 2 membership is concentrated among the top five PCMP sites which includes our FQHC partners, Sunrise and Salud. NHP will expand access to care coordination for target high Member PCMP sites and any other willing providers that would like to build this capability internally or delegate to NHP.

Progression Plan

Our PCMP payment model is progressive. We will support practices as they transition from one level to another. Through that transition, we will be able to build a financial glide path for them, from one payment model to another. This financial modelling support will help practices evaluate and understand their true costs in practice transformation and enhancement. For example, if a practice is considering an upgrade from their existing care coordination system to a new system, we can provide them with preform financial models based on their progression from a Collaborative to Accountable Provider contract with NHP so that they can use that revenue differential to understand their investment against the opportunity. We believe this level of financial support exceeds the requirements of the RAE, but is directly in the spirit and purpose of the RAE.

Shared Accountability

As the RAE, we believe one of our key functions will be to align the provider community across different locations and places of service to those performance metrics that are most important to the region. Alignment will come from provider network management and outreach, Member education, care coordination, population health management, and through our financial support model and value-based design. We aim to encourage all providers to maximize their earnings by providing broad services and support to the Health First Colorado community. However, we will do so in a

practical and pragmatic approach whereby we prioritize those practices with the greatest scope and scale, or ability to influence and impact their local population with the most generous payments from NHP, with the expectation that these payments will reflect our expectations as described above. Through the use of our business intelligence systems, we can profile Region 2 providers to access the practices that would fit into our categories, model our payments to see how we would stand against the 33 percent minimum requirement, and begin to predict the contracting goals at the Operational Start Date so that we have enough providers working on the same KPI measures across the region to achieve Year 1 success for the program. Perhaps most importantly, we believe that by allowing the Accountable Providers to share in the KPI earnings achieved by NHP and receive supplemental earnings on top of their payments, we can create the right incentives for providers to work with each other in achievement of the next round of performance measures. An aligned community of Accountable Providers can and will share best practices and support each other in achieving these clinical and financial goals.

In short, Accountable Providers will not only be accountable to NHP, but also to each other since KPI funds are only available if the entire region meets it performance metrics. If one Accountable Provider falls short, the others will have an incentive to attempt to affect change.

Flexibility in Model Design

While we have established what we believe is a traceable, accountable, and value-based model, we understand that not all practices will fall into one of our convenient groups. Therefore, we have planned for this and expect to evaluate practice needs on a case-by-case basis if they do not fit into one our categories and require an alternate payment arrangement. For example, we have proactively identified practices that are associated with a larger organization that they will be able to delegate their care coordination services to. In this case, the individual practices will qualify as Collaborative Providers and their delegated care management funding will be directed to their parent organization that will be held accountable, by NHP, for the provision of the care management services. This removes the burden on the individual practices from managing the provision of these delegated activities, allowing them to focus instead on the delivery of cost effective and clinically appropriate care.

Health Neighborhood Providers

In addition to PCMP providers, NHP also intends to financially support Health Neighborhood Providers and stakeholders that need assistance to work through specific business challenges that may be a barrier to serving the regional Health First Colorado membership. In our proforma budget and business plan as the Region 2 RAE, we have included an innovation fund with the intention of using these funds to invest in people, process, technology, and Health Neighborhood projects. NHP's Regional PIAC meetings and provider forums will be used to gather ideas from the community and to present investment options back to those stakeholders for selection and implementation in Region 2.

In addition, we will also implement a community re-investment program whereby a portion of the bonus earnings are re-invested in the local region and communities we serve. NHP's Governing Board will determine which projects are funded. Initiatives may include assisting Health Neighborhood providers or agencies with one-time grants or start-up costs for new programs or service expansions as well as funding of grants or existing programs, such as the provision of housing vouchers in support of addressing social determinants of health.

OFFEROR'S RESPONSE 18

Describe how the Offeror will administer the Capitated Behavioral Health Benefit within the broader Accountable Care Collaborative while ensuring the continued delivery of sufficient Behavioral Health services and successfully managing the financial risk. Specifically address how the Offeror will:

a. Administer the Capitated Behavioral Health Benefit according to the principles outlined in Section 5.12.4.
b. Deliver services in multiple community-based setting.
c. Ensure compliance with federal managed care regulations.

a. ADMINISTERING THE CAPITATED BEHAVIORAL HEALTH BENEFIT

Northeast Health Partners, LLC (NHP) is fully prepared to administer the Capitated Behavioral Health Benefit within the context of the Accountable Care Collaborative (ACC) Program model. We will ensure the uninterrupted delivery of all medically necessary State Plan and 1915(b)(3) behavioral health services while also managing the financial risk and maintaining program quality. All services will be delivered according to the principles outlined in *Section 5.12.4* of this RFP.

We are uniquely positioned to deliver on these commitments. Our administrative agent, Beacon Health Options, Inc. (Beacon) has met this requirement by contracting as both a Behavioral Health Organization (BHO) and a Regional Care Collaborative Organization (RCCO) in the counties that comprise Region 4 since the inception of the RCCO in 2010. Beacon has been working in southeastern Colorado and the Pikes Peak regions serving BHO contracts for more than 20 years through Colorado Health Partnerships, LLC (CHP) and other various organizational structures. Also, Beacon was a partner and the administrative agent when Northeast Behavioral Health Partnership (NBHP) held the BHO contract for the Northeast Region from 2009-2014. Within these partnerships, Beacon has delivered consistently on key outcome and process metrics, ensuring program compliance, integrity, and quality for all Medicaid covered lives in their regions.

Similarly, our provider partners also have met the requirements of this section. Each of our Community Mental Health Center (CMHC) partners (i.e., North Range and Centennial) have a proven track record for delivering high quality behavioral health services in their region. They were also partners in NBHP as noted above, which previously held the BHO contract serving all counties involved now as Region 2, plus Larimer and Elbert Counties. They offer Health First Colorado Members a comprehensive continuum of behavioral health services that are closely coordinated with other medical services. Our CMHC partners have been leaders in their communities for nearly 60 years, and they are seen by Members and stakeholders as the provider of choice for integrated behavioral health care and medical care.

Our Federally Qualified Health Center (FQHC) partners (Salud and Sunrise) form the third pillar in this efficient model of care. Both of these organizations have been community mainstays for decades. For many Health First Colorado Members, they are the source of primary care medical services and a long standing source for behavioral health services. Both organizations have demonstrated their ability to develop and maintain a wide array of innovative and relevant prevention and intervention programs within an integrated care model.

At the foundation of all our services, NHP and our provider network is committed to several key principles. First among these principles is a Member-centered service philosophy that supports Member recovery and resilience. Services are designed specifically to support Member and family empowerment, increased competency, and self-efficacy. Members are the leaders in their own recovery, yet they are supported fully by a team of caring professionals and para-professionals. Members define their own treatment goals and help set their own pace for change. They may work

with therapists, case managers, peer specialists, psychiatrists, and other medical professionals to develop and implement a treatment strategy that is created to meet their unique needs and goals. We have had particular success with the use of peer specialists and Member advocates. These staff are individuals who have "lived experience" of mental illness, substance use disorders, or those who have chronic or acute medical conditions that affect their behavioral health. These team members often serve as role models for successful coping and recovery.

We are also committed to providing services within a trauma-informed care perspective. We recognize that Members have often suffered trauma, and this experience has affected their ability to cope with daily stressors. This perspective results in an increased understanding of the whole person, rather than simply seeing them as a collection of symptoms or behaviors. Trauma-informed care is respectful, welcoming, safe, and non-stigmatizing. It acknowledges a person's capacity for recovery and resiliency. Below, we have developed a governing statement listing the 10 guiding principles for trauma-informed care.

Elements of our Family-Centered and Trauma-Informed Care

Family-Centered Care

- Focusing on dignity and respect for Member/family
- Maximize family involvement in care
- Respect Member/ family wishes for interdependence and privacy

Family-Centered and Trauma-Informed Care

- Integrated in every Member interaction
- Share information with Member and family
- Encourage family participation
- Building upon family strengths and needs
- Cultural competence and sensitivity

Trauma-Informed Care

- Minimize potential for distress during medical care
- Address distress in the course of treatment
- Promote emotional support
- Encourage return to daily activities when possible

NHP is committed to delivering behavioral health services in the least restrictive environment. We recognize that timely intervention and crisis stabilization services can mitigate the need for inpatient or residential treatment, and Members can get the treatment they need while remaining in their homes and communities. Through our extensive provider network, we can offer home and community-based treatment that is equally or more intensive than residential services, yet provided in the familiar home setting. Examples of home-based services include our Assertive Community Treatment (ACT) for adults and the Virtual Resident Program (VRP) for youth.

Our services are sensitive to the cultural traditions and language needs of our Members. Each of NHP's organizations have developed and maintained comprehensive cultural competency plans to ensure that all providers are aware of Members' cultural differences, how they might impact treatment, and how to treat Members within culturally sensitive boundaries. Our network includes a large number of providers who can work with Members who do not use English as their primary language. We have providers who often can work in the Member's primary language, or can use translation services effectively.

NHP emphasizes the importance of prevention and early intervention services. We offer a full continuum of clinical services that includes several prevention and early intervention components. These services focus on two primary goals: education and empowerment of Members, and the identification of Members who need more support. We accomplish these goals through a variety of means, including data analytics, provider and Member education, community networking, and Member advisory committees. These efforts have resulted in reducing the stigma associated with

behavioral health care and attribution to primary care physicians rather than the use of emergency department for routine care.

Covered State Plan Services

NHP is fully capable of providing all of the required State Plan Services identified in *Sections 5.12.5.6 through 5.12.5.7.16* in the RFP. These services are offered in multiple settings throughout the service region. In many cases, a Member will receive multiple services that can be well-coordinated because they are provided by care teams from a single provider organization and in a single location. Each of these services is described briefly below.

Screening and Assessment Services

NHP is capable of providing individualized assessment throughout its entire region. Its existing network of providers, who are already credentialed through Beacon's BHO contracts, is adequate to meet the access to care requirements for routine, urgent, and emergent clinical needs. Members may initiate care by calling our dedicated Access to Care line, or by calling one of our Colorado Behavioral Healthcare Council (CBHC) partners, or another network provider. For network providers, most assessment procedures do not require prior authorization, thereby streamlining and facilitating the process for Member engagement. Each Member is offered a comprehensive and holistic assessment, which includes exploration of behavioral health and substance use disorder symptoms, history, developmental history and disability factors, mental status, co-existing medical conditions, and more. The assessment process results in a preliminary plan of care and referral for additional services, when appropriate. In addition to reviewing a Member's behavioral health treatment needs, the assessment may help identify other challenges that affect daily living and treatment outcomes. These factors might include needs such as housing, food security, recreation, child care, employment, need of medical care, and transportation. We have a variety of referral tools, including Beacon's proprietary provider directory available via ReferralConnect, to help Members identify and access the most appropriate provider to meet their needs.

Individual, Family and Group Psychotherapy

NHP and our treatment network is capable of providing individual, family, and group psychotherapy to its Members. Individual therapy is provided in sessions that are 30 minutes to less than two hours in duration; and brief individual psychotherapy is provided for intervals up to and including 30 minutes. Family therapy is a face-to-face therapeutic intervention with two or more participants who are part of the Member's family or primary support group. Group psychotherapy is a treatment intervention with two or more Members and it is typically one to two hours in duration.

Through our current partnerships, we have implemented a variety of evidence-based outpatient programs over the last several years. Some of these programs have been so successful that they have been offered continuously for more than a decade, with best practice updates as needed. These programs were chosen because they provide Members with high-quality treatment interventions that have demonstrated efficacy for specific sub-populations or conditions. The following list includes examples of the specialized individual, family, and group psychotherapy programs we have supported in one or more parts of our service area. These programs often address key service needs of specific communities and each is aligned with our core treatment philosophies. A sample of these programs includes the following evidence-based treatments or promising practices:

- Dialectical Behavioral Group Therapy (DBT) is designed to teach coping skills that promote resiliency
- Functional Family Therapy is a family-based prevention and intervention to treat high-risk youth and their families

- Multi-Systemic Therapy (MST) is a family and community-based treatment program that has proven effective for individuals who are involved in multiple systems, including juvenile justice services
- Seeking Safety program assists Members in attaining safety in their relationships, thinking, behavior, and emotions and is a model program for integrated treatment of behavioral health, trauma, and addiction issues
- Integrated Dual Diagnosis Treatment uses multiple clinicians working together, in a single setting, to provide coordinated behavioral health and substance use disorder interventions
- Parenting programs, such as Incredible Years and 1,2,3 Magic, include developmentally-based curricula for parents, teachers, and children that are designed to promote emotional and social competence and prevent, manage, or treat behavioral or emotional problems in children
- Trauma-Focused Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing are two programs that are specifically designed to address Posttraumatic Stress Disorder and other symptoms of trauma.
- Moral Reconation Therapy is a group for adults or juveniles involved in the criminal justice system. This therapy offers a cognitive-behavioral approach that leads to enhanced moral reasoning, better decision making, and appropriate behaviors. The goals of the program are to confront beliefs and behaviors, assess current relationship, reinforce positive behavior, create positive identity formation, enhance one's self-concept, decrease in pleasure-seeking, develop frustration tolerance, and improve one's moral reasoning.

These are just a few examples of the evidence-based programs our partners have implemented in the last several years, but they are representative of our ongoing efforts to improve Member outcomes through the range of outpatient services we offer within our care network.

Medication Management and Other Psychiatric Services

Psychiatric services in our network may be provided by:

- Board certified, licensed psychiatrists
- Licensed and supervised psychiatric physician assistants
- Masters-level psychiatric nurse practitioners with Colorado prescribing authority and the appropriate collaborative agreements with supervising psychiatrists
- Registered Nurses, Licensed Practical Nurses, medical assistants and case managers work with our prescribers to ensure medication management, monitoring, and adherence. Member education is an essential part of our psychiatric care.

Medication management services are critical to good quality care. Access to psychiatric care is a critical problem throughout the state in both urban and rural areas. Due to unmet demands for psychiatrists across the state, fees have escalated and many psychiatrists have limited their practices to cash paying and compliant Members. High no-show rates and stringent documentation requirements make Medicaid Members even more unpopular with private sector psychiatrists, who are in high demand. Our staff have worked to increase capacity for psychiatric services throughout the counties that comprise Region 2 and to reduce inefficiencies related to no-shows and missed appointments. Some of our innovative approaches have included same-day or walk-in access to psychiatric appointments, automated reminder calls, use of mid-level prescribers and physician extenders, telemedicine services, and transportation assistance to appointments.

NHP has also taken definitive steps to eliminate access barriers for Members who are referred from their primary care providers or other specialty medical providers, who have already assessed the Member in their medical home setting. We are evaluating alternative referral mechanisms that prioritize primary care referrals and eliminate the need for a full behavioral health intake prior to

treatment by a psychiatrist. We are committed to working with primary care providers to improve our responsiveness to referrals.

As the Regional Accountable Entity (RAE) for Region 2, our staff will take proactive steps to eliminate barriers to recruitment and retention of psychiatrists in our care network. Our provider network will be open to any willing psychiatric physician and we also are willing to contract for single case agreements. Our fees are re-evaluated on no less than an annual basis. We do not require prior authorization or continued treatment reviews for most psychiatric services. Additionally, we have reduced other administrative burdens that might be a deterrent to psychiatric network membership.

Examples of steps taken by our administrative agent, Beacon to maintain qualified psychiatrists in their network include:

- We take a responsive approach to problems our psychiatrists have with claims processing or credentialing
- Our Chief Medical Officer will personally contact and recruit psychiatrists, as well as provide support and consultation, as needed
- Our partner behavioral health centers have enrolled in the federal student loan repayment program that financially incentivizes providers to work in rural or underserved areas
- We have developed a robust tele-psychiatry capacity that allows us to bring highly qualified psychiatrists into our care teams through tele-video connections

Through efforts like this, we will build a robust psychiatric provider network, which allows us to continue serving Members without interruption. This network of psychiatric providers is larger than it otherwise would be, if we had not implemented and maintained our recruiting efforts.

Processes for Psychiatric Services. Psychiatric services include:

- Comprehensive diagnostic and whole person medical assessments
- Prescribing appropriate medications
- Member/guardian medication education regarding risks and benefits (e.g., effects and side effects)
- Ordering and review of necessary laboratory work
- Ongoing medication monitoring and adjustments
- Provision of direct care in psychiatric inpatient hospital and Acute Treatment Unit (ATU) settings and Residential treatment facilities
- Consultation with primary medical providers

Access to psychiatric services is obtained by several means. Members and/or their family can:

- Access services from any independent provider network psychiatric service directly, without referral or prior authorization.
- Access services as a part of a comprehensive treatment program offered through a CMHC provider.
- Call NHP's Engagement Center operated by Beacon in Colorado Springs and obtain referral assistance to nearby psychiatric service providers with their contact and office information. This information is available at our toll-free number 24/7.
- Our psychiatrists provide direct consultation to Primary Care Medical Providers (PCMPs) and/or see Members in FQHCs.

Members who already have a psychiatric provider and wish to keep their provider, can request a Single Case Agreement (SCA) for that provider to continue working with them.

As previously noted, NHP has an established network of psychiatric care givers located within the urban, rural, and frontier communities throughout Region 2. We will require every psychiatric provider to provide emergency services, as needed, closely monitor, and actively respond to complaints from Members regarding timely access. We have implemented several innovative interventions to ensure Members have timely access to psychiatric services, including physicians who travel to multiple offices to provide easier access for those living in remote areas, use of locum tenens physicians for areas in which psychiatric physicians are difficult to recruit, the addition of psychiatric nurse practitioners and physician assistants as physician extenders, flexible scheduling, and widespread use of telemedicine. Many of our behavioral health center partners have introduced walk-in or same-day access to psychiatric clinics that reduce no-show rates and increase Member access to psychiatric services.

Outpatient Day Treatment Services

Day treatment services are a structured, non-residential program of therapeutic activities lasting more than four hours and less than 24 hours per day. These services are available to NHP Members through our provider/facility network. Day treatment services for youth are typically provided in a school setting with specialized therapeutic supports, including individual, family, and group therapy. Members participate in a therapeutic milieu that offers real-time intervention and redirection. Our staff members will work closely with school and program staff to identify treatment goals and to monitor progress. Treatment can be tapered to allow the Member to gradually transition back to a regular school setting with appropriate Special Education supports, if needed. Day treatment and partial hospitalization services are available for adults, as well. These services are typically used as a diversion from inpatient hospitalization or as a step-down for Members who require an extended period of intensive treatment, but do not meet the medical necessity criteria for the inpatient level of care. Adult day treatment services have been used successfully by our provider partners for clinical populations that require specialized care, such as eating disorder treatment.

School-based Services

Reviews of studies of children’s access to behavioral health services indicate that schools and health care settings are important portals of entry into treatment. In fact, children are more likely to access behavioral health services through primary care and schools than through specialty behavioral health clinics (National Child Traumatic Stress Network, 2009). Engagement in non-traditional treatment settings, such as schools, may be especially important for Members from minority racial and ethnic cultures. School-based treatment may be seen as less stigmatizing and an ideal forum for psycho-educational interventions.

Our network will provide a variety of innovative onsite, school-based, behavioral health services in Region 2. Our NHP partner, Centennial employs a School-Based Specialist that provides risk assessment and consultation to any district that requests it. They, along with North Range, also provide direct services in several schools as well as a great deal of prevention in schools. The most common school-based services are assessment, counseling, consultation, prevention, and early-intervention activities. School-based behavioral health providers routinely observe at-risk students’ behavior in the classroom, provide consultation to the students’ families and teachers on problem behaviors and work closely with physicians and other medication prescribers in school-based health clinics. School-based therapists also provide resource information to families and assist in the coordination of needed services. Family therapy services are available at provider offices, in schools, or in the students’ homes after school hours. Services for students do not stop with the end of the school year, but are continued during school breaks and summer vacation. Services may be provided in traditional school environments or as part of special education or alternative school programs for students with identified special education needs.

School services allow our providers to serve more Members and increase penetration rates among Members and their families, offer more specialized therapeutic services than school counselors can typically provide, and assist school personnel in managing their students' behaviors. This often decreases a school's need for suspension and expulsion as a way to handle problem behavior by offering effective alternatives for behavior modification.

For over 20 years, our NHP partners have built relationships with school administrators, teachers, and other stakeholders throughout our communities. These relationships are critically important. By having such an extensive onsite presence in community schools, NHP and our school-based providers understand and are sensitive to the cultural issues and variables unique to specific schools and regions. In Weld County, Sunrise operates a school-based health clinic with North Range behavioral health staff embedded. As the Region 2 RAE, we will explore expanding school-based health clinics where NHP's behavioral health providers will be able to work alongside medical providers in these clinics.

NHP's provider partners also offer services in Head Start and Early Head Start pre-schools across this service region. Early childhood behavioral health specialists consult with early childcare educators and families, as well as providing consultation to childcare staff, facilitating community outreach for young children, and promoting cross-system program collaboration. Our provider partners are active participants and leaders in early childhood councils across the region.

As part of the service planning process, the provider and family discuss the family's goals and develop a plan of action aimed at achieving the family's objectives regarding both physical and behavioral health care. This plan may include:

- Having a clinician in the classroom for observation and consultation with the teacher
- Having the youth involved in onsite support, therapy, and social role playing groups
- Providing individual counseling sessions on school grounds
- Utilizing Member and family advocates to assist families with IEP and 504 plan proceedings
- Bringing parents to the school for education on psychiatric illness, behavior problems, and parenting interventions
- Integrating the behavioral health clinician into Individualized Education Planning meetings with special education staff members

Targeted Case Management Services

NHP views case management as the mortar between the bricks, tying together the array of behavioral health services we provide to many Members and integrating this treatment with the other medical and non-medical services the Member receives. Our network providers are experts at using case management services in conjunction with care coordination to assure the full spectrum of total care is addressed with individuals and families in need of targeted case management. We use this key intervention to keep treatment on track and maintain Members in the least restrictive setting that is possible.

Case management comprises four specific services: assessment of needs, care plan development, referrals/connections, and follow-up. Assessment of needs is a critical part of case management. It ensures Members receive all of the services they need, resulting in better outcomes. After the assessment is complete, a NHP case manager is responsible for developing a Member-centered care plan. The care plan documents treatment goals, cultural issues, and Member goals, and it lists the actions necessary to provide the Member with all necessary medical, social, and educational services he or she may need.

After a care plan is developed, the Member is referred to care providers for the required services. Depending on the needs of the Member, the referral process can also include assisting the Member to schedule an appointment and even arranging for transportation.

Monitoring and follow-up activities are essential for ensuring the care plan is effectively implemented and addresses the needs and goals of the individual. Follow-up may include the individual, family members, providers, or other entities, and is conducted as frequently as necessary. Changes are made to the care plan, when needed, to ensure the Member is getting the level of assistance required.

We have enhanced our case management services by training and hiring peer specialists and advocates throughout the service region. Trained peer specialists and recovery coaches, who meet the competency guidelines approved by the Department, are employed at partner provider offices. Peer specialists have a unique understanding of the service delivery system, having used services themselves. They are able to help other Members navigate the system, find services, and advocate for themselves. Most importantly, they are able to act as role models and mentors, empowering Members to achieve their own personal goals.

Targeted case management services for substance use disorders are those services aimed specifically at special groups of enrollees, such as those with co-morbid developmental disabilities or chronic mental illness, who are being treated for substance use or dependency issues. Our substance use disorder targeted case management services will focus on these groups:

- Those at risk for re-incarceration for legal infractions due to substance use
- Those at risk for re-hospitalization due to severity of relapse
- Those with co-occurring substance use disorder and behavioral health disorders who are not yet able to identify symptom reoccurrence, master coping skills, or implement an action plan that impedes relapse or symptom exacerbation
- Those with advanced physical health deterioration due to substance use disorder
- Families at risk of having their children in out-of-home placement due to substance use in the family

Our targeted case management services include bio-psychosocial assessment and development of an individualized, coordinated case management plan to ensure the Member has access to needed medical, social, education, and other related services. This plan is developed with the Member and may also include input from family, significant others, and community agencies knowledgeable about the Member's needs and goals.

Targeted case management also includes coordination and consultation with other agencies, such as County Departments of Human Services and providers, to ensure the most appropriate interventions and services are provided to the Member. The case manager periodically assesses the Member's status and, where needed, modifies the targeted case management service plan or the Member's clinical treatment plan.

Rehabilitative Services

Rehabilitation is defined as "the process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal, or as near normal manner as possible." This is the daily goal for our partners and network providers, a goal that is fully aligned with our overall mission and vision.

NHP already has the capacity to provide all of the services that are defined in this requirement. This includes long- and short-day services, as well as individual and group services. We also provide

medication assessment and monitoring, case management, vocational services, and peer support services.

We will offer a comprehensive array of traditional, evidence-based, and promising practices that focus on increasing the level of functioning of Members, so they may feel confident interacting, living, and working in their communities.

Examples of the specific rehabilitation services we provide include:

- Individual, individual brief, and group therapy using evidence-based interventions such as cognitive behavioral therapy, dialectical behavior therapy, trauma-focused CBT, and co-occurring substance use disorder and behavioral health treatment
- Disease management interventions for those with co-morbid behavioral health and medical illnesses
- Group therapy involving peer mentors that focuses on rehabilitation skills such as social interactions, independent living skills, living without drugs and alcohol, communication skills, personal appearance, income management, and symptom management skills including early warning signs, medication management, and action plans when one is in need of additional support.

Vocational Rehabilitation

Vocational rehabilitation services include school-to-work preparation and job seeking groundwork such as resume writing, job application completion, volunteering, interview techniques, and interview rehearsal. Our providers also engage in job coaching and interventions with employers. Job-related skills training includes teaching the Member techniques for working with colleagues and supervisors, and on-the-job problem solving.

Recovery-based Psychosocial Rehabilitation

Our providers will adhere to a set of methods for determining rehabilitation readiness, setting an overall rehabilitation goal, conducting a functional assessment, and providing skills training. After the evaluation is complete, a plan is developed with the Member using his or her strengths, supports, preferences, and choices. For example, if a Member is living in a residential setting, and his goal is to live independently, his plan may include individualized instruction on how to manage banking and finances. This could include instructing him how to make deposits, pay bills, read bank statements, and balance his checkbook. Another Member may construct a plan that teaches her how to manage the symptoms of her mental illness, and how to recognize when her symptoms are becoming unmanageable. This will allow her to live more independently because she will have learned how to manage her illness.

These methods are consistent with our fundamental philosophies related to recovery, resiliency, Member-centered care and trauma-informed practice. They emphasize Member empowerment, advocacy, a Member-centered planning process, and Member choice.

Psychosocial plans also may include:

- Assistance in understanding and coping with one’s illness
- Crisis planning
- Skill development to counter stigma
- Daily living skills (i.e., using public transportation, managing finances)
- Education on topics of mental illness, medications, treatment options, and choices
- Recreation and leisure time use

- Social interactions and information on peer-related resources such as peer-related mutual support groups or drop-in centers

Substance Use Disorder Assessment

NHP is fully capable of providing all of the substance use disorder assessment and treatment services required by this contract. We have an extensive provider network that is anchored by the CMHCs throughout Region 2. Members will have access to services within their local communities. Providers work closely with other relevant stakeholders, including county Departments of Human Services, probation and parole authorities, and local law enforcement agencies. This coordination is essential to help Members satisfy the assessment and/or treatment requirements imposed by these entities.

Each Member seeking substance use disorder treatment will receive a comprehensive assessment to determine the most appropriate level of care. Our level of care and utilization management decisions are based on the criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug or alcohol use or dependence, related behavioral and lifestyle problems, and the comprehensive treatment needs of the Member. Our substance use disorder provider network includes a range of professionals, including licensed counselors, social workers, psychologists, psychiatrists, and certified and licensed addiction counselors.

Alcohol/Drug Screen Counseling

Our Members will have easy access to drug screening and monitoring services (e.g., blood or urine assays to detect drug use) throughout the service region. Laboratory work is covered by the medical Health First Colorado benefit, while the associated counseling services are covered by NHP. Our Members will have an opportunity to discuss screening results with a qualified counselor, and this information is used to plan treatment, achieve long-term sobriety and prevent relapse.

Medication-Assisted Treatment (MAT)

MAT is an evidence-based intervention for addressing opiate dependence and its associated symptoms and impairments. Methadone or other controlled substances are administered to the Member to decrease or eliminate dependence on opioid drugs. Members will have access to a wide range of psychiatric medications, including Methadone, Vivitrol, and Suboxone, for the treatment of substance use disorders. These services are available through our provider network, and they are integrated with other behavioral health and primary care services. Medication therapies are used as one part of a holistic approach to treatment that typically includes other interventions such as medical care coordination, group therapy, individual therapy, or case management services. MAT is provided by an appropriately trained/certified licensed physician, physician assistant, or psychiatric nurse practitioner who carefully monitors the Member’s treatment progress and adherence.

Social Ambulatory Detoxification Services

Our detoxification services are provided in a social detox facility that are licensed by the Colorado Department of Human Services, Office of Behavioral Health, according to ASAM criteria, and have less than a 23-bed capacity. Treatment staff provides face-to-face monitoring of the physical process of withdrawal from alcohol or other drugs. The focus of this service is to stabilize the Member and return him or her to the community and the appropriate level of care.

Processes for level of motivation assessment. Our level of motivation assessment covers multiple domains related to a Member’s motivation for treatment. It is completed by trained and appropriately credentialed staff in one of the partner behavioral health centers, or by an independent provider in our network. This service can be provided in a variety of settings, and it is often a key component of social detoxification treatment. Areas of assessment include an evaluation of the Member’s reasons for seeking treatment, past success or failure with treatment, family’s response to

treatment, potential obstacles to treatment, and more. The level of motivation assessment also is enhanced by our use of the evidence-based practice of motivational interviewing.

Processes for provision of daily living needs including hydration, nutrition, cleanliness and toiletry. For some Members, alcohol or drug addiction can be so devastating that it compromises their ability to manage the usual activities of daily living. Without appropriate support during their recovery, such individuals may deteriorate significantly and experience dehydration, malnutrition, or other problems related to their incapacity to maintain cleanliness. These Members may benefit from personal care services that can be provided in their home environment. As with other services, this need is assessed by NHP treatment staff during the initial phase of treatment and then periodically reassessed throughout the course of treatment.

Personal care services to meet daily living needs are provided in the Member's home environment. These are often supplemented by skills training or classes in cooking, nutrition, and other self-care skills. The need for these services is often identified during the initial assessment, but could be identified at any stage of treatment. These services are typically short-term and are needed only until the Member is sufficiently stabilized to meet these needs independently.

Processes for safety assessment. As part of the assessment process, all Members have access to a face-to-face safety assessment. This assessment identifies risk factors and protective factors that affect the Member's potential for self-harm or harming others. When significant risk is identified, it is addressed immediately through crisis services, or if the risk is not imminent, it is addressed through treatment planning and intervention.

A safety assessment is completed by an appropriately credentialed network provider who is working within the scope of their training and supervision. The safety assessment is initially completed during the intake process, but can be repeated at any time during the course of treatment, particularly when the Member experiences relapse or other crisis. Safety assessment includes the development of a safety plan that can help prepare the Member for a future crisis.

Outpatient Hospital Services

NHP has the capacity to provide the required outpatient hospital services, including services typically described as partial hospitalization services. These services are an intermediate level of care that often serve as either a diversion from inpatient care or a step-down from that level of care. The services are provided within a cohesive program structure in a health care facility (i.e., hospital), but the Member does not remain in the facility 24 hours per day.

We acknowledge that, if awarded this contract, we will be responsible for outpatient hospital services based on the diagnosis and billing procedures of the hospital, as outlined in this RFP. NHP will be fully compliant with these expectations and has billing and technology solutions in place to guarantee our compliance.

Emergency and Post-Stabilization Care Services

We have an emergency response program that includes a telephone crisis support line that operates 24 hours a day, seven days a week, and is supported by trained clinicians strategically located throughout the service area. Our call center consistently maintains an average call answer speed of less than five seconds and a call abandonment rate that is less than two percent. When a psychiatric or substance use emergency arises, early and effective intervention prevents disruption of Members' lives, promotes rapid stabilization, reinforces strengths and hopes for recovery, and fosters family resiliency.

Our rapid response system sets the standard for reliable and responsive service. Our goal with these rapid response services is both to resolve the current crisis and to foster resiliency as protection against future crises. NHP's providers, along with our care management crisis line, will function as the foundation and hub for intensive emergency services throughout our service area.

Processes for emergency services. Emergency services may be readily obtained 24/7 by:

- Calling our emergency services line
- Going directly to a hospital emergency room
- Going directly to a detoxification center
- Going directly to the Northeast Region crisis center in Greeley
- Calling the Colorado Crisis Services Hotline
- Calling any of the partner CMHCs
- Calling the Member's private network therapist

Through Beacon's current contracts with the Department, we operate a crisis support line 24 hours a day, seven days a week. On average, this line is answered in less than five seconds, and it is monitored by staff members who are both trained and experienced at responding to emergency requests and crisis situations. The clinician documents all information captured during the call in our CareConnect electronic records system. This information is used to assist in the initial assessment of a Member and in all subsequent care. Members may seek emergency services from any hospital emergency room, and these are covered services that do not require prior authorization.

In addition, our CMHC provider partners have an after-hours call center where local office phones are forwarded, as well as available walk-in appointments and 24/7 emergency assessments. State rules mandate a response to emergency assessment requests within one hour in urban areas and within two hours in rural and frontier areas.

We do not limit where clinical staff can go to perform a mobile emergency assessment. In fact, we have the capacity to perform emergency assessments in homes, schools, nursing homes, jails, primary care physician offices, and public places such as under bridges where some homeless Members reside or congregate. Our only requirement is that arrangements must be made for the personal safety of the staff members who respond.

In addition to the emergency triage services provided by NHP's clinical staff, independent private practitioners who are under contract with NHP are required to provide emergency coverage 24 hours a day, seven days a week. A sample of contracted providers is called each quarter to ensure compliance with this expectation. Emergency services include 15-minute telephone response, face-to-face assessments within defined timeframes, mobile crisis response, diversionary interventions in the community, and acute inpatient hospitalization.

NHP is responsible to pay claims for emergency room services billed on a CMS-1500 and ANSI 837-P-X12 form for Members diagnosed with a covered behavioral health disorder. We also acknowledge our understanding and willingness to provide or arrange for the provision of all emergency services and post-stabilization services, as specified in this solicitation. We will comply fully with all requirements related to the billing of psychiatric and substance use disorder emergency and post-stabilization services covered by the contract.

Inpatient Psychiatric Hospital Services

NHP's utilization strategy for inpatient hospitalization has been tested and refined over the last 22 years that Beacon has operated as a partner to the BHO in the South/West Service Area, and more than 40 years that our CMHC partners have been working in their respective communities. We have continually refined an innovative model that improves recovery and resiliency while making the best

use of community resources, collaboration with community stakeholders, and in partnership with the Member to develop their own strengths to successfully live in the community of their choice. Inpatient hospital services can be accessed through any of NHP's emergency services or through transfer from a medical/surgical hospital unit.

Regardless of whether a Member is a child, adult, or senior, NHP uses inpatient hospitalization to stabilize individuals whose needs are more serious and require more intensive or restrictive care than what is available or possible in an outpatient clinic or other community-based setting. Involuntary hospitalization may be used for Members who are deemed a danger to themselves or others and those who are acutely and gravely disabled. A Member who recognizes that he is seriously ill may seek voluntary hospitalization, when it is medically necessary. Having the ability to seek help promotes empowerment and self-determination—both of which are fundamental to the principles of recovery and resiliency.

As a result of this progressive recovery-oriented approach, a number of system transforming outcomes have been achieved during the BHO-era by Beacon and their partner CBHCs. For example, the number of overall admissions per 1,000 Members has decreased from pre-BHO rates, while the average length of stay has remained relatively constant. There are two important conclusions we can draw from these outcomes. First, more Members are receiving comprehensive outpatient services that allow them to stay out of the hospital and in their homes. Second, more financial resources are available to treat those Members who do require hospitalization.

Processes for providing inpatient services. When a Member requires inpatient hospitalization, the psychiatric admission evaluation, inpatient treatment interventions, and transitional discharge planning are implemented simultaneously. NHP has developed a streamlined admissions process that is responsive to the immediate needs of the Member. It begins with a holistic health care assessment that involves the Member as well as family members, support system members, and treating professionals. The objective is to make sure the Member begins receiving care as quickly as possible, and caregivers capture the information they need to build effective treatment interventions that seamlessly continue as the Member is discharged from the inpatient setting. Our evaluation process includes the assessment of both behavioral health and substance use disorder needs.

All pertinent information from this crisis assessment is captured in the CareConnect data system by the care managers at our 24/7 call center. The CareConnect record also contains key information concerning prior treatment. Collectively, this information often holds the key to effective and rapid stabilization, as well as comprehensive discharge planning that prevents subsequent re-hospitalization. Each step is critical to building resiliency and enhancing recovery.

A well-crafted, Member-centered discharge plan, which is co-created by the Member and the treatment team, ensures the Member receives the follow-up services necessary to promote recovery and resiliency. Discharge planning includes a variety of transitional services, such as transportation, housing, medications, primary care appointments, coordination with social services or probation, and other services as needed. By ensuring services are not interrupted as Members transition from a hospital setting to a community setting, we are able to decrease the likelihood that serious crises will result in additional hospitalizations.

Processes specific for those under 21 years of age. While it is generally preferable to keep youth in the home setting with their families, there are situations in which hospitalization is required. In these cases, we work diligently to admit the child or adolescent to a facility that is close to home. This allows family members and friends to be part of the care team and to remain active in the Member's treatment. Ongoing contact with family and other supports is a key value that is threaded through our Member-centered, trauma-informed care process. This contact facilitates a recovery

process that is non-blaming and keeps the focus on the needs of the family system in addition to the needs of the individual Member.

It has been estimated that approximately 25 percent of children and adolescents in the U.S. experience at least one traumatic event, including life-threatening accidents, disasters, maltreatment, assault, and family and community violence (Costello et al, 2002). Exposure to traumatic events can impede psychological development and increases the risk for poor academic performance, engagement in high-risk behaviors, and difficulties in peer and family relationships. Likewise, trauma exposure is associated with increased juvenile justice involvement and increased use of crisis behavioral health services.

Outcomes are improved when families participate in the treatment process. Therefore, we provide a variety of services that allow families to build an effective at-home support structure following inpatient discharge. Onsite care coordinators work with family members to help them understand mental illness, the treatment process, and how they can participate in that process. NHP staff members also assist families to navigate the behavioral health system, as well as other systems such as social services, juvenile justice, and primary health care when services are not being provided in an integrated care setting. Care coordinators work with the family to develop long-term treatment planning, assess family goals, and where necessary, provide for basic unmet needs, including housing and transportation.

All of the facilities we use are medically staffed and psychiatrically supervised. Because they are specifically designed for youth under age 21, they also provide educational services.

Processes specific for those age 65 and over. Integrated care is always an important issue, but it is essential and a basic standard of care for Members who are 65 and older because they typically have higher rates of co-occurring medical conditions than the general population. For this reason, NHP staff will work to ensure all care is coordinated and all caregivers are in close contact with each other.

When an older Member requires inpatient hospitalization, our staff will make sure all relevant caregivers and family members are included in the admission process. Evaluations are often scheduled at an acute care facility or nursing home. This important step ensures the initial assessment is as comprehensive as possible, as well as affording comfort, convenience, and safety for the Member.

As with all ages, we have onsite continuity of care coordinators working with family members to help them understand mental illness, and more specifically, to help them understand psychiatric issues often found in the elderly. NHP staff members also assist families by helping them navigate the behavioral health system, as well as other systems such as long-term care facilities, primary health care, and how Medicare and Medicaid benefits interplay with one another. As with other age groups, care coordinators work with families to develop long-term treatment planning, assess family goals, and where necessary, provide for basic unmet needs. At discharge, transitional services are arranged that typically include providing or arranging for transportation, housing or other care facilities for the elderly, and the scheduling of primary care and behavioral health appointments.

These extra efforts ensure Members 65 and older receive the coordinated and integrated care they require for complicated and complex physical health and behavioral health conditions.

b. DELIVERING SERVICES IN MULTIPLE COMMUNITY-BASED SETTINGS

NHP's provider partners have been managing the capitated behavioral health benefit since the BHO program was first implemented in 1995. Over the last 20 years, we have worked diligently to add programs, recruit providers, and build relationships in each of the communities we serve. We believe in the value of Member choice and alleviating barriers to Member's access to behavioral health services. Our successes have ensured that every Member has access to high-quality behavioral health services.

Varied Geographic Location of Providers

We already have the capacity to be fully compliant with this requirement. Despite the geographic challenges of the region we serve, we have experience in building networks of providers adapted to its characteristics and in implementing a variety of access channels across the entire service area.

One of the biggest challenges with providing behavioral health services across this service area is the region's tremendous size, which is exacerbated by the numerous areas of sparse population. Many parts of this region are classified as either rural or frontier, based on their low population density. In some areas, it has been difficult to recruit and retain qualified behavioral health providers. Despite these factors, we have developed a robust provider network that can ensure everyone who needs behavioral health services has access to them either via face-to-face or tele-video services—no matter where they live or work.

Services are available in one or more locations in each of the counties we serve. We have worked tirelessly to recruit qualified private providers into our rural and frontier counties to ensure providers and services are accessible to Members who live in sparsely populated areas. These efforts include co-locating behavioral health providers in primary care settings such as FQHCs and rural health centers.

Provider Locations with 30 Miles or 30 Minutes

According to our most recent provider GeoAccess mapping reports, more than 90 percent of NHP Members are within 30 minutes or 30 miles of a network behavioral health provider. This is an extraordinary achievement considering the geographic area we serve. We have the ability to meet Members where they are when medically necessary services are needed. NHP providers can travel to various locations including Member homes, nursing facilities, schools, homeless shelters, employment sites, FQHCs, detention centers, clubhouses/drop in centers, and group homes.

Community-based Access

Community-based access is critical to our philosophy of engaging Members in treatment, and it is a necessity in our rural and frontier areas. In addition to our sizeable provider network, NHP's behavioral health center providers offer many accessible satellite locations and offer medically necessary services at numerous alternative treatment sites. These include:

- Primary care offices/clinics
- Public health nursing clinics
- Homeless shelters
- Member homes
- FQHCs
- Hospitals
- Intellectual/developmental disability treatment clinics
- Social/human services
- Alternative care facilities
- Detention facilities
- Community centers
- Rural Health Clinics
- Schools
- Nursing homes

NHP has also partnered with emergency rooms across our region to help provide crisis intervention and diversion services that ensure treatment in the least restrictive, yet most appropriate level of care. Crisis services are also provided at many community locations in addition to hospital emergency rooms, including:

- Assisted living facility/custodial care facility/group homes
- Nursing facilities
- Schools
- Substance use disorder treatment facilities
- Member homes
- Community agencies
- Homeless shelter/streets
- Jails/correctional facilities
- Medical hospitals

Evening and/or Weekend Support Services

Locally, Health First Colorado Members and families have worked with our CMHC partners to develop Member-centric and family-centered care practices that meet their needs, one of which is availability outside of standard business hours. Clubhouses, drop-in centers, warm lines, respite and acute care facilities, intensive case management, and home-based services are available. We have expanded clinic hours during many evening and weekend hours, and to meet the needs of working parents, expanded hours are regularly available for youth and family, and they include such services as family therapy, groups, home-based services, educational and skills training classes, and more.

NHP’s call center also has a toll-free telephone number that provides Members with 24/7 access to clinical staff. Staff members are available to respond to emergencies as well as more general questions related to Member benefits, names and locations of network providers, or queries regarding community resources. Comprehensive call center phone statistics, including call volumes, average wait time, and number of dropped calls are monitored on an ongoing basis to ensure clinical staff are easily reached.

In addition, all network providers are required to make after hours support services available for urgent and crisis contacts on a 24/7 basis. This availability across our entire network of independent as well as behavioral health center providers will be monitored by NHP.

Access to formal crisis services is also available through any hospital emergency department. We are able to dispatch mobile behavioral health crisis teams to every hospital emergency department in the service area. The ATU in Greeley serves as an additional Region 2 crisis service location. This ATU provides 24-hour access to crisis services 365 days a year.

Ensuring Access to Care through Strategic Use of Technology and Improvements in Operational Efficiencies

NHP’s providers and partners have a long history of meeting access to care standards at very high levels in our prior BHO and RCCO contracts. In fact, we have met the required access standards more than 99 percent of the time. We have accomplished this by developing proven operational workflows that provide efficient use of IT systems, staff, and workspaces. Our processes are continuously evaluated and improved. Performance reports and audits are monitored at the highest levels of our organization to ensure we are continually improving access to care.

A few of the strategies we employ to improve access to care include:

- We emphasize ongoing communication among providers, Members, and families to clarify expectations about the service delivery and scheduling process. We require that the service delivery and scheduling process is posted on our providers’ websites with a written copy provided during intake

- We have detailed information in our Member handbook concerning the process for requesting services
- When a Member contacts us for assistance with scheduling, we can live-transfer the Member to a provider, and we follow-up with both the Member and provider to ensure that the appointment was scheduled
- We reinforce access to care targets with provider front desk staff and clinicians through ongoing core competency and annual trainings
- We provide practice consultation that includes adjusting staffing roles and responsibilities and standardizing processes to ensure that appointment setting is tailored to the Member's current need—whether that is an immediate or routine need. For example, front desk staff are able to make routine appointments, but when they feel they cannot appropriately assess the Member, they immediately transfer Member to a clinician
- We provide quarterly access to care reports that show our performance on the routine, urgent, and emergent access standards. For those providers that are not meeting access standards, corrective action plans are required and monitored by our Provider Relations and Quality Improvement Departments. This gives continuous feedback and promotes a culture of commitment to meet access goals
- We are making telehealth a core program to expand access to services in the FQHCs, CMHCs, and primary care settings
- We are improving access to care by deploying automated appointment and prescription reminders and targeting identification of gaps in care to improve care coordination
- Our FQHC and CMHC provider partners have invested in Electronic Medical Records as a means to provide a common communication system and ready access to records for staff to look up Members information and available appointments
- Implementation of 'Just in Time' scheduling in our most populated region to ensure timely access to medication evaluation and monitoring with our prescriber staff
- Finally, we have reduced the administrative burden on providers by means of a dedicated, intuitive web portal to allow providers to focus more time on the delivery of care and less time on mundane administrative tasks.

c. ENSURING COMPLIANCE WITH FEDERAL MANAGED CARE REGULATIONS

NHP asserts that we will fully comply with all applicable state rules and contract requirements, if awarded this contract. Likewise, we will comply with all federal managed care requirements. As the RAE, we are fully committed to ensuring our compliance with all applicable privacy and confidentiality laws, regulations, standards, policies, and procedures. Our program integrity, fraud and abuse detection, compliance, quality, and utilization management programs will ensure the quality and safety of our clinical and administrative services. We strive continuously to improve on all of these.

Our Compliance Program is structured to ensure adherence to Health First Colorado rules, requirements, and applicable regulations. The Compliance Program is administered through the Compliance Oversight Group (COG). The Compliance Program's objectives include:

- Implementing systems, policies, and training that support and reinforce adherence to state and federal regulations
- As new integration efforts move forward, ensuring associated systems, policies, and education are implemented to support compliance with applicable state and federal regulations and requirements
- Meeting and exceeding the requirements of the Health First Colorado RAE program and contract, including timely and accurate compliance reporting

- Protecting the integrity of program data and medical records
- Ensuring effective systems are in place to safeguard against potential fraud, waste, and abuse
- Ensuring compliance with applicable privacy and confidentiality laws
- Focusing on providing high-quality, medically necessary services through a utilization management program that does not impede timely access to care
- Ensuring that encounter and claims data is complete, accurate, and valid

Our Compliance Plan guides the program's compliance monitoring activities, which are designed to proactively identify areas of risk that include process and system issues, errors, fraud, waste, abuse, and training needs. The written plan is designed in accordance with the seven elements of an effective compliance program as originally established by the US Sentencing Guidelines as follows:

- Policies, procedures, and standards that promote commitment to compliance, including a code of conduct
- Designation of a Compliance Officer who reports directly to the NHP Board and a compliance committee who meets quarterly to review compliance issues, directs monitoring processes, determines actions to mitigate non-compliance, and addresses deficits and systemic issues identified through compliance monitoring
- Each partner provider organization has a designated compliance officer to assure federal and state requirements are met and incorporated into day-to-day operations, that routine monitoring processes are in place, and that education is provided to staff on a regular basis
- Regular, effective education for employees about compliance
- A hotline for reporting compliance issues. All individuals who report compliance issues are protected against retaliation through internal policies and the Whistleblowers Employee Protection Act
- Disciplinary guidelines which are well-publicized for enforcing standards, including a system for responding to allegations of improper conduct or activities

Processes for internal monitoring and auditing that identify and deter fraud, include the following:

- Major areas: double billing, false claims/encounters, false or over billing, services provided do not match standards of care, misrepresented or non-covered diagnoses, encounter data does not match service provided, encounters for non-existent or deceased Members, failure to reimburse provider or subcontractor, and ensuring data validity accuracy and completeness
- Adjudication software for claims payment that includes built-in checks to avoid payment errors
- Specific software programming to review encounters, including:
  - Procedure code is not provided or is not on State-approved list
  - Place of service is not provided or is invalid
  - Start time is invalid or not provided and duration is invalid or not provided
  - Units is not provided or valid based on duration
  - Provider credential is invalid or not provided
  - Invalid modality code
- A data report card presenting the overall health of the encounter submissions is reviewed by NHP's Audit Committee, which develops actions necessary to ensure complete, valid, accurate and timely encounter data submissions
- Procedures for ensuring prompt response to detected offenses and development of corrective action plans when necessary

NHP's Compliance Plan will be updated annually to ensure consistency with regulatory and contract changes, to identify areas of focus for risk reduction, and to delineate monitoring activities, education and other plans for the upcoming year.

OFFEROR'S RESPONSE 19

Describe the Offeror's process for providing or arranging for the provision of each Covered Service and how 1915(b)(3) Waiver services will be used in conjunction with State Plan services to maximize available resources and outcomes for its Members. The response should specifically include the following:

a. Comprehensive list of the Offeror's package of 1915(b)(3) Waiver Services using the table in Appendix S. This comprehensive list shall include the type of services, the capacity/number of Members to be served, the number and location of service sites, and any special population(s) to which these services shall be offered.
b. Description of the Offeror's utilization management program and procedures.
c. Description of how the Offeror will meet the service planning, care coordination, and transition of care requirements.
d. Description of how the Offeror will leverage and coordinate with other agencies, particularly the Colorado Crisis System, Managed Service Organizations, and the Department of Child Welfare, to maximize available resources and outcomes for its Members.

Northeast Health Partners, LLC's (NHP) partners have extensive experience providing Covered State Plan and 1915(b)(3) Waiver services throughout Region 2. We have the necessary resources, expertise, experience, and infrastructure to continue to deliver these services without interruption as we transition from partners in the Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) programs to the Region 2 Regional Accountable Entity (RAE).

We believe a fully integrated, regional approach is critical to improving Member health outcomes and quality of life through the coordination of quality services and supports across systems of care while emphasizing Member choice, preferences, access, wellness, independence, and responsibility. We will continue providing or coordinating all Covered State Plan and 1915(b)(3) Waiver services through our established regional infrastructure that includes the relationships, provider network, processes, and systems necessary to meet the needs of our Members. With our unique partnership arrangement, NHP offers Members and their families a true system-wide continuum of care. We will also educate our care coordinators and provider and Health Neighborhood partners about these services so that Members can achieve the best possible outcomes by utilizing all of the services available to them across our region.

a. 1915(b)(3) WAIVER SERVCIES

NHP and our network of providers are fully capable of delivering all of the mandatory Waiver services identified in this section of the RFP. Our partners have been continuously delivering the mandatory Waiver services through BHO contracts since 1995, and through the RCCO contract since 2010. The Department of Health Care Policy and Financing (the Department) is assured that we have the resources and infrastructure in place to continue providing all of these services without interruption. Detailed information regarding these services, including the type of services, the capacity/number of Members to be served, the number and location of service sites, and any special population(s) to which these services are offered, is provided using the table in *Appendix S* of this RFP as **Attachment 8**.

Vocational Services

The vocational services provided by NHP will be designed to assist adult and adolescent Members who are ineligible for state vocational rehabilitation services and require long-term services and support in developing skills for employment and/or in obtaining employment. The vocational services provided by NHP assist Members in multiple programs through an integrative approach that recognizes that work and community engagement leads to recovery. By providing behavioral health Members with access to meaningful and competitive career opportunities, NHP utilizes an evidence-

base practice known as Individual Placement and Support (IPS) that is a powerful tool for fostering recovery. Furthermore, evidence suggests that 60-70 percent of individuals with serious mental health conditions want to work and that vocational involvement results in reduced mental health treatment costs.

We have established community relationships with employers and through our contracts with the Colorado Division of Vocational Rehabilitation (DVR) and Weld County Department of Human Services, which allows us to offer a continuum of high quality educational and vocational services to behavioral health Members. Through these programs, Members have access to an extensive list of vocational and educational opportunities, which include:

- Aptitude/vocational/cognitive testing
- Pre-employment training in job-seeking skills and resume writing
- Work skills training in areas such as computer skills, clerical skills, construction, food service and custodial certification through our Clubhouse Transitional and Supportive Employment Programs
- Volunteer and paid employment placement through our Peer Specialist model
- Job retention services (e.g., extended job coaching and support services)
- Guidance in daily living skills such as time and budget management
- Targeted services required for gainful employment via individualized treatment planning
- Work crew experience through our Assertive Community Treatment Team

Intensive Case Management (ICM)

NHP recognizes that recovery is not always a linear process. Members may experience occasional setbacks that destabilize their lives. However, with appropriate support, these setbacks do not inevitably lead to crisis or removal from the community. ICM services are used to assist these at-risk or high-risk Members and families.

As part of the service planning process, the provider and Member and/or family discuss the desired goals of treatment and develop a plan of action to achieve the family's goals. ICM services are designed to provide enhanced support in an effort to assist a Member and family in maintaining quality of life, as well as preventing the need for a higher level of care. NHP will provide a wide range of services within ICM, which may include all or some of the below, depending on level of Member need:

- Medication monitoring
- Advocacy and mentoring
- Life skills education
- Symptom recognition and guidance
- Education and skill-building
- Medication home delivery
- Strengthen family and parenting skills
- Linkage to other community resources

By arranging for these and other services, we are able to help many Members and avoid difficulties that might interrupt their recovery. Our provider partners have extensive experience providing ICM programs and services.

Prevention and Early Intervention Services

We emphasize the importance of prevention and early intervention offerings in our array of services. These services have two primary goals to:

1. Educate and empower Members to maintain healthy behaviors and lifestyles
2. Identify Members who may need additional help

Our experience informs us that prevention and early intervention education can be done via health fairs, informational booths, community trainings (e.g., QPR), and other types of presentations. This is also accomplished through brochures placed in various locations.

To accomplish these aims, we use four key strategies: information distribution, networking with community resources, data mining analysis to target at-risk populations, and health fairs.

Information Distribution

We will publish a variety of information, both online and in hard copy format related to health conditions and other topics. We will also offer information related to health and well-being through our website, the websites of our local partners, and through Achieve Solutions, Beacon's award-winning health information website. All of these resources provide information for adults and children on a wide range of health topics and issues. Our website also includes a provider directory and contact information so Members can seek help, if they need it.

Networking in the Community

Since working with the Department under the BHO Medicaid program since 1995, NHP and our provider partners have been building relationships with local community organizations including schools, law enforcement agencies, social service agencies, and more. Our staff are also working in homeless shelters, senior centers, and other settings where Members who need services might gather.

These community relationships are an important part of our prevention and early intervention efforts. Because we are out in the community every day, other Member-serving organizations know who we are and what services we offer. They routinely refer Members to our treatment providers. For example, our work with the North Colorado Health Alliance Action Lab allows us share information about people in the Greeley community with chronic issues. This may include Members who have suddenly stopped treatment and have encounters with law enforcement. This type of collaboration allows us to identify and outreach to people with issues earlier and to get them the appropriate level of care before matters escalate.

Data Mining and Analysis to Target at-risk Populations

NHP has a variety of information technology tools and methods that use diagnostic, epidemiological, cultural, and other demographic data to more accurately identify health risks for the Medicaid populations we will serve. For example, data from the Centers for Disease Control suggest people of Latino origin are 50 percent more likely to develop diabetes than people of other ethnicities. Further, evidence suggests a bi-directional link between diabetes and depression. With this information, we can proactively target at-risk Members to educate them about how to prevent or deal with diabetes and depression. Member education can occur through brochures, mailings, and health screenings.

This type of approach shows great promise in allowing us to better identify and treat our underserved populations. Ultimately, such strategies allow us to configure more effective outreach programs to ensure that Members are receiving the services they require.

Health Fairs and other Community Outreach

NHP and our providers look for opportunities to promote behavioral health issues and wellness throughout the communities we serve. In some cases, this includes prevention and education programs based on an identified need or specific request. For example, we frequently present to various community groups on positive parenting, suicide prevention, addressing bullying and underage substance use, common myths surrounding behavioral health, stress management, anger management, and the availability of state crisis services. In the wake of local tragedies, including recent floods and fires, many of these prevention efforts have resulted in the establishment of semi-permanent community support teams that have worked closely with emergency personnel and with survivors in the days and weeks after the event.

We also provide community health screenings at various events and health fairs. These include depression, alcohol, and anxiety screenings, and at a more general level, screenings that identify at-risk individuals who are not currently enrolled in mental health or substance use disorder programs Another community outreach method of note is North Range's well-attended school district "Mental Health Nights" evening breakout sessions about behavioral health topics of interest to teens, parents, and teachers.

Clubhouse and Drop-in Centers

A Clubhouse or drop-in center is often a starting place for recovery. A Clubhouse is not a service, but a community that provides support to empower Member recovery. It offers respect, hope, support, and limitless opportunities for friendship, education, and employment. Participants in Clubhouse programs refer to themselves as Members, not patients, clients, or consumers. The focus is on their strengths, rather than their illness. They laugh, share, socialize, learn, and gain hope.

We believe that Members must be involved in their own recovery and take responsibility for their own paths. One of the fundamental ideas behind Clubhouse and drop-in programs is that Members design their own services. This means that each facility is unique, and it also means that each Member has the opportunity to participate in their own recovery in a meaningful way. Our providers currently offer peer-run support groups for behavioral health conditions such as schizophrenia, bipolar disorder, depression, and anxiety. Other offerings might include exercise groups, craft groups, educational activities such as learning to sew or cook nutritious meals, and other similar organized peer-support activities.

Residential Services

NHP is able to provide residential treatment programs for adults and children. We believe a fundamentally important part of building long-term resiliency is providing a Member with the necessary resources to turn a crisis into an opportunity to learn to better manage one’s illness. This approach empowers the Member to recognize and take control of potentially harmful situations and turn them into positive life-changing events.

We will apply this principle to residential care, as well as to inpatient hospitalization. We will provide the necessary outpatient and ICM services so a Member has the resources and tools to manage a crisis at home. This allows the Member to preserve more choice in his or her recovery while avoiding the need to resign independence to the more structured and restrictive care associated with a residential setting. However, some situations make it necessary to provide a supervised, supportive living environment to give the Member access to specialized services and to ensure safety. In these cases, we will provide a variety of residential service offerings for adults and children.

NHP has a high-tech and high-touch approach to residential care management that sets a high standard for case management effectiveness. Our care managers and residential treatment liaisons at each of our partner Community Mental Health Centers (CMHCs) will be involved at each step to ensure Member and family needs are met:

- Upon admission
- With discharge and transition services
- During care planning and delivery
- With in-home follow-up

Services provided in the residential setting are customized to reflect the individual needs of each Member. For example, one Member might require a brief residential stay as a step-down to community services after a psychiatric crisis and inpatient admission. Other Members might require longer-term, more intensive psychiatric treatment services, supervision, and monitoring that can only be provided in a residential setting.

A vital part of any residential treatment episode is the transition back to the community. All NHP residential programs will offer an array of transitional services that help make this process a seamless one. Transition services may include assistance with scheduling medical and psychiatric appointments, medication management, transportation, assistance with meeting housing and daily living needs, Clubhouse, IPS services, and more. The high-tech elements of this care involve the documentation of treatment information in an electronic medical records system, automated reporting, electronic access to outcome data, and treatment planning updates for all members of the treatment team, and access to tele-psychiatry services for those who live in remote areas or those in need of access to a specialized provider.

Residential Services for Children

Children and families in times of ongoing distress, who cannot be successfully treated in the community, can be referred to NHP's network of residential services for youth. We have an established network of top-quality residential care facilities. These facilities offer a safe, controlled environment, including supervised 24/7 care.

Intensive therapeutic intervention and individualized programming are provided to children and their families by an interdisciplinary team that includes a psychiatrist, nurses, social workers, clinicians, and educators. The primary goal of residential care is to resolve behavioral issues and increase the level of functioning so children can be reunited with family in their home and maintain supportive aftercare services in the community.

Assertive Community Treatment (ACT)

NHP participating organizations have ACT services implemented within our partner CMHCs. For example, Centennial has ACT teams in two locations—Fort Morgan and Sterling. As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to Members with severe mental illness. ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and case managers. ACT is characterized by:

- Low Member-to-staff ratios
- Providing services in the community rather than in the office
- Shared caseloads among team members
- 24-hour staff availability
- Direct provision of all services by the team (rather than referring Members to other agencies)
- Time-unlimited services

Typically, the Member to case manager ratio is 10:1; an ACT program with 10 case managers would therefore limit enrollment to 100. These dedicated teams provide medication management, home services, wellness education and activities, medication delivery and monitoring, and case management services that are appropriate for each Member's individual needs.

ACT in Rural and Frontier Communities

It is possible that some bidders will propose to offer formalized, fidelity-adherent ACT programming in all Region 2 counties. This "promise" undoubtedly stems from a lack of knowledge and experience with rural characteristics of this region. In locations where ACT teams are not feasible, our partner providers have established systems and services in place to provide emergency assessments, in-home services, ICM, and medication evaluations and monitoring in an expedient manner. The positive outcomes we have achieved with our specialized ACT programs are significant in both scope and number. This innovative approach ensures that Members receive needed ACT-like services, no matter where they live in our service area.

Recovery Services

NHP will provide a variety of services focused on recovery, which is one of the foundations of our organization's care and service delivery system. Recovery services are provided by our partner CMHCs, often in multiple locations. We also will provide recovery training and educational materials to all of the independent practitioners in our provider network. The principles of trauma-informed care, recovery, and resiliency guide and shape all of the treatment and service options we provide Members. These services span the entire continuum of care, from teaching symptom management skills and developing mutual support groups to providing wellness planning training at residential and inpatient facilities. The following sections focus on specific programs that demonstrate our commitment to recovery and resiliency for all of our adult and youth Members.

Our programs focus on resilience when working with families who are raising children with serious emotional disorders (SED) or serious mental illness (SMI). Children and families have individualized needs, and require specialized support. Our providers offer this support through clinical services, advocacy programs, and family-directed, peer-support services. Services for families may include in-home support, behavioral coaching, parenting skills, family support services, and family education. Treating the family as a whole increases the natural resiliency in which children are able to grow, and it gives parents the ability to nurture a child with special needs.

NHP will provide a wide variety of programs for children and their families including, but not limited to:

- **Family crisis planning.** Many families are unprepared when children return home from an out-of-home placement. Our family peer specialists and Safety Planning can help families identify triggers and interventions to avoid family crises that result in their children being hospitalized or admitted to an out-of-home placement.
- **Advocacy.** We already have an advocacy system in place to protect the rights of individuals diagnosed with mental illness. Each CMHC has a Member and family advocate who can help Members with grievances and assist them in voicing their concerns in a variety of ways. Rights protection is a major component of our advocacy program.
- **Parent advocacy.** Parents raising a child with SED/SMI deal with a variety of systems when advocating for their child. In addition to support from our member service representatives, we provide access to family peer specialists. These peer specialists help families navigate the system and empower them to advocate for their children. Our family peer specialists receive specific training about the Individualized Education Program (IEP) process and the Individuals with Disabilities Education Act. Their advocacy work includes helping parents advocate for their children in the school system.
- **Alcohol and substance use disorder education.** As a prevention strategy, many of our CMHCs and independent providers conduct alcohol and drug awareness programs, particularly for adolescents. These programs teach Members about the pitfalls of drug and alcohol use, how to be "cool" and still say no to drugs, and problem-solving skills they can use when they are confronted by peers who use drugs.
- **Parenting skills.** Our parent advocates and family peer specialists provide education and teach parents skills involving behavioral interventions, communication, stress management, family play and recreation, and more.

Adult Recovery Services

NHP will offer recovery services to each Member across our service area. With the Member, we will assess his or her interests and abilities, and together develop a service plan to reflect the Member's stated goals. Recovery services may include assistance in understanding and managing the illness and symptoms, crisis planning, coping skills development, daily living skills, and education around

such topics as medications, medication side effects, treatment options, everyday choices, home financial management, and social interactions.

Peer services are an integral part of recovery services and are available in all of our partner organizations. These services provide Members and their families with mutual support. Our partners began formally training peer specialists in 2003 using the Georgia Peer Specialist Model. This model, developed in the late 1990s, has been used to train thousands of peers nationally. The curriculum has been adapted, when needed, to the unique cultural needs of Colorado, and it teaches Members and other interested people with “lived experience” the skills that are necessary for work in the mental health, substance use, or criminal justice fields. The formal curriculum has expanded to include all of the competencies approved by the Department in 2008, and revised again in 2013. After several days of intensive classroom training, peers are tested for competencies and some participate in internship programs at partner provider agencies or in other settings. A separate component has been added to address the unique role of parent advocates.

NHP will provide self-help and peer support addressing a wide range of topics, from substance use to parenting to surviving domestic violence. Other adult recovery services include:

- **Crisis prevention planning and wellness and recovery planning**. A mental health crisis or hospitalization can have consequences long after the person is discharged. A person might lose his or her housing, job, friends, and even his or her self-respect after a long hospitalization. Recovery and crisis planning helps a person with a potential crisis avoid these and other negative consequences in the aftermath of a mental health crisis.
- **Drop-in centers and Clubhouses**. These programs, managed by Members, provide support, training, and opportunities for socialization in a relaxed environment. Many Members enjoy and thrive in the less formal nature of Member-run programs. A key component to our accredited Clubhouse is the work-ordered day which is a way for Members to experience work schedules in preparation to enter or re-enter the work force. From there, Members can consider transitional or supportive employment opportunities at the center or in the community.
- **Housing assistance.** Safe, stable, and independent living is critical to recovery. All of our provider partners will offer help with finding affordable, safe housing in the least restrictive environment possible that a Member is successfully able to manage. For instance, North Range Behavioral Health administers over fifty HUD vouchers for the community, has its own supportive and independent housing units, and has embedded a case manager at the homeless shelter and supportive housing units associated with Catholic Charities in Greeley.
- **Wellness education.** Knowledge and skills education that promotes wellness and prevents illness is essential to our Members' overall health. We not only teach Members about the role of proper nutrition, exercise, smoking cessation, and other healthy lifestyle behaviors, we support their efforts to maintain a healthy mind and body by providing access and supervision to a local Recreation Center. Education will be offered through peer programs and NHP's Office of Member and Family Affairs. We also will collaborate with all of the service area's local chapters of the National Alliance on Mental Illness (NAMI) to offer health educational information to our Members.
- **Warm lines/Outreach.** Several of our partner organizations currently operate active warm lines, outreaching to Members who are homebound. They call Members to ask how they are doing, remind them to take their medications, and provide peer support as needed. Additionally, when appropriate, certain services require us to actually provide support in the community. This may come from our ACT team; nursing homes; our care management level of care; or from designated case managers.

Respite Services

NHP will provide a variety of formal and informal respite services designed to help family caregivers take time for themselves, so they can better manage the challenges of caring for a Member with a serious mental illness or behavioral disturbance. These services are available through our provider partners throughout our service area.

Formal respite services are available through local child placement agencies, foster homes, or other sub-acute treatment programs. Respite services for caregivers of adult Members are available through assisted care facilities or adult foster homes.

In addition to these formal services, we recognize that respite support also can be provided through a variety of informal channels. These include developing partnerships among caregivers, using volunteer-based programs such as Friendly Visitors, and identifying resources through local NAMI chapters, and the Federation of Families for Children's Mental Health.

Evaluating the Effectiveness of 1915(b)(3) Waiver Services

NHP will continuously monitor the effectiveness of the overall system of care and the utilization and quality of the alternative services, in particular, authorization, paid claims, and encounter data will be used to identify utilization and quality performance trends related to various levels of care and types of services. Additional information related to Member grievances, appeals, and Member satisfaction surveys will be used to help inform and improve the system of care. We will prepare an annual report of the Utilization Management (UM) Program, and this will be reviewed by our Quality Improvement Committee and the Governing Board.

NHP will work closely with the Department and its contract managers to remain fully compliant with all contract requirements related to alternative services. We will submit a quarterly report to the Department, following the prescribed template in Appendix R, 1915 (b)(3) Services Report.

b. UM PROGRAM AND PROCEDURES

UM for NHP will be delegated to our administrative agent, Beacon Health Options, Inc. (Beacon), a nationally recognized leader in health care management programs. Over the past 22 years in Colorado, Beacon has developed strong collaborative relationships with providers and many community organizations across our service areas. Our experience with quality management, Member services, and robust data reporting come together as a part of our UM program to monitor and support Member care. The success of our approach is evident in the small number of complaints put forward by providers and Members. Our Colorado-based, full service call center also provides exceptional customer service to our Members and providers while providing referrals, benefit education, and service authorizations. Our staff consistently maintain the best of quality metrics on service delivery, call answer rates, and Member satisfaction.

Beacon's ability to provide UM across all levels of care, while identifying providers and Members who may benefit from more focused support, also speaks to our experienced staff's dedication to Member health care and continued recovery and improved overall outcomes. Our dedicated care managers and intensive case managers are all licensed and experienced behavioral health professionals with an investment in our community and provider networks. Beacon combines the ability to provide innovative and progressive UM models with successful experience at managing the financial risk.

While behavioral health care services are a vital component of overall Member health, we also realize that providers benefit from UM to collaborate for improved outcomes for the Members we serve. Beacon has developed UM programming to ease providers' burden of reviewing requests for authorization of services. Their ProviderConnect online tool facilities Member eligibility verification,

authorization requests, claims submission, and allows providers to also submit treatment plans and other documentation through an upload process. Further, Beacon has eased provider billing of outpatient services by making many services payable without authorization. For many Members who have dual coverage of Health First Colorado and another insurer, inpatient providers may submit a claim with the primary insurer's Explanation of Benefits. As such, we will pay as the secondary source without review of clinical data. Additionally, we have a case rate payment program with two inpatient providers, which further reduces review frequency while encouraging providers to engage in improved care outcomes.

Our care managers and intensive case managers provide input into service delivery, aftercare planning, and involve high-level medical review when questions and concerns arise for how best to provide services at the appropriate and least restrictive level of care, while working to ensure that service delivery is not interrupted during transitions of care. Our clinical staff also participate in referring quality of care concerns to our local quality analysts for further review when inconsistencies of care delivery or problematic errors are suspected.

Via our ICM process, we seek to serve the Members with the most complex and acute needs. Members with ICM needs are identified by several methods, including internal referrals from care managers, referrals from the Department of Human Services (DHS) and other agencies, the Department's Creative Solutions cases, and UM data reporting. After a referral is received, an ICM clinician begins to seek additional information and identifies the Member's needs and potential community resources which may assist in resolving those needs. This often includes meetings and ongoing collaborative work with other health care professionals and agencies to bring together the best possible solutions for the Member.

Our clinical staff often communicates closely with local CMHC staff in our regions to discuss aftercare planning and transitions from higher levels of care to the community. We seek to ensure that appropriate services have been identified and scheduled, and that Members have follow-up following discharge from higher levels of care services.

With support from quality and provider relations staff, the Beacon substance use coordinator has provided many hours of trainings to the providers of substance use services, as well as supporting auditing and utilization review functions. Since 2014, we have worked diligently to improve the quality of services, provider documentation records, and billing ability for our network of providers of substance use disorder services. As the benefit has grown and developed, we have eased the ability of providers to submit claims by making medication-assisted treatment (MAT) and social withdrawal (detox) services payable without authorization. Our review of outpatient therapy and intensive outpatient programs serves to encourage continued development of quality services from providers and delivery of individualized services to our Members.

Beacon enables providers to seek approval of services through several points of contact:

- Our Access to Care line brings a provider into contact with our customer service staff who screen the request to connect the caller with the appropriate staff for assistance.
- ProviderConnect is an online Web-based tool available 24/7/365 that allows providers to seek authorizations for many services, upload documents, submit claims or verify payment, and check Member eligibility.
- TeleConnect is a telephone line that allows providers without online access to verify eligibility and seek authorization of care.
- Providers also submit requests via fax to our clinical call center staff.

All requests for care are managed within CMS timeframes, and our staff maintain phone statistics that are consistently within industry standards for speed of answer and abandoned call rates.

Member services staff are trained to screen for Members' crisis or urgent needs, grievances or complaints, benefit education needs, and serve as Beacon's initial point of contact to resolve many provider and Member needs. The typical flow of a call received by member services also demonstrates the close working relationship our clinical staff have with member service representatives.

The UM program is under the direction of the Chief Medical Officer and the Director of UM. Experienced, licensed clinical UM staff members are accessible 24 hours a day, seven days a week through the call center and decisions are rendered within CMS-required time frames for all levels of care. A Colorado-licensed Chief Medical Officer or psychiatrist designee will also be available 24 hours a day, seven days a week to provide consultation to care management staff and to provide telephonic peer review for medical necessity determinations.

Provider Training and Education

Beacon staff review quality indicators, claims data, provider and Member feedback, and other data management sources to monitor provider training needs. When a potential need is identified, leadership from clinical, provider relations, quality, and other departments come together to study and define an issue that may benefit from training and support we then offer to a provider. We work alongside the provider to bring improvements through onsite and offsite trainings, staff education, and continue to supply support and feedback as needed.

One recent example demonstrates the collaboration Beacon offers to assist providers:

A formerly successful provider of child and adolescent services began a new program focusing on intensive in-home outpatient services. It became apparent that the provider was struggling with accurate billing which impaired successful claims payment, thereby creating financial concerns, and involved staff education on billing and authorization request submission to Beacon in a timely manner. The provider representative met with provider relations, operations, financial, and clinical staff at Beacon to discuss the broad scope of the issues involved and find solutions to assist the provider in improving their services and resulting claims payments. Training has now been provided to the provider's staff on billing, coding, documentation, requests for services submissions, and we will continue to monitor for improvements that will enable to provider to continue their mission of providing services to child and adolescents in our region.

Utilization Review Accreditation

NHP's partner, Beacon, has achieved and maintains full accreditation by the Utilization Review Accreditation Commission (URAC) for UM. The accreditation process involves evaluation of our UM and quality improvement procedures against national standards for our operations. Currently, 34 states and the District of Columbia recognize one or more of URAC's accreditation programs. Beacon will continue to seek and maintain URAC accreditation should NHP be awarded this contract.

Use of Clinical Guidelines

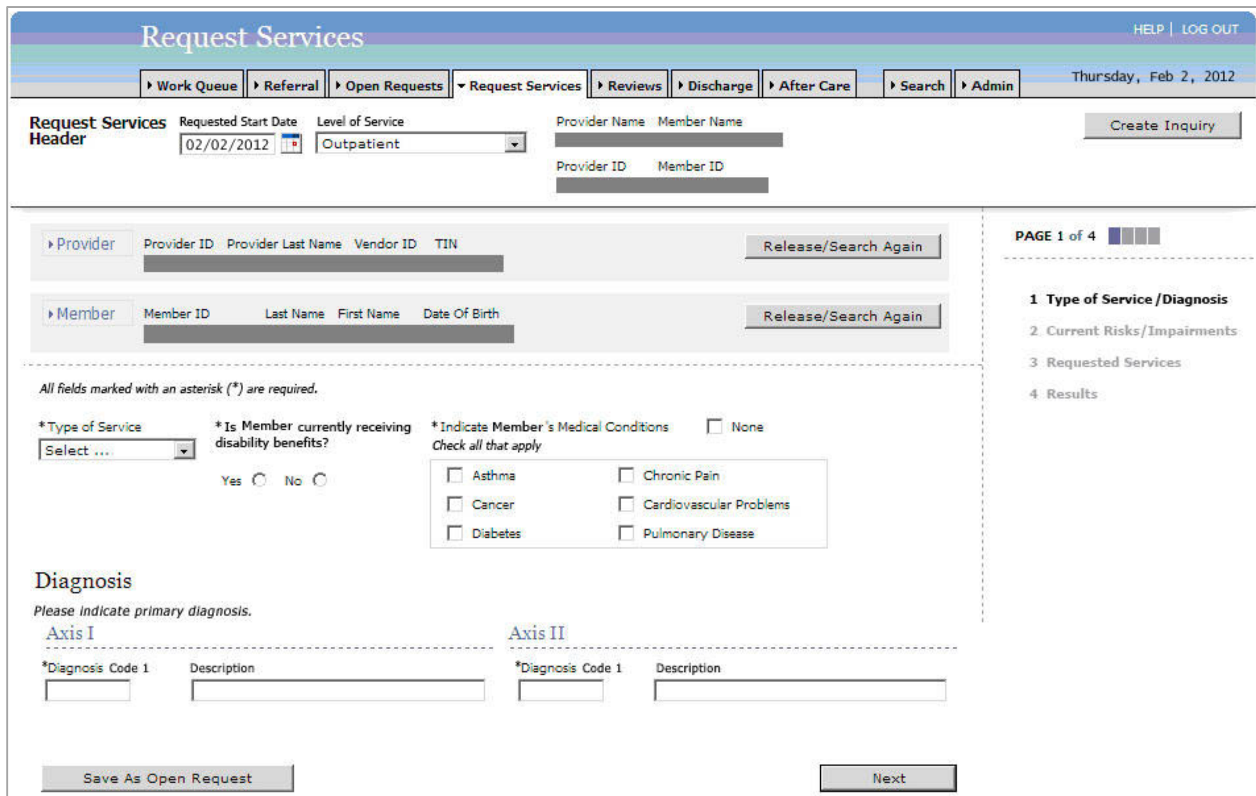
Beacon has developed, monitored, and updated evidence-based clinical practice guidelines for its Colorado BHO contracts since 1995. These guidelines are created and maintained by clinical committees that include extensive representation from practicing providers and incorporate national consensus and evidence-based guideline practices. This consists of 22 level of care guidelines covering 12 distinct levels of care plus crisis services and consumer operated services, which are used to guide all level of care decisions at the point of initial assessment and during utilization management. Fourteen diagnosis-based treatment guidelines will be used to guide clinician training

and supervision in our provider network, as well as to establish outcomes and clinical process of care indicators for the most common and complex disorders we serve. Care management staff and providers will use these criteria to guide their decision-making to determine whether a Member meets medical necessity for a particular level of care. Beacon views them as guidelines for treatment and not as substitutes for sound clinical judgment vital to the proper care of patients. These guidelines take into consideration the clinical needs of the Member, while upholding the model of recovery and the principles of trauma-informed care. Level of care guidelines and diagnosis-based treatment guidelines will be readily available to both Members and providers at no cost, and they will be posted on our website.

Use of Beacon's UM Technology

Beacon performs UM and case management via our CareConnect system, a component of our CONNECTS system. CareConnect, shown on the following page, supports direct interchanges between providers and Beacon, and produces clinical data demonstrating the effectiveness of various programs, therapies, and services we offer. The following provides a sample of CareConnect functionalities:

- Uses data fields to capture reportable outcomes and other clinical data to track and exhibit the effectiveness of services
- Delivers an effective work management system that integrates across other Beacon applications to allow for seamless continuity
- Allows providers to register care online via a secure website and unique provider ID
- Minimizes administrative burden of both the clinical staff and providers
- Allows for multiple, longitudinal data exchanges with providers for complex outlier cases



CareConnect supports direct interchanges between providers and NHP to facilitate timely authorizations for services.

The CareConnect application allows for referral tracking, while supporting all clinical care management functions, and documents all case activity from the point of referral to any utilization, through all levels of managed care. The referral tracking system featured in CareConnect allows users to access a search engine to identify providers by location, discipline, and clinical area of expertise. The system also tracks the caller's provider preferences and whether these were met. CareConnect is designed to be easy-to-use and the screen layout is optimized for efficient data collection and tracking capabilities. Online entry of clinical data with maintenance of clinical case history allows the care manager to easily enter and access all clinical information, for example:

- Member identification and demographics
- Priority (emergent, urgent, routine)
- Reason for the call (access to services, referral, benefits)
- Nature of call (information, authorization, reauthorization, discharge, appeal)
- Who called (Member, provider, provider staff, family)
- Diagnoses
- Clinical symptoms, risk assessment, impairments
- Disposition of call (authorization of requested level of care, authorization of a lower level of care, reauthorization, discharge to another level of care)
- Follow-up required (date of next review, referral for peer review, referral to Member/family advocate)

CareConnect assigns a unique number to each authorization with information included in an authorization header file and an authorization detail file. The authorization number is the key to both of these files as all authorizations are associated with a specific Member and a specific provider linked to a case. The system also assigns a unique number to each case. A case is comprised of one Member, one or more providers, and one or more treatment settings. The case may also be associated with a specific set of clinical notes.

The system supports functionality to search for all authorizations and/or all cases for a specific Member or for a specific provider. Denials are designated by a denial code that is associated with the reason for denial. A Member's complete authorization history is documented within CareConnect. Moreover, care managers have access to authorizations from the CareConnect and ServiceConnect applications. The following data elements can be employed to search authorization or cases:

- Case number
- Member number
- Alternate provider number
- Authorization type
- Authorization number
- Provider number
- Level of care
- Date range

Comprehensive UM Policies and Procedures

Building on Beacon's national experience, NHP will operate according to a set of policies and procedures that have been subject to repeated reviews by URAC, the Department's Education Quality and Accountability Office, and NHP's Board.

When awarded this contract, NHP will provide the Department with a copy of our UM Program Description and related procedures within 30 days of the contract's effective date. We will also provide a copy of these documents within 30 days after any significant change is made. Our UM Program Work Plans and Evaluation Reports will be produced annually.

Additional Assurances

NHP affirms that we will not provide any incentives, through conditional or contingent payments or by any other means, for those making the determination to deny, limit, or discontinue medically necessary services. If we determine that the Member does not meet standards of medical necessity for behavioral health and substance use disorder services, NHP will inform the Member about how other appropriate services may be obtained pursuant to federal Medicaid managed care rules, and coordinate care within our system and the Health Neighborhood to refer them to the appropriate providers, such as Single Entry Points (SEPs) and Community Centered Boards (CCBs), and Managed Service Organizations (MSOs).

NHP will create and submit an annual Child Mental Health Treatment Act (CMHTA) Report that lists all the children/youth authorized for placement in a residential treatment setting by NHP under the CMHTA. The report will be submitted to the Department annually on or before September 1st for each fiscal year. We will have an identified CMHTA liaison at each of the mental health centers in this region.

NHP will also provide relevant education and ongoing guidance to our Members and providers about our UM program and protocols.

c. SERVICE PLANNING, CARE COORDINATION, AND TRANSITION OF CARE REQUIREMENTS

Care Coordination

Basic care coordination is required of all network providers and is reinforced through the following processes:

- Provider trainings
- Utilization management
- Reminders generated by our online Colorado Client Assessment Record (CCAR) application
- Compliance audits looking for documentation

We will strategically place regional integrated care managers throughout the region who work in tandem with clinicians to ensure seamless coordination of care around significant Member transitions. The Engagement Center also has an ICM service that will assist PCMPs, rare coordinators within Primary Care Medical Homes, child welfare case workers, long-term care facilities, and other agencies with care coordination when Members are involved with multiple systems or have specialized health care needs.

ICM services have been part of our program for many years. We have always included general health care needs in addition to behavioral health needs in our care management focus. ICM is designed to assist Members with the most complex care needs. These Members are typically assessed to be at the highest risk within the health population for negative clinical outcomes related to mental health/substance use issues and co-morbid medical issues. The primary goals of the ICM program are to help individuals maintain community tenure, regain optimal health, improve life functioning capability, and promote resiliency and recovery. Interventions include needs assessments, referrals and appointment reminders, care coordination, and overall monitoring of treatment engagement. ICM is based on the premise that individuals are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met.

All network behavioral health providers are expected to provide basic care coordination services including collaboration, with Member consent, with primary care. If intensive case management is needed for complex Member needs, the behavioral health professional is required to communicate

with other care coordinators who are assigned through other programs, such as the SEPs, CCBs, MSOs, school districts, and the child welfare system. The function of this communication shall be to designate and document the lead care coordinator for each Member and to ensure that the care coordination plan is an integrated plan that is inclusive of behavioral health needs.

The integrated care coordination plan goals will:

- Promote effective identification of Members with high-risk and/or complex medical/ behavioral health conditions
- Deliver intensive, individualized case management through appropriate outreach including assessment, assistance, coordination, and consultation related to health care benefits
- Coach Members to develop optimal self-care health management skills
- Involve the Member, caregivers, and treatment providers in the development of a mutually agreed upon care plan (using person centered recovery model)
- Provide resource options to help Members and families to effectively cope with the stress and life changes resulting from living with behavioral health conditions
- Promote health, wellness, independence and optimal psycho-social functioning with minimal symptom burden
- Promote recovery and resiliency principles as a core program tenet

Transition of Care

Our service delivery system is based on the need for optimal systems integration and alignment, as well as care coordination for our Members, through a comprehensive and well-organized service delivery model. We help our Members successfully navigate complex systems and ensure that they receive services in a person-centered, trauma-informed manner. We recognize that providing integrated services through seamless transitions will help our Members by increasing access to care and minimizing the confusion that can occur when navigating multiple systems.

NHP recognizes that transitions are essential. NHP includes hospital, residential, inpatient, criminal justice, LTSS, foster care, provider, and region transitions to be part of the overall transition of care system. This system includes three basic components that can be utilized in any setting, with a goal to provide continuation of current services and referrals for new services. When a transition occurs NHP ensures the following occurs:

1. The Member is aware of where they are being referred.
2. The transition agency is contacted with the Member's information.
3. NHP follows up to make sure the transition agency has the information needed to care for the Member

NHP will coordinate transitional services with the other RAE organizations whether we are receiving the Member's eligibility or losing the Member's eligibility. If the Member is changing providers, our member services staff can assist in the search for a suitable provider in the Member's new locale. When a Member is identified as requiring complex care management during a move—for instance, a Member needing both medical and behavioral health services—we will assist in coordinating all aspects of the transition.

Member Transitions between Modes of Treatment and from Long-Term Services and Supports (LTSS) Treatment

All transitions between higher levels of care or between higher levels of care and outpatient treatment are managed closely by our centralized clinical care managers working with the regional transition coordinator from the Member's home area. Clinical care managers must arrange and document the entire transition plan and challenges to implementation, and the results. Transitions

from acute treatment to long-term recovery are long and require the ongoing attention of the treatment team, supported in many cases by community supports and peer specialists.

Member Transitions When the Treating Service Provider Becomes Unable to Continue Service Delivery for any Reason

NHP has a protocol for managing situations when providers become unable or unwilling to continue services, such as frequently occurs due to illness, death, pregnancy, retirement, moves, or a change in practice. When such a provider situation is identified, a list of all open authorizations is used to drive Member outreach. As each Member is contacted, a brief telephonic assessment is completed to assess safety and impact of the transition. Members are triaged as to the need for emergent, urgent, or routine ongoing treatment. An appropriate provider is identified with the Member, and necessary authorizations for care are put in place.

Member Transitions to or from an Assisted Living Facility or Long-term Care Placement

NHP works closely with skilled nursing and alternative living facilities in the region to ensure seamless transitions from one level of care to another. Our LTSS coordinator will address inquiries and work with providers and community stakeholders to help Members with transitions. We recognize the efforts to transition Members from nursing facilities back to the community through the Colorado Choice Transitions program and will coordinate with this program as well. Our centralized program includes a hotline that links to the LTSS coordinator.

NHP will coordinate closely with SEP agencies in this region to help Members obtain home- and community-based services upon discharge from a long-term care placement where appropriate. Our integrated care managers will ensure linkage to services and work to address additional needs that will help with successful and seamless transitions.

Member Transitions from the Correctional or Community Corrections Systems Back into the Community

NHP recognizes the challenges faced by our Members released from correctional facilities. One of our partners, North Range, works closely with Weld County Probation to provide beds to those probationers with mental illness. This ensures Members are able to access behavioral health services immediately--whether from North Range or an appropriate provider in the community the probationer would like to settle long-term. We will also provide a centralized program that includes a hotline for all correctional facilities to reach our correctional system services coordinator.

Member Transitions from Inpatient, Sub-acute, Residential, or Mental Health Institute Services

Discharge planning starts at admission, and we employ clinical care managers who work closely with behavioral health centers and the hospital providers to assess the needs of Members and ensure that strong plans to transition out of the hospital are in place. The clinical care managers work with hospital staff to determine medical necessity and authorize care. At the same time, behavioral health staff is in touch with hospital social workers to provide relevant history, crisis plans, and coping skills that have been helpful for Members in the past.

Continuity of care is the focus of discussions to make sure that inpatient treatment providers are well informed about the outpatient treatment plan, medication history, and other clinical and social determinant factors that will influence treatment and aftercare service and resource needs. The hospital providers are asked to provide their assessment and recommendations to inform the outpatient discharge plan and needs for the Member to have a successful discharge. The mix of services and focus of treatment are evaluated collaboratively to determine whether changes need to

be made in the plan. Clinical care managers provide oversight of this process, working to make sure care is coordinated closely between our inpatient and outpatient providers. Discharge needs inform our medical necessity decisions and we work to ensure that services are not duplicated.

Regional integrated care coordinators work with the clinical care managers to identify resources for any new needs that are identified. Other system resources, such as DHS and SEP agencies are involved appropriately to connect Members with needed home and community-based services, transportation or physical health care. Close communication is required to ensure that all parties are aware of the treatment timeline and plan for discharge. Prior to discharge, follow-up appointments are set with the Member's input, and clinical care managers work with inpatient providers to make sure Members know what the next steps are in their treatment. NHP staff follows up with the Member to ensure that they attend their discharge appointments, and if appointments are missed, Members receive outreach to help engage them in treatment as quickly as possible. Contacts with the Member are frequent during this time of transition to make sure that they are participating in ongoing care as seamlessly as possible.

Member Transitions When Member Requires Temporary or Longer-term Treatment in another RAE Region

NHP staff work with providers and Members to help provide information about how a move and change in residence may affect treatment. Providers and Members receive education about how Medicaid eligibility can be continued during a move. If a Member relocates from one county to another, they receive education that they need to re-apply for their Medicaid in their new county of residence. Case management services may be provided to assist the Member with this administrative process and to ensure that they are connected with the right services, or to monitor that services are not interrupted during a move.

Members or guardians who are in need of a provider in their new area are given assistance in locating a provider. Any Members having difficulty finding a provider can receive assistance from NHP staff in finding additional providers or assistance in talking with them to resolve any provider questions regarding authorization to see the Member. If there are no contracted providers located in the new area of residence, single case agreements (SCA) are offered to non-contracted providers with the goal that the Member's treatment continues without interruption. Members moving from another RAE area into our region are also offered SCAs to continue seeing their current provider so that continuity of care is achieved whenever possible, as long as the provider is willing to continue providing care and that is a convenient option for the Member. If the Member does not continue with their previous provider, they receive assistance in connecting with a new provider.

Member Transitions into the Adult System

The transition from the child to adult behavioral health system presents unique challenges to youth and families. NHP has staff available to assist Members in this age group with completing applications for adult Medicaid benefits, service and provider changes, and service coordination. Our education coordinator attended the Transitions to Independence process training to further our understanding of these issues. Transitions to Independence process is an evidence-based method of addressing the issue of young people with emotional and behavioral difficulties transitioning into adult life. Our education coordinator developed a program overview and is available to provide this training to our provider network, as well as community stakeholders.

North Range also recently added a program called Transitional Age Community Treatment (TACT). This program provides early intervention for youth experiencing first-episode psychosis, which is a proven strategy for helping young adults achieve educational and vocational goals while receiving treatment that enhances long-term functioning and recovery.

Service Planning

NHP's service planning and delivery system is well-organized and includes mechanisms for ensuring service plans are individualized and measurable for every Member's care and treatment. The initial service plan uses information gathered at intake and assessment, and is updated with current information as the Member progresses through the treatment process. These updates include specific elements of treatment interventions (e.g., school services, home services, pharmacology, supportive aspects of recovery and resiliency, and areas of specific diagnostic focus such as depression and substance use). Service plans also are reflective of elements such as transitions between levels of care and coordination of care among various providers.

Input for the service plan is first and foremost obtained from the Member and facilitated by the behavioral health provider. If possible and appropriate, input also may be obtained from the Member's family or caregivers. Family involvement will depend upon the Member's age, disability level, consent, and other clinical factors. Depending upon the Member's circumstances, it also could include input from other stakeholders, such as probation, county departments of social services, foster parents and guardians, primary care physicians, school personnel, or others.

The actual content of the treatment plan is in part based on current symptoms, diagnosis, previous treatment history, assessment of level of functioning and motivation for treatment, and current psychotropic medication regimen. However, the essence of the plan is centered on the Member's and/or family's goals, desired treatment outcomes, and strategies to achieve these goals. The overall purpose of the plan is to inspire hope and optimism while identifying a clear pathway to achieve the treatment goals. Goals and subsequent interventions are written in a measurable format, so progress can be assessed over time. Strategies to achieve goals can include a wide range of interventions and are individualized for each and every Member. Service planning steps include:

- Assessment
- Identification of goals and treatment objectives
- Discussion and agreement on treatment strategies
- Implementation
- Ongoing evaluation, adjustments, and updates
- Referrals and follow-up on referrals
- Successful achievement of goals or re-evaluation

NHP requires an intake assessment to be conducted by a qualified, credentialed clinician. Assessments must meet professional standards of care and result in a diagnostic assessment and a service plan. Furthermore, we conduct regular audits of intake documentation to ensure comprehensiveness and appropriateness. Through our provider credentialing process, we ensure that network clinicians have at least three years of clinical experience beyond the minimum required for licensure or are subject to the clinical supervision requirements within a CMHC. Beacon's UM system ensures that Members whose treatment is not progressing as expected receive case reviews at regular intervals that re-evaluate diagnosis and treatment approach. Our network includes psychologists and psychiatrists who can assist with the assessment of complex cases, such as Members who present with co-occurring disorders, including substance use disorders, medical problems, autism, developmental disabilities, or neurological conditions such as traumatic brain injuries. Members are offered choice about geographic service location, provider's licensure type and clinical specialty, and treatment options.

d. COORDINATING WITH STATE AGENCIES AND MSOs

Relationships with State Agencies

For NHP, coordination of care with other service providers and stakeholders is part of the way we do business and it has been our practice for many years. Care coordination planning and interventions

are part of every service plan. Care coordination is one of the key responsibilities of the treating behavioral health professional. This obligation is clear in policies and Provider Handbook and is routinely communicated to our providers and partners through training. Modalities for care coordination include face-to-face meetings and case conferences, telephone contacts and reminders, and information sharing by email or letter. One example of this principle in action is our Web-based CCAR form, which must be completed for each Medicaid youth or adult receiving treatment. It incorporates coordination and information exchange reminder messages, as a provider completes the form. These reminders are linked to specific CCAR items, such as referral sources, completed during the online CCAR process. For example, if a provider indicates that a child's current living arrangement is a foster home, a reminder will be generated automatically as the CCAR is completed to ensure key information is shared and treatment is coordinated with DHS.

For high-need Members, such as those who are being referred or served by the child welfare system or those who have complex clinical needs, we have developed processes and programs that help to coordinate care and navigate transitions between care providers to avoid fragmentation and duplication of services. We are able to identify these high-need Members through:

- The admission process, where physical and medical healthcare history are gathered
- Service planning, where physical and medical conditions are incorporated into the Member's overall treatment plan and treatment goals
- During contacts with nurse practitioners, who conduct routine screenings of Members taking medications to monitor blood pressure, heart rate, body weight, and other physical health indicators
- Contacts with primary care physicians, nurse practitioners, and physician assistants who deliver onsite screenings and care for minor medical conditions in conjunction with the behavioral health screenings. Some of these professionals serve as the medical home for our Members.
- Disability and disease management programs. In addition to our provider network being able to identify and intervene with high-risk Members. These programs address the needs of Members who have behavioral health conditions and one or more chronic health conditions, such as asthma, diabetes, hypertension, or heart disease.

Coordinating Services for Children in the Child Welfare System

For children in out-of-home placements (i.e., foster care, kinship care, and subsidized adoptions), we require providers to make assessments available, upon request from County DHS, and to coordinate with county caseworkers, if behavioral health services are provided. This includes coordination of behavioral health and substance use disorder referrals. We will work collaboratively with DHS and local county offices to ensure that all children who have a positive trauma screen receive a formal follow-up trauma assessment and, subsequently, any trauma-informed covered services that are indicated. All of these services will be provided within the contractual timeframes.

NHP also will provide ongoing contact with the case workers and updates about progress in treatment for any referred Members, including both children and adults who are involved with DHS on either a voluntary or involuntary basis. We will ensure that behavioral health professionals and care managers coordinate with county case workers about significant events in treatment, including discharge, clinical deterioration, or repeated no-shows to appointments.

Relationships with Managed Services Organizations (MSOs)

Managed Service Organizations (MSOs) manage a statewide substance use disorder treatment system in Colorado. There are currently seven MSO regions in the State and two serving Region 2 of which we have existing relationships. As regional entities, MSOs support the delivery, expansion, and quality management of the entire continuum of substance use disorder treatment. The RAE will work collaboratively with our regional MSOs to reduce duplication of services, overuse of low value

services, and fragmentation of care. NHP's network of substance use treatment providers work collaboratively with the Member's local MSO to access services based on funding source. This helps to ensure that Member's treatment needs are covered and transitions between levels of care are seamless.

NHP recognizes the role of the MSOs and their providers. We will contract directly with providers within the MSO networks who meet Medicaid provider enrollment criteria and will partner with them to deliver comprehensive substance use treatment to improve member health.

MSOs are an important part of the Health Neighborhood. NHP will continue to use and expand our partners' collaborative relationships with MSOs in the State to ensure coordination of services and arrange for the full continuum of substance use disorder treatment, particularly those services that are not currently part of the current behavioral health benefit, such as withdrawal management (detox), outpatient, residential, substance use disorder psychoeducation, and sober housing.

OFFEROR'S RESPONSE 20

Describe how the Offeror will support PCMP practices that utilize licensed behavioral health providers to deliver primary-care-based behavioral health services. Include a description of how the Offeror will track utilization of the six (6) FFS short- term behavioral health sessions delivered in primary care settings and how the Offeror will work with PCMPs when a Member requires more than six (6) sessions.

Colorado has done a tremendous job of integrating care for Medicaid Members and has built an extensive behavioral health infrastructure to serve the needs of Medicaid Members. In Region 2, we have embedded primary care in the Community Mental Health Centers (CMHCs) and embedded behavioral health practitioners at Primary Care Medical Provider (PCMP) sites. For example, North Range Behavioral Health staff are embedded in 8 different primary care locations (5 with Sunrise; 2 with Salud, ad 1 with NCFM). The CMHCs and Federally Qualified Health Centers (FQHCs) have worked in collaboration with each other to house behavioral health specialists at PCMP sites and establish referral protocols. North Range has a total of 18 behavioral health staff embedded in primary care locations throughout Region 2.

Due to Medicaid expansion, Northeast Health Partners, LLC (NHP) have seen Medicaid membership grow and transform. Many of these new expansion Members have not had health insurance in the past and have learned to rely on the acute care systems in place. By treating only events and not symptoms, we know many of these Members have seldom used primary care and have never used the behavioral health system or treatments.

Accessing behavioral health care may be challenging for Members due to administrative barriers or stigma that remains in our culture around behavioral health access. Many individuals refuse to seek care because they think they can "deal with it" or don't want to be labeled with a specific diagnosis. Some may simply need a little help during a difficult or stressful stage in life but are not appropriate for a DSM diagnosis, or aren't aware of their options to access care.

We believe that in many situations, Members with low-acuity or episodic behavioral health needs can be most effectively treated in the context of an integrated primary care setting. Behavioral health should be available as a routine part of the care received by any Member. This reduces stigma and normalizes Member involvement with a behavioral health provider; it also promotes ongoing preventive treatment which can dramatically reduce the likelihood of needing specialty care and decrease utilization of higher acuity services like inpatient care, detox or long term treatment.

We understand the current workforce is not adequate to address all behavioral health needs in our communities. NHP is a strong supporter of the SIM program and believes in the need to increase access to behavioral health services in the PCMP setting. NHP has used the SIM pillars as our framework to implement this program and as the Regional Accountable Entity (RAE), NHP will support SIM providers in Region 2 who are receiving practice transformation assistance, we will also extend our services to any other PCMP who wants to implement primary care behavioral health services.

NHP partners have significant expertise on integrating behavioral health in the primary care setting. For example, all Salud sites are participants in SIM Cohort 1 and will be part of Cohort 2. Salud has made significant advancements in all aspects of Bodenheimer's 10 building blocks via collaboration with SIM Practice Facilitators and Clinical Health Information Technology Advisors (CHITA). All partners have successfully created Level 5 and 6 integrated care models and will continue to replicate best practices within the region to support providers who do not have integrated care.

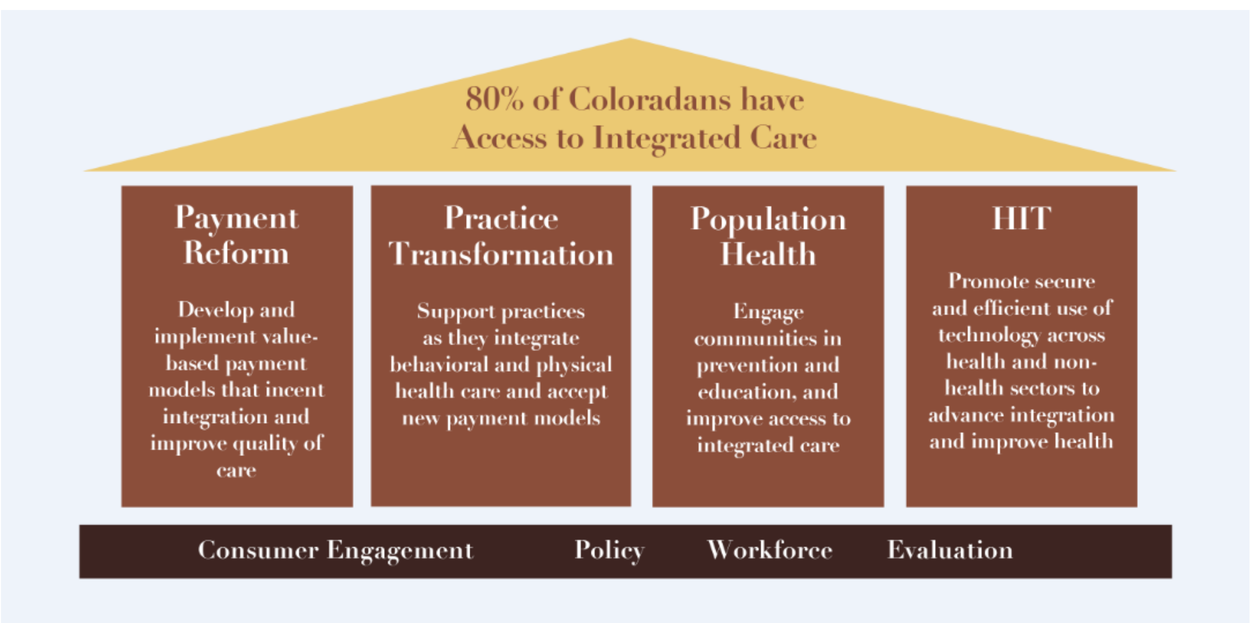
With the past progress in mind and additional future improvements to deliver, we are excited to implement this new model in Region 2. We believe it will help those that meet the situations above and others to gain entry into the treatment where and when they need it. In many instances, we expect Members to participate in some sessions without the need to progress into a longer-term therapeutic relationship, but in others this may be an entry to a longer-term treatment and an opportunity to identify needs that otherwise may not have been discovered. Our plan to support this model includes providing people, process and technology to each provider as well as objective evaluation to the Department of Health Care Policy and Financing (the Department) so that the program can be refined and enhanced throughout the term of our contract.

Through our partners' experience, our staff have deployed new initiatives locally and in other Medicaid programs. Through this experience, we have learned that all new programs require thoughtful, comprehensive change management and deployment support. They also require flexibility to adjust processes, technology, and support based on how providers and Members respond.

ALIGNMENT WITH SIM PROJECT

As illustrated on the following page, we have aligned our design for the delivery of primary-care-based behavioral health services with the four pillars of the SIM program.

The Four Pillars of the SIM Project



1. **Payment Reform:** We will support the Department's fee-for-service payments for these sessions through implementation support, tracking, measuring and reporting through additional supplemental deliverables we have defined and will submit to the Department. We will also provide utilization management (UM) consultation through multiple channels to these behavioral health practitioners to assist with seamless transitions of care for their Members when and if necessary.
2. **Practice Transformation:** We will support the practice's transformation activities as well as the University of Colorado Medical Center practice transformation experts working with any SIM practices in Region 2. We will also provide similar support to any practice wanting to implement this model, but not part of the SIM program.

3. **Population Health:** Our population health programs are available to all applicable Members and will supplement the sessions provided by the behavioral health practitioners.
4. **Health Information Technology (HIT):** We will offer our technology such as the Ieso infrastructure (detailed further in our response to *Offeror's Response 17*) to allow remote access to cognitive behavioral therapy (CBT) when a PCMP site wants to offer these sessions but does not have the volume to justify a behavioral health practitioner on site.

SUPPORTING PCMP PRACTICES

We will continue to support PCMP practices using qualified behavioral health providers in existing PCMP practices in order to meet the demand of Members presenting with behavioral health concerns of mild to moderate severity. Further, we will provide support through the Learning Collaborative, newsletters, practice transformation support, and individual sessions with our Providers Relations Managers and Chief Clinical Officer. This will ensure that PCMPs without the support from SIM practice transformation or requiring additional support are successful in implementing this new model, including:

- Training for the PCMP practices in identification of behavioral health needs using standardized and evidence-based screening tools
- Training for the behavioral health providers in identification of short-term versus long-term service needs, as well as adequate documentation of services provided
- Continued focus on expansion of integration of primary medical and behavioral health and the integration support and practice transformation support services available from NHP

Training for PCMP Practices

We will create and deploy a training program for PCMP practices so that Primary Care Practitioners know what to look for, know what basic tools to use for evaluation purposes (e.g., PHQ-2 and PHQ-9 depression screens) and how to distinguish if a Member would be better suited for these sessions or a referral for a longer-term therapeutic relationship. We recognize that not every practice needs this support, for example, a practice that already has high levels of integration might just need help with continued collaboration, streamlining the referral process so that the BH system can ensure patients are seen in the most appropriate setting possible (i.e. when a patient is stable, and has run the course of therapy at the CMHC and becomes "meds only"). Although these Members will be referred back to the PCMP, this "transition" will require coordination and collaborative relationships. Our training will also provide up to date base practices and guidelines for PCMPs to identify and deal with crisis situations and challenges such as suicidal ideation and risks and look for this in particularly vulnerable populations in support of our Zero Suicide campaign.

In this campaign, we support organizations to pursue safer, more effective suicide care approaches in health care systems by implementing evidenced-based strategies to address issues related to suicide prevention, treatment and post-intervention, including safety plans, counseling on restricting access to lethal means, and maximizing natural supports.

Our training will also encourage PCMPs to use their clinical judgement as well as their personal relationship with their patient to make a final determination in how care should be delivered. These tools will allow providers to make more accurate referrals to the behavioral health system.

Training for Behavioral Health Practitioners

We will create and deploy a training program for behavioral health practitioners to understand the profile of a Member with a short-term behavioral health need versus a longer-term need. These tools will use standardized survey methods to set objectives to ensure that the right people are served in the right way. At first thresholds, behavioral health practitioners will be able to identify whether short-term sessions or longer-term higher level of care will be needed.

These clinical decisions will also leverage our proprietary behavioral health clinical criteria that can be adjusted as we study the implementation of these fee-for-service sessions. Finally, we will provide training and toolkits to behavioral health practitioners on how to document all of these sessions and report them to NHP. Our goals with this training are to create a smooth roll-out of this new feature, achieve consistent documentation, and increase access to services to low-acuity Members. At the same time, we will ensure that we are not inappropriately assigning Members to this course of therapy, which can result in additional care transitions, fragmentation, and duplication of services to the Member, and unnecessary costs to the Department.

INTEGRATION

The participating organizations of NHP have been providing integrated care for over 15 years. We will offer tools and technology to PCMPs so that behavioral health practitioners can be accessible by the PCMPs that do not have the opportunity to staff and co-located behavioral health practitioners in their facility. Tools we are considering include:

- Virtual CBT via Ieso in support of the PCMP practices for this purpose where integration does not exist or where Member choice aligns with this modern channel
- Prescription Drug Intervention Program (PDIP)
- Teleconsultant services offered through psychiatric access programs specifically in rural and frontier communities to increase access to services

Integrated Care Service Delivery Model

While the expansion of sites and penetration into the physical health care market has been substantial, the delivery model has been challenged in fully aligning all integrated care components necessary for a successful and sustainable product. It has been difficult to ensure that each core domain, to include clinical delivery, data integration, outcome measures, partner relations, and overall financial sustainability are fully operational.

Throughout this process, we have learned a lot about service delivery mix. We know from the research that the most effective ways to have integrated behavioral health care be successful in the PCMP world is to adopt similar workflows. This includes the behavioral health practitioner huddling every day with the primary care team, which includes the PCMPs and other support staff (e.g., nurse, medical assistant, reception). In this huddle, the team is made aware of Members that will need certain services while they are being seen and gives the team a chance to identify and resolve potential issues before they occur.

Some examples of integrated services are:

- **New Member appointments:** Behavioral health practitioners can assist with any screenings to be done at this visit and gives providers an opportunity to explain to the Member about how an integrated clinic works
- **Well-child checks or annual physicals:** Behavioral health practitioners can assist with screening tools, milestone assessments, depression screenings, and a variety of other yearly functions
- **Pregnant mother 28-36-week checkups:** Behavioral health practitioners can assist with depression screenings, parenting concerns, anxiety over giving birth, etc.
- **Newly diagnosed chronic disease:** Behavioral health practitioners can assist with anxiety reduction, psychoeducation, support building, and referrals for specialty behavioral health
- **Referral based on screening scores:** Members complete a screener (e.g., PHQ-9, SBIRT, DAS, substance use disorder) and is referred to behavioral health practitioners when a pre-established cutoff score is reached

The last type of visit typically involves a behavioral health practitioner through a follow-up visit. These visits vary from clinic to clinic and are used to various degrees depending on the work flow of the practice. Follow-up visits are intended to be brief and often are set either right before or right after the Member's appointments with the medical provider. Topics can include psycho-education, check of skills taught last visit, provide resources to the Member, care coordination with other providers, follow-up screening tools, and even brief therapeutic interventions.

Tracking Sessions

Tracking the short-term behavioral health sessions will be a critical activity for NHP to successfully implement this new service. It will also help the Department measure the volume, preferences of Members, behaviors of providers, and results from the program to Members and the provider community. We will build new interfaces to track the utilization of the six fee-for-service short-term behavioral health sessions delivered in primary care settings in a real-time manner. This will allow NHP to monitor the progress of the Member through the episode of care and engage with the behavioral health practitioner on behalf of the Member before the last visit. By doing so, we ensure that care is disrupted in the event that the Member needs additional therapy.

We have several plans for how we can accomplish this. For example, with our existing experience building interfaces to the new Colorado interChange, we believe we can extend that experience to create custom interfaces to acquire this information at the time of claims submission. This will capture some sessions, but is not expected to provide complete contemporaneous data. Because of that limitation, we will also ensure that behavioral health practitioners are also submitting these visits to NHP as encounters so that we can track this information. Services provided by the CMHCs will fall into this category. It is important to note that we will need to collaborate with the Department to establish the appropriate coding or encounter-cleansing algorithm so that these encounters can be used for reporting purposes, and will not conflict in any way with the fee-for-service claims to be paid for these services.

NHP will track every Member receiving these services and setup a UM alert process at Session 4 to begin the transition process from these sessions into a deeper relationship. Referrals can be sent from the PCMP to NHP through a portal or via our toll-free number. We believe successful transitions in care require some planning and input from the Member. We will begin this process before the last session so as to not introduce a gap in the Member's continuity of care.

If a behavioral health practitioner identifies the need for additional sessions, we will confirm that an eligible DSM-5 diagnosis is applied to the Member. Concurrently, we will ensure the behavioral health practitioner is prepared to continue a therapeutic relationship and that they will submit the necessary encounters to track care delivered, or ensure that the Member has all of the appropriate resources, tools, and support mechanisms to thrive.

TRANSITIONS OF CARE

In cases where the PCMP does not have an embedded behavioral health practitioner for the types of services the Member require after their short-term sessions, NHP will coordinate this Member's transition of care from this setting to the next place of service. Our UM program will be enhanced for these specific services and will include monitoring of sessions to identify Members that may need an authorization for an extension beyond six sessions, or a transition of care. Our inbound provider line will provide a simple path for behavioral health practitioners to access a care manager to assist with a transition of care, including finding a provider at a convenient location for the Member. This will facilitate a seamless and clinically effective transition to longer-term care.

In addition to the methods described above, we believe all new things need to be tracked, objectively measured, and reported so that we all understand the performance of the new process and identify any unintended consequences early so that adjustments can be made. We have a long history of implementing new program features in our partners' Behavioral Health Organization and Regional Care Collaborative Organization (RCCO) programs and intend to create the following deliverables that are above and beyond the RFP requirements.

Our UM program will monitor primary-care based sessions using the "Low-acuity Behavioral Health Service Procedure Codes" defined in *Appendix P* when submitted by the behavioral health practitioner linked to this program at a PCMP setting. These include:

- 90791 Diagnostic Evaluation without Medical Services
- 90792 Diagnostic Evaluation with Medical Services
- 90832 Psychotherapy-30 minutes
- 90834 Psychotherapy-45 minutes
- 90837 Psychotherapy-60 minutes
- 90839 Psychotherapy for crisis-60 minutes
- 90840 Psychotherapy for crisis-each additional 30 min
- 90853 Group Psychotherapy
- 90846 Family Psychotherapy (without Member)
- 90847 Family Psychotherapy (with Member)

We will also create an inbound avenue for these clinicians to get an authorization for additional sessions or a seamless transition to a higher level of care or longer-term relationship if that is necessary.

REPORTING AND MEASURING THE SUCCESS OF THESE SESSIONS

In addition to the activities described above, we have also identified a number of unstated needs of the Department in order to track, study, and measure the success of these primary-care based sessions. We will create reports and deliverables to allow policy makers and the Department to objectively understand the benefits of this new service as well as our implementation in Region 2. Our reporting will leverage the Colorado interChange and our local data warehouse to assemble data sets triggered from these fee-for-service short-term behavioral health sessions so that we can measure and report the following:

- **Volume of sessions by a PCMP and behavioral health practitioner.** This will allow us to understand how often and where these services are being performed. From this data, we can confirm that our roll-out was successful and access has increased.
- **Progression from sessions to longer-term or higher levels of care** including a breakdown and distribution of diagnoses of Members that progress beyond their six initial sessions. From this data, we can understand if these sessions are being appropriately applied to lower-acuity Members or begin to simply supplement the higher-level care, which would be an unintended consequence on this service.
- **Retention and drop-off rates for Members and by PCMP and behavioral health practitioner.** This will help us understand how Members respond to the therapy and identify flag certain providers as potential to need additional training in whom to offer our training to. For example, if a large percentage of Members from a single provider go through fewer sessions than the regional norm and that provider delivers these sessions to a larger percentage of their Members than their peers, then we may want to dig deeper into the provider panel to understand if this service is being "over-prescribed."
- **Prescribing behavior associated with these visits.** We do not expect to see prescriptions without associated diagnosis codes; however, we will monitor the medication regimens of

Members with these sessions to ensure that this is not occurring with a drug that could be prescribed across behavioral or physical health conditions.

- **Mapping visits to historical diagnoses** to ensure these is not duplication of services, medications, etc.
- **Number of Members that have been recommended to a higher level of care, but prefer the short-term visits** and create and deploy a reporting mechanism to track this throughout the region. This will help us understand if Member preference is driving demand for these sessions which can indicate that the need for alternate sources of therapy may be understated and underserved in the community.
- **Mapping Members who have received these sessions against their claims history** to see if they have had a prior diagnosis or could be received services in multiple places of service.

OFFEROR'S RESPONSE 21

Describe how the Offeror will receive, process, and manage data and use analytics to meet the goals of the Accountable Care Collaborative, specifically addressing how the Offeror will create meaningful and actionable data, share data with Network Providers, and meet the privacy regulations.

Northeast Health Partners, LLC (NHP) leverages the complimentary experience and expertise of our partner organizations and blends the best attributes of local, regional, and national organizations to better serve Colorado's Health First Medicaid Members in Region 2. NHP will also enhance those systems and tools as necessary to successfully operate the Accountable Care Collaborative (ACC) Program of the Regional Accountable Entity (RAE) in Region 2.

NHP will be a data-driven organization and, as such, will integrate a comprehensive set of information systems to meet the operational and strategic health information needs of Region 2 and the Department of Health Care Policy and Financing (the Department). Proven technologies have already been assembled to create and manage a system that efficiently collects, safely stores, and securely shares health information. The core systems that will be used by NHP are already operational and in use by our administrative agent, Beacon Health Options, Inc. (Beacon) for Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) programs. These systems are also already fully integrated into the Colorado interChange, the the Department's health information systems and the new Business Intelligence and Data Management (BIDM) system.

Our systems report to the Department an average of 645,382 services per year

The organizations that comprise NHP have over 20 years of experience working with the Department's information systems. Over the years, our administrative agent, Beacon, has tailored its processes to align with the Department's requirements by complementing its information systems—not duplicating the efforts and investments of the Department. Through this experience in working with the Department and providers, it has thoughtfully put in place an information system that is stable, configurable, and efficient. As an example of this experience, Beacon has consolidated claims, encounter, Colorado Client Assessment Record (CCAR), and Drug/Alcohol Coordinated Data System (DACODS) data submissions for 13 Community Mental Health Centers (CMHCs) in Colorado. Since 2009, over 5.8 million services have been reported to the Department, which is an average of 645,382 per year.

Data and Actionable Analytics Strategy

NHP's data and analytics strategy will be sophisticated, but also realistic. We will balance high-tech with high-reliability and create a system of people, processes, and technology that can meet any provider where they are to share actionable analytics in a meaningful and efficient manner. As a result of our experience, we have learned that while health information standards exist, the most successful managed care organization provides multiple options to the provider community so that any provider can find a meaningful way to receive information and collaborate with the organization. We believe the RAE's role is to provide actionable and impactful information to providers that augments what they will leverage from other Department investments like the BIDM System. To meet those objectives, NHP has developed a data and analytics strategy based on the following core concepts:

- We intend to **leverage the investments of the Department such** as Colorado interChange, BIDM, and CORHIO to the greatest extent possible so that we provide consistent information and messaging to providers and bring the greatest value to the Department.
- We will **augment the Department's investments** with our own technology and the use of innovative new solutions like our machine learning and natural language processing tool. This is

our messaging infrastructure that can deliver actionable analytics to providers along with a suite of data processing, management, and integration tools that have been developed and refined in service of Colorado programs for over 20 years

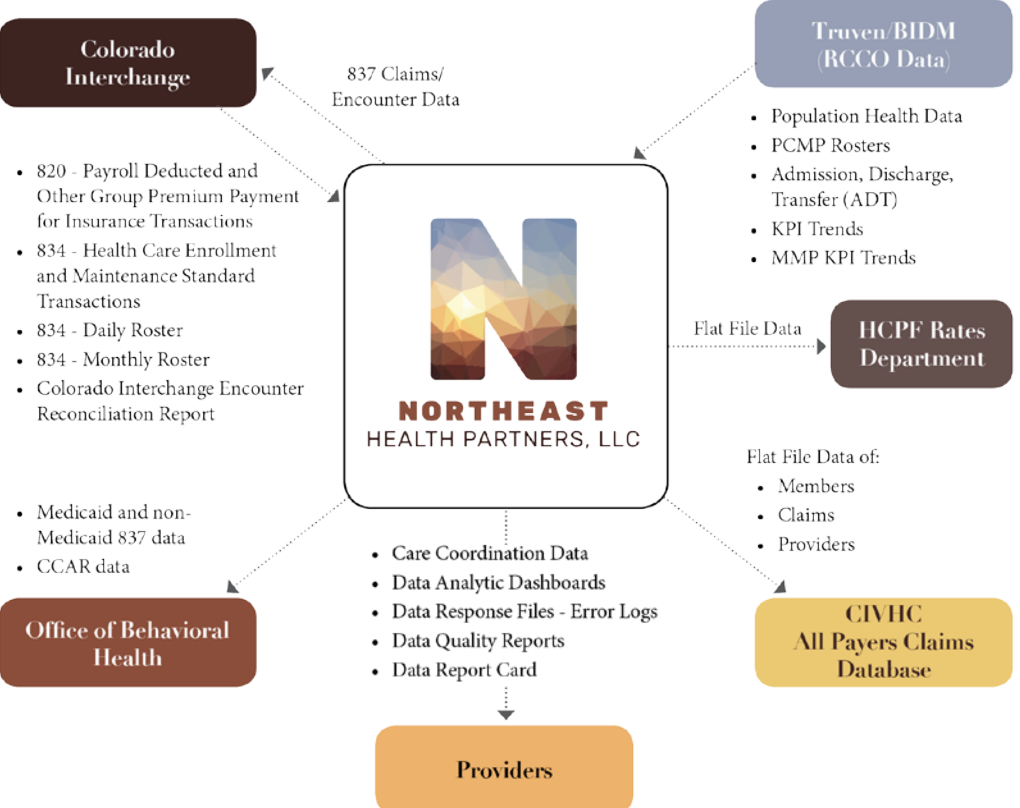
- We recognize that providers have made different investments of their own and appreciate how difficult it is to get a provider to alter their workflow to Member information that a managed care organization believes is useful. With this in mind, our data sharing and provider integration strategy will **accommodate all types of providers regardless of where they are on the technology adoption continuum**. This includes:
  - Interfacing with those that have invested in electronic medical records (EMRs) through HL7 standard transactions
  - Offering technology to those that have not invested and would like to use our CONNECTS management information platform
  - Supporting custom integrations for those that have built or adopted custom or technology solutions that do not support recognized standards
  - Messaging actionable information directly to providers through reliable but lower-tech solutions such as delivering messages to their voicemail before each day through our TeleConnect system or a simple but effective fax message

DATA MANAGEMENT

Our administrative agent, Beacon, has a fully automated electronic data interchange (EDI) process from the Colorado interChange system, provider data submissions, and CMHCs' data submissions. As files arrive, they are automatically logged and processed without any user intervention. Notifications are sent to the application business owner stating the files have arrived and are in process. A large portion of the processing includes verifying the integrity of the data by scrubbing for errors. After the data is verified, it is prioritized and then loaded into our data warehouse for processing. Beacon runs extensive tests in a local testing environment so that providers can test for data errors in claims and encounter files before we submit data to the Department.

Our information systems workflow, graphically depicted below, illustrates the key health information data flows that drive our integrated systems. Through scheduled data interchanges, data are securely and reliably routed between participating systems using HIPAA-compliant and State-specified formats.

Key Health Information Data Flow



Interface with Colorado interChange

NHP makes full use of the data provided by the Department to identify and confirm membership and as a basis for payments, adjustments, and reconciliation of claims and encounters. We use the data from the interChange and BIDM System to drive our system processing, including, but not limited to: authorizations, claims payments, member mailings, recoupment activities, quality improvement, provider contracting, financial planning, reporting, and auditing.

Our information systems compliment the Colorado interChange and BIDM System. Adopting the Department's systems as the "single source of truth" allows us to provide clarity and confidence of decision-making to the Department, providers, and Members. In addition, we will thoughtfully and judiciously augment our systems with new technology to enhance our capabilities and ability to serve the Region 2 providers and Members throughout the term of the RAE contract. We will also ensure that we are not duplicating expenses or investments in overlapping technology that would not be cost efficient for the Department or NHP, or create confusion among our providers, Members, and others users of our data and systems.

The State has provided a secure file transfer server traditionally used to distribute data from the State to their Contractors. NHP uses automated programs that interact with the interChange using

Secure File Transfer Protocols (sFTP) methods. These automated programs search for new files and downloads them to a structured folder system on a secure file server. Each file has a custom program to support its file format and validation by the programs that load the information into the databases to ensure consistency and accuracy. The file type drives where the location of the file will be processed. As soon as they are made available by the Department, 820 Payroll Deduction transactions, 834 Health Care Enrollment and Maintenance standard transactions, 834 Daily Roster, and the 834 Monthly Roster are all processed into our system. The interChange Encounter Reconciliation Report will also process when 837 files are submitted and adjudicated. We will use the Encounter Reconciliation Report to improve the quality of our encounter submission. The data is then verified and loaded into our internal databases for error correction, reporting, and analytics.

We load 820 Payroll Deduction transactions, 834 Health Care Enrollment and Maintenance standard transactions, 834 Daily Roster, 834 Monthly Roster, and other industry standard formats from the State systems to support our validation of the information received from other sources and distribute information to our analytics section for reporting and trending. Extracts and reports are sent to those teams that turn the information into action.

Interface with BIDM System

Our systems are also integrated into the BIDM System through backend data processing. Our automated processes check for posted files from the BIDM System and once files are posted, they are verified and processed accordingly. Data is loaded into our systems and distributed to providers via the CONNECTS EDI module, File Connect and our messaging/alerts capabilities. Our systems are flexible enough to import and export any file format that the Department provides, including all standard Medicaid file formats like X12. These data elements are then available to NHP in a relational database for the analytics, clinical, quality, finance, and provider relations staff to process for follow-up, key performance indicators (KPIs), audits, reporting, and trending. The data we load is presented in interactive Web tools, reports, and spreadsheets following industry best practices.

NHP will build on our partners' experience ensuring provider education and support efforts are maintained related to provider capabilities with data management and technologies. Our Provider Relations Department has a team system to manage administrative and technical support to providers within the region. Staff is assigned to territories to be in contact with providers over the life of the contract. Each team contacts their assigned offices regularly to obtain demographic updates, determine if any problems exist, and assess any training needs, including utilization of the BIDM System Web portal. Provider Relations staff are trained to ask questions related to the practice's comfort level with the system to identify opportunities to overcome barriers so the practice successfully adopts the system. Also, they are knowledgeable on how to use the system so they can support staff to navigate the system and increase comfort level in using it. Our staff have a variety of communication and education tools at their disposal to facilitate the interaction with providers over the phone or in-person. This includes self-service via our online provider services accessible through out website. This site also provides links to training modules available on the BIDM System. Our staff will use these tools to conduct desktop training or troubleshoot provider issues on-site or over the phone as the provider and practice staff become fluent and comfortable with the BIDM System.

NHP will also leverage the BIDM System to acquire key population information from the Department such as abut not limited to physical health and specialty claims, medication data, and utilization management data. This information will be loaded into our data warehouse and used for analytics functions such as generating actionable alerts for care coordinators, Members, and providers. These alerts will be shared with providers via voicemail messages, faxes, electronic interfaces, and/or data exchanges selected based on the provider's needs and capabilities.

Automation of Data Management

NHP's partners have extensive experience developing Colorado Medicaid-specific data management systems capable of capturing accurate data to create meaningful and actionable information. Automation is the key to delivering high quality data to the Department and our partners. Our EDI system, FileConnect, processes files from the Department and providers, loads files into our structured database, and delivers reports and extracts back to the Department and providers. Most of these processes run overnight and during weekends so that our Business Intelligence team has access to fresh and actionable data available the next morning. Our automation services include data quality and integrity checks to ensure that all overnight processes run smoothly. By scanning the logs produced at every step along the way, we know if there were any challenges, changes to files, or other issues that delay that smooth processing flow and are on call to take immediate action to remedy the issue. Our data management systems and resources serve the business and clinical teams and define success by delivering accurate, timely and actionable data to those teams so that they can focus on their responsibilities.

Our systems check each day for new files on the Colorado interChange system. System processes track files already downloaded by name and file modified date to create a historical and traceable log of all activity. Each file has a specific folder so the processing application knows where to look and can process multiple files if needed. Files are also uploaded by providers and employees of the Department through the FileConnect application. Our automation tools assess if any files need attention. Data collected electronically includes:

- Authorizations
- Eligibility and third-party liability
- Client Over-Utilization Program (COUP) data
- Claims and encounters
- Credentialing documentation
- Nurse Advice Line data

New files that NHP is planning to process for the Region 2 RAE include:

- Health needs survey data
- Diagnostic cost groups (DCG) risk scores from the BIDM System
- Provider performance data from the BIDM system
- Member clinical performance (e.g., gaps in care) from the BIDM System

Once the file collection is complete, file processing or transformation and loading jobs are executed. This allows us to process files as soon as they are available. Once a file is downloaded, the process calls for an application to load the file into our database or distribute the file to other locations. The application captures a detailed runtime log and runs a program to scan the log for errors. Errors are reported to three on-call resources in case the primary is not available. This enables us to respond to data processing issues quickly and efficiently.

By using automation to handle the bulk of the data collection, loading, and distribution, we enable our IT staff to spend more time working on higher value tasks such as analysis and design activities relating to how to improve the distribution of the information in a form that our stakeholders can use quickly and easily.

Electronic Claims and Encounters Submissions

For the past 22 years, NHP's administrative agent, Beacon, has consolidated claims, encounter, CCAR, and DACODS data submissions for 13 CMHCs. For more than seven years, Beacon has successfully submitted monthly encounter and claims data on behalf of the CMHCs to the Department on time.

Submissions via FileConnect

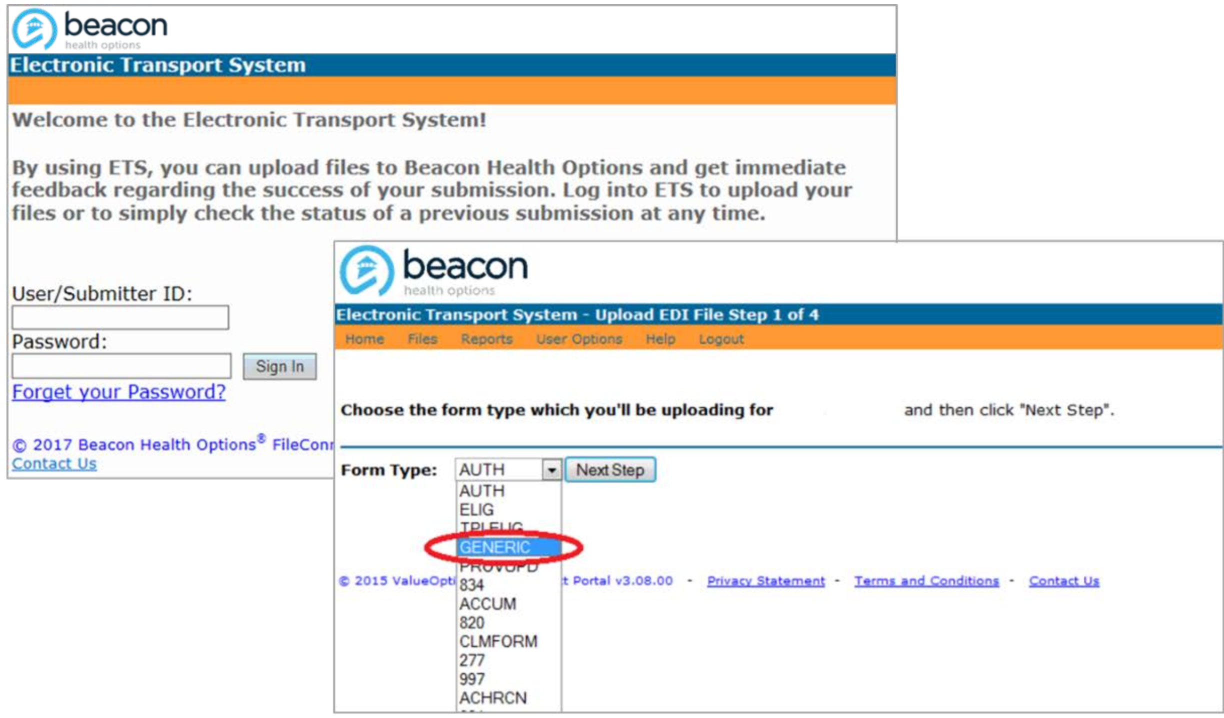
For electronic encounters and claims submission, NHP uses an enterprise-class EDI system called FileConnect, shown below, to communicate large data files securely over the internet. This system uses 2048-bit RSA technology to protect all data sent or received, so active encryption of data is not necessary.

2016 Electronic File Transfers via FileConnect

Incoming Files – 635,159

Outgoing Files – 776,989

Providers and partners upload encounter data via FileConnect and any response files, error logs, or other data that may contain protected health information (PHI) is then available for download. The Department's Rates Division also uses FileConnect to send Beacon financial data and files for auditing purposes.



Since 2009, over 5.8 million services have been reported to the Department at an average of 645,382 per year using FileConnect.

Submissions via ProviderConnect

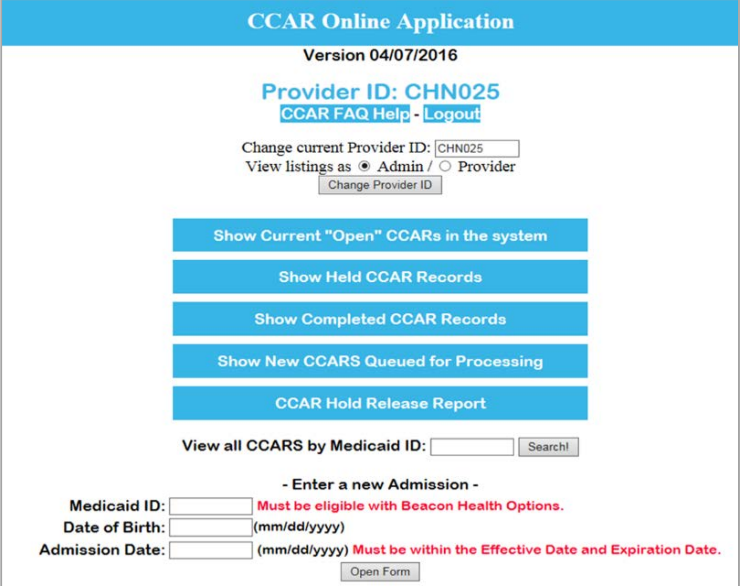
For claims submission, providers in Region 2 have already adopted and incorporated our ProviderConnect system into their workflow. NHP will continue to use ProviderConnect, which is our online tool that allows providers to make direct electronic data entry into our system. Providers can also download authorizations and remittance advices electronically from ProviderConnect allowing them to interact with NHP in a modern and efficient electronic manner. This application is a springboard of tools and links to help providers submit claims, review submitted claim status, and obtain electronic payment of claims directly to the providers' banks.

Our ProviderConnect system saves providers time and gives them immediate access to the information they need to manage their business efficiently so that they can focus more of their efforts and attention on the delivery of care. We designed this tool to be modern, simple, and easy-to-use and have deployed it in Medicaid and Commercial markets across the U.S.

ProviderConnect allows providers to electronically:

- Check status of a Member's enrollment
- Register a Member for services
- Check a Member's benefit information
- Review and submit requests for authorization of care, as well as, the ability to print or save requests into their management information system (MIS) or electronic medical record (some requests will receive immediate authorization based on benefit)
- Review a detailed payment status of submitted claims
- Communicate directly with Members via the communication center
- View and submit updates to demographic data for providers
- Submit/attach documents to all authorization requests and other submissions
- Directly enter and submit a claim or upload HIPAA-compliant claim files online (as a registered user and claims submitter on ProviderConnect, providers can elect to register for Electronic Funds Transfer (EFT)
- View and print online correspondence, such as authorization letters and provider summary vouchers
- Create and view other types of inquiries via a personalized message center
- View authorization history and letter history
- Enter Member reminders for appointments and medications
- View provider handbooks and obtain information on trainings, current clinical articles, and workshops
- Access client-specific network information
- Download and print standard forms
- Review and submit individual plans and treatment plans, enter special program applications, and communicate directly with external care coordinators and care teams that are either using the NHP provided CONNECTS platform as their care coordination tool, or are integrated with NHP

Providers can also complete and submit CCAR forms over the internet. Shown below, these online forms provide real-time error checking and feedback, thereby reducing the need for mailing, correction of mistakes, and manual processing. To accommodate providers in rural regions, some of which do not have high-speed internet connections, a Hypertext Markup Language (HTML) version of the CCAR form was made available to all providers in 2009. This allows providers with slower internet connections to submit data more efficiently.



Third Party Liability Data

Third party liability reporting is also automated. Member primary insurance information is received from the Department and providers monthly and will be loaded directly into our system. We will then use these data during the adjudication phase of claims processing to make sure that Medicaid is truly the "payer of last resort."

Behavioral Health Encounter Data Processing and Reporting

NHP will use a proven system for collecting, analyzing, and submitting encounter data to the Department. Over the past 22 years, the Beacon Encounter Submission System is a collection of applications, transmission methods, and documented procedures that has been tuned to ensure that the State receives encounter data for each service provided to each Member under the Mental Health Program. Collection begins with the providers where services are rendered and recorded.

NHP's goal is to submit all encounter data for the previous month in the current month. Only encounter data which contains fatal errors or eligibility questions are held in queue ensuring that encounter data reporting to the Department is 100 percent accurate. When eligibility questions and errors are resolved, the encounters are then released to the Department. Most capitated encounters are submitted within 30 days of receipt from the providers. These systems and data checks have evolved over our 22 years of serving the Department and have been pressure-tested, refined, and updated so that they will all be available and 100 percent operational for a seamless and worry-free operational start on July 1, 2018.

Data certification ensures data submitted are accurate, complete, and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members. Prior to the monthly submission of encounter data to the Department, we review the raw data for completeness and accuracy and compare it to previous submissions' totals as a reality check. Once the encounters are submitted to the Department and no questions are raised, the letter of certification is then submitted.

NHP will submit to the Department flat files with all Encounter Data for State Plan and 1915(b)(3) Waiver Services in the ANSI ASC X12N 837 format directly to the Department's fiscal agent by the end of every month. Each month, providers submit their encounter data in a flat file format. To ensure the quality of the data, claims and encounters are processed through our Encounters Auditing and Reporting System (EARS). The data are subjected to more than 100 different edits to test for completion and accuracy including specific checks for eligibility. The table below provides a monthly roll-up of encounter data submitted to the Department.

Monthly Flat File Data Submission Report

	State Plan	B3	Total
Provider-Reported Value of Services	$14,119,652.31	$1,837,568.76	$15,957,221.07
State Plan vs. B3 Composition	88.48%	11.52%	100.00%

Source	(All)		
	Values		
Procedure Modifier Grouping	Total Units	Total Charges	Encounters/Claims
(HE) State Plan Services	115,182	$14,119,652.31	75,838
(HJ) Vocational Services	833	$41,596.01	222
(HT) Prevention & Early Intervention	5,908	$425,217.29	2,683
(HQ) Clubhouses & Drop-in Centers	3,201	$110,637.50	423
(TM) ACT Services	428	$25,322.32	192
(HK) Residential Services	1,086	$751,435.64	1,104
(U4) Intensive Case Management	6,354	$414,256.97	3,582
(HM) Respite Care	332	$7,821.75	107
(TT) Recovery Services	984	$61,281.28	327
Grand Total	134,308	$15,957,221.07	84,478

Data submitted to NHP will be monitored using the monthly Data Report Card (DRC), shown below. The DRC documents the quality and timeliness of encounter files submitted by the provider, as seen in the spreadsheet of Encounter Files Submitted by Providers and File Timeliness in *Offeror's Response 22*. The DRC also identifies trends in types of errors and provides a quality check between the providers' data file we have processed and the data submitted to the Department.

Our partners have a 98 percent acceptance rate for claims and encounters submission.

Example of Encounter Data Report Card

Northeast Health Partners FY2017 Encounter Data Report Card – Executive Summary

File Timeliness Rankings (Cumulative FY2017)

Providers	Avg Days Late	
Provider1	-1.2	
Provider2	-0.84	
Provider3	-0.21	
Provider4	On time	
Provider5	On time	
Provider6	On time	
Provider7	On time	
Provider8	On time	
Provider9	On time	
* Integrated Program		

Data Quality Rankings (Cumulative FY2017)

Providers	Non-Submittable	MedCap Volume#
Provider1	0.00%	30,821
Provider2	0.02%	20,637
Provider3	0.09%	39,698
Provider4	0.22%	25,212
Provider5	0.23%	171,143
Provider6	0.81%	24,245
Provider7	1.00%	94,743
Provider8	1.77%	1,130
Provider9	4.03%	116,623
# Corrections Included		

Comments and Observations

CMHC	Notes
Provider1	Error rate this month at .1%. Error rate below 1% for the entire Fiscal Year.
Provider2	Excellent data quality. Error rate at 0% entire FY.
Provider3	Error rate at .1%. Four months of .1% or less.
Provider4	Error rate increased to 4.2%. Duplicates and provider credentials are high.
Provider5	Error rate at 1.0% this month.
Provider6	Error rate at 0.0% for fourth consecutive month.
Provider7	Error rate at .2% for the past two months.
Provider8	Excellent data quality. Error rate at 0.3% this month.
Provider9	Excellent data quality. Error rate at .2%. Error rate .2% or zero for the entire fiscal year.

Non-Medicaid Conversion (Cumulative FY2017)

Providers	Rate	(Clients)	Charge
Provider1	0.12%	(5)	$3,105
Provider2	6.41%	(736)	$611,554
Provider3	7.52%	(57)	$37,886
Provider4	8.32%	(410)	$372,796
Provider5	9.41%	(97)	$77,930
Provider6	18.19%	(209)	$174,171
Provider7	27.30%	(783)	$871,376

Beacon Correction Rate (Cumulative FY2017)

Providers	Corrected	Elig Released
Provider1	0.20%	64.72% of 564
Provider2	0.00%	0.00% of 132
Provider3	0.61%	23.31% of 2741
Provider4	0.00%	9.09% of 11
Provider5	0.44%	20.00% of 25
Provider6	0.14%	95.45% of 44
Provider7	0.00%	0.00% of 5
Provider8	0.40%	76.81% of 138
Provider9	0.33%	84.47% of 219

Executive Summary | Errors Summary | Errors Trend | File Reconciliation | File Timeliness

Beacon has developed an exceptional record of exceeding standards for claims processing, payment, and submission to the Department with **98 percent of claims paid within 14 days**. Additionally, Beacon has consistently maintained **a 98 to 100 percent financial and procedural accuracy through internal audits**. Finally, automation within the claims system includes built-in edits to avoid errors, and the system is designed to identify instances of potential fraud or incorrect billings.

Once data is loaded into the system, a more comprehensive analysis is performed by joining it with other data. Some examples of analyses include:

- Determining continuous enrollment for a given Member to detect breaks in eligibility
- Change in eligibility status, such as retroactive enrollments

- Identification of unusual trends or anomalies in data through routine frequency analyses of encounter fields

Encounter Data from Integrated Primary Care Medical Providers (PCMPs)

NHP will receive flat file data for behavioral health encounters delivered within primary care settings, if the PCMP facility has this technology, using sFTP exchange sites for secure transfer of data. For PCMP facilities without this technology, we have developed an integrated care tracking system that allows for the capture of encounter and referral data for behavioral health professionals embedded in PCMP facilities. We are also able to capture limited practice penetration data from this system.

Other Data Transmissions

Through our data management system, we will be responsive to new data needs as requested by the Department. We will quickly build the additional data into existing or new data extracts for submission to the Department. We will deliver and test sample files before Departments deadlines so there are no issues with the new format when production deadlines are reached.

NHP will receive the daily X12 834 Health Care Enrollment and Maintenance file. This file will be loaded to adjust our current enrollment database with the latest information available from the Colorado interChange. All transactions in the 834 are processed to update the current membership enrollment status information. This information is used to validate encounter data to ensure only Medicaid eligible encounters are sent to the Department. The 834 Monthly Enrollment roster is used to ensure that the database matches the State’s Membership Enrollment database in the Colorado interChange. Through this process we make sure we have matching enrollment data for all active Members and that the encounters submitted are valid.

Colorado interChange Encounter Reconciliation Reports are the reply files from 837 submissions. These reports detail any potential errors and informs us which encounters have passed into the State’s system and those that were rejected. We will receive and process these files (one for each batch of 837s submitted) to ensure that all encounters submitted are properly adjudicated.

Updating Systems to Keep Pace with the Department’s Innovation

As the Department makes changes to data structures, systems, and coding, NHP’s information systems are aligned according to the Department’s requirements through an internally managed change and configuration management process. This process creates an agile environment where we can easily and efficiently respond to changes made to the system we interface with. We use a Microsoft Team Foundation Server to manage all our core source code for applications and processes which allows us to “check out” the core source code for applications and make configuration changes in a testing environment before moving changes into production. Our process and technology ensures that we keep pace with the evolution of technology systems and update our integrations without unexpected system down-time.

INTEGRATION APPROACH WITH PROVIDER SYSTEMS

NHP has not only invested in data systems that integrate with the Department, but also systems and integrations for providers so that all of our Region 2 provider, Health Neighborhood, and stakeholder partners can continue to perform their duties using the systems they have invested in or adopt our systems. This flexible approach accommodates the needs of the community we serve and will enhance our ability to successful connect the Region 2 network. Health information technology systems remain more closed than we would like, but fortunately standards do exist such as HL7 standards and our infrastructure and expertise is agile and can also accommodate custom integrations where those standards cannot be adopted.

Our CONNECTS system was developed with end-users in mind; the user community extends beyond our staff to providers and Health Neighborhood partners in Region 2. Just as we have implemented a Member-centered approach to our engagement and communications models, we used a user-centric design approach for all our systems. These systems, which have been in place for BHO and RCCO operations in Colorado and Medicaid programs elsewhere in the U.S., offer different paths to engagement and use by user type. We have developed a technical architecture and system that is cognizant of the provider community's diverse set of needs and capabilities. For example, we have classified providers into three user personas and offer a different set of capabilities for each as described in the graphic below.

User Persona Examples

Persona 1	Persona 2	Persona 3
"We recently implemented an expansive EMR system such as Epic or Cerner and have built care coordination modules and workflows into this system. We do not want to access another system."	"We primarily serve Medicaid members and could benefit from access to a Care Coordination system and integrated health record that feeds us the viewing actionable analytics and alerts we should respond to."	"Our attention right now if focused on areas other than technology upgrades. We have some home-grown systems in place but these have been in use for many years are not up date on all of the HL7 standards."
CareConnects Platform HL7 Data Interchanges	**CareConnects Platform and Spectrum unified patient record and actionable alerts**	**CareConnects Platform and FileConnect custom EDI data transfers**
Users access RAE information in their EMR system via existing worflows. RAE sends and receives all information to the EMR via HL7 standards	Users access the CareConnects Platform and Spectrum Unified Patient Record and Alerts for those patients in which they have access to view	Users have access to information via a custom data load to their system and RAE receives information from user via custom file exchanges

Persona 1 Providers are the most technically advanced providers that have made significant investments in their EMR infrastructure and business processes. Their workflows have been designed and implemented for consistency and efficiency and their EMR is their single system of truth for all clinical operations. These providers are not interested in accessing another system from one payer and often serve multiple payers and lines of business such as Medicaid and Medicare, or Medicaid, Medicare, and commercial health plans. For this type of provider, seamless integration with their EMR system is a must. In fact, most of these providers have already established integrations with other partners to bring clinical information into their systems and act on it. They also publish data to subscribers with the right credentials in standard formats like HL7. For Persona 1

Providers, NHP will offer our CareConnect platform and standard HL7 data interchanges using our scalable EDI infrastructure.

Persona 2 Providers are providers interested in using an external system. Many of these providers have had access to systems in the past by other local partners, but have chosen not to make the investment on their own. NHP will offer these providers access to the CareConnect platform with a single unified Member record with the appropriate role-based security and access to allow the provider to see and enter information and share data with other users. These providers may serve a single payer, like Medicaid, and conduct care coordination functions above and beyond the basic provider expectations whereby a care management system will assist them with consistent delivery of assessments, use of standardized screening tools and development of a Member-centric care plan. These providers will receive alerts from the CONNECTS system when a clinical or coordination need presents itself for one of their Members. These email alerts will direct the provider to access the system via a link and review alerts for any of their Members. Actions are documented directly in the system.

Persona 3 Providers are providers that are comfortable with the system they have in place whether a custom software solution, older, or more basic non-meaningful use level 3 conforming platform or some other tool and either are not interested or do not have the capacity to make a change. In this case, NHP will still pursue integration with the provider and will offer the third potential option to send and receive actionable health information about their Members. For these providers, we will evaluate their IT capabilities and develop custom data transfer programs to send and receive information. These files will likely be CSV or Pipe delimited flat files and transferred on a regularly scheduled basis. While these are not real-time data exchanges, they offer an integration path for all providers not just those that prefer a specific type of tool.

USING ANALYTICS TO MEET THE GOALS OF THE ACC

NHP recognizes the central role that leveraging data plays in the effective administration of a RAE and achievement of the Quadruple Aim in Region 2. The proper application of data analytics and reporting improves quality of care, lowers cost, drives informed decision-making, and provides vital information that promotes better coordinated care and economizes use of resources. In short, if adopted, this information can improve care, reduce costs, and allow providers to focus their time and energy where it matters most—the delivery of superb clinical care. We access, normalize, and consolidate multiple data sources to minimize noise and guide operational and programmatic decision-making and drive Member-centered activities related to: care coordination, population health, quality initiatives, Member outreach, performance improvement, program design, and stakeholder accountability.

Our current IT infrastructure generates a substantial amount of data, but meaningful insights are only achieved from sifting through this data, identifying the actionable elements, and then distributing that data to the right people at the right time to make a difference. NHP will provide the infrastructure to determine where and how to direct expert resources, where to find alignment with other activities to create more streamlined processes for providers/partners and care coordinators, and to provide insights necessary to identify systemic issues at the provider/care coordinator level. Internally, our Quality, Provider Relations, and Care Coordination staff will use actionable insights from the data we receive and process to focus efforts and monitor the quality of services and the health of our Members. When data indicate that providers or care coordination entities are struggling, we will provide onsite technical support, trouble shooting, and education to bring about a solution.

Potential provider issues uncovered through monitoring data include:

- Inaccurate claims information submitted by providers that impact their KPIs
- Staffing patterns not conducive to efficient Member care

- Lack of understanding regarding how to use available data and reports at the provider level to guide care and coordinate interventions
- Breakdown in communication between outpatient providers and hospitals
- Difficulty meeting access standards

In addition to the numerous data submissions, including BIDM System data, we share actionable analytics with providers to inform the care management process, assist providers on their journey towards practice transformation, align their practice with evidence-based guidelines, and help to identify Members with open "gaps in care" such as HEDIS Effectiveness of Care measures. We conduct weekly, monthly, and sometimes daily monitoring of key data elements so we can implement real-time interventions with providers as indicated.

Actionable Analytics

NHP fully supports the State's initiative to implement BIDM System and the ACC 2.0 goals to improve Member health and life outcomes and to use State resources wisely. To ensure we are using those resources wisely, we plan on augmenting the State's data analytics investments for our specific operations and region, and to leverage statewide resources to create consistency.

This supports the Department's goals of consistent, reliable, and actionable data for NHP and to providers regarding their Members. Through the visual BIDM interface that is being developed and the data exchanges that will be available, we will be a primary advocate and expert in the launch and use of the BIDM tools. We will consume and use key information like the "My Clients" data that will include Members' Conditions, Risk Weights, Emergency Room Visits and Well-Child status.

Truven Physician Performance Assessment (BIDM)

Field	Description
Client ID	Clients' Medicaid Identification Number
Client Name	Clients' Name
RCCO	Regional Care Collaborative Organization
PCMP ID	Primary Care Medical Provider Identification Number / Billing ID
PCMP Name	Primary Care Medical Provider Name
NPI	National Provider Identifier
Client DOB	Clients' Date Of Birth
Client Gender	Clients' Gender
Client County	County of Client's Residence
Client Zip	Zip code of Client's Residence
Condition Description	Primary Chronic Condition Description
Risk Weight	Clinical Risk Group Weight - Clients' CRG Relative Resource Intensity Weight
ER Visits	Number of Emergency Room Visits
Eligible For Well-Child Check Rate	Identifies clients that are eligible for the well-child check performance measure
Well-Child Checks	Number of well-child check claims submitted within the 12 month reporting period
FBMME Demo Enrolled	Identifies clients enrolled in the FBMME/Duals Demonstration population

In addition to leveraging the State's significant investment in the BIDM System, we have chosen to invest in cutting-edge, advanced analytics to help us manage and impact the total cost of care in Region 2.

NHP's advanced analytics tool brings the power of supervised machine learning to the RAE. This investment will help us to use existing data—from health needs surveys, to health risk assessments, to claims, to call center transcripts—to address these the challenges of identifying the Members

most likely to benefit from more intensive care management, securing resources to keeping Members healthy, and establishing a listening post to monitor and re-connect with Members whose health is in decline. Our process uses machine learning and natural language processing to leverage all the information in both clinical and administrative healthcare data, including non-traditional and unstructured data like case notes. It allows us to supplement the BIDM System and focus on **actionable risk** and **prioritize Member outreach** based on the potential to impact each individual Member considers for specific use cases as defined by and customized for NHP. This enables care management interventions to be targeted with unparalleled accuracy.

Our advanced machine learning analytic tool has helped 20+ government-sponsored plans get the right care to their Members sooner, contributing to over $100 million in cost savings. The advanced machine learning and natural language processing software has been “trained” on the data of over 10 million members with chronic/complex conditions.

Our goal is to move from being a reactive model that solely looks at what has happened historically to being a much more predictive, proactive, and targeted service provider.

This technology and approach is the result of decades of research on applying machine learning and natural language processing to improve health care. This approach is not only evidence-based but is evidence-producing, with over 20 published clinical studies resulting from collaboration with more than 250 hospitals and plans. Its supervised machine learning and natural language processing is modelled after the use of technologies in products and services such as Amazon.com, Pandora, Facebook, and Google.

Machine learning is not new to health care. One of the machine learning originators, IBM Watson technology, has become a household name. Until recently, many of the machine learning applications talked about for health care had been used to teach computing systems enough to be able to suggest a diagnosis on a specific disease. IBM took things further. It essentially sent Watson to medical school. IBM had Watson ingest large amounts of medical literature to learn everything physicians are taught about Member’s conditions, and then taught it to make diagnoses. The experts that applied this knowledge to healthcare knew that more than 50 percent of what is considered clinically relevant is unstructured free text in the medical record.[1]

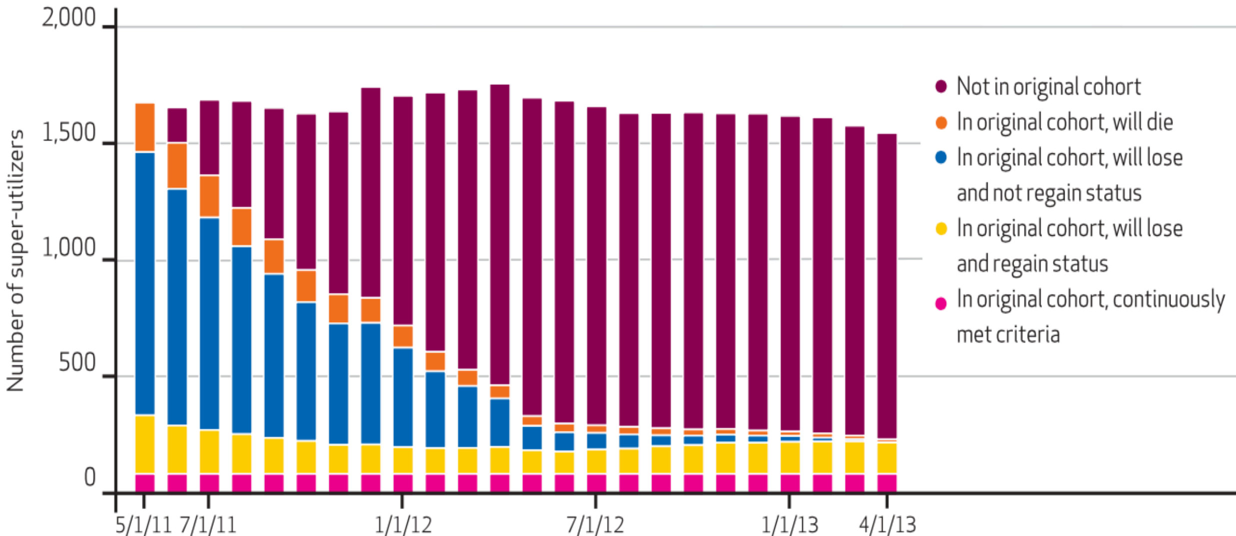
Traditional predictive analytics solutions use structured data such as historical claims, medications, lab results, and demographics to predict future utilizations. This information often suffers from different lag times, making it less relevant than real-time data. These tools have proven to be very useful, but we have learned that they are only as good as the algorithms they are built on and the data that is available to those algorithms. Unstructured data like case notes, health needs surveys, and social determinants hold a wealth of information that our industry has previously left untouched.

Historical data such as claims has its shortcomings. First, utilizations are not always preventable. Secondly, studies have shown that only 50 percent of super utilizers remain super utilizers after seven months and 28 percent after one year. Understanding this is critically important to focusing resources on the Members that are effective, and present an opportunity for NHP. As graphically illustrated in the chart of the following page, a model relying only on historical information and cohort tracking over time will naturally show that costs by Member will decrease as individuals “regress to the norm” over time without any causative intervention from the RAE.

[1] http://www.healthleadersmedia.com/technology/machine-learning-healthcare-takes-another-step?utm_source=Friends%20of%20Cyft&utm_campaign=9eaaec5a8c-Cyft%20Update%20Dec%202016%20%231&utm_medium=email&utm_term=0_1148fd982b-9eaaec5a8c-30647325

Population and Individual Level Analysis (May 1, 2011 – April 30, 2013)

(Adult Super-utilizers in Denver County) [2]



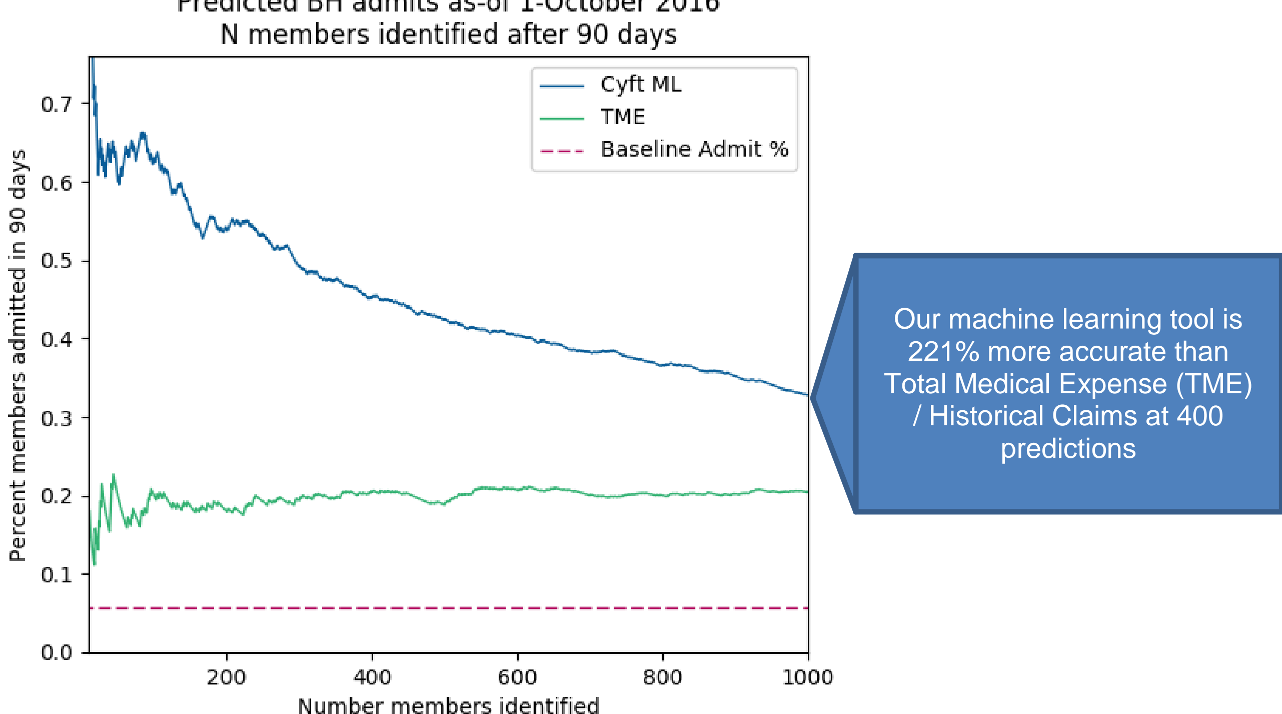
In addition, a select number of predetermined variables that are expected to be important mean that selection is often influenced by intuition. With a machine learning tool, algorithms can consider millions of data points and find patterns without needing to be told where to look.

To summarize, with machine learning, we provide the tool with the question that needs to be answered, and then through an iterative process, the tools learns what criteria are meaningful. For example, in order to prevent a re-admission, a traditional model would look at the reason for admission and date of discharge. Some models have also looked for other indicators such as level of care, acuity, chronic conditions, emergency department visits, and frailty to predict likelihood for re-admission. These predetermined variables are predictive, but miss other critical elements that are hypothesized to matter, or should be identified by the tool for their predictive power.

In the world of machine learning, NHP will supervise the model and adapt it based on performance against KPIs, stakeholder and community input, and needs identified by providers and the Department. Our complimentary analytics will help us to create rank-ordered lists of Members to target for different care coordination interventions at the point of care or by the RAE directly and predict Members who are likely to experience events that we need to identify for our region before those predictions are available from the Department via the BIDM System or supplemental to them.

As an example of the predictive power from this advanced analytics tool, users of the tool have been able to improve predictions of inpatient admissions by Members who are seriously mentally ill (SMI) by 221 percent over a standard total medical expenditure (TME) model, which is commonly used by regression analysis and neural network generations of predictive modelling tools in the market.

[2] For Many Patients Who Use Large Amounts Of Health Care Services, The Need Is Intense Yet Temporary. Health Affairs, 34, no.8 (2015):1312-1319



Precision Engagement and Care Coordination

Our advanced analytics tool will use new and highly descriptive sources of data (e.g., care management notes, health needs survey, health risk assessments, call center transcripts) to identify exactly which Members need additional support from their provider, community, or care coordinators. This information and these models will augment the BIDM System's risk information, profiles, and gaps in care to create actionable lists of Members and their needs so that we can get in front of events before they occur. This information will flow to providers and care coordination teams in a variety of methods such as voicemail alerts, fax alerts, data exchanges, and care coordination system alerts with secure email prompts so that provider and care coordination teams can:

- **Predict upcoming admissions** in very specific sub-populations and engage Members before those admissions occur
- **Achieve better outcomes** by quickly identifying those most likely to benefit from specific interventions such as medication regimen changes and medication compliance counseling
- **Reduce medical costs** via preventable utilizations

Data Informed Quality and Performance Improvement

All quality and performance improvement activities are also data-driven iterative processes that utilize all available data and reporting sources to guide program development, track progress, evaluate outcomes, and inform decisions about targeted interventions that positively impact Member care. Quality and performance improvement activities are based on a review of relevant data combined with anecdotal information from providers and care coordinators, knowledge of regional and sub-regional characteristics, as well as feedback from Members and other stakeholders.

Our quality and performance improvement staff analyze data regularly including the Department's generated reports, internal reports, and ad hoc reports to identify opportunities for improvement as well as areas where best practice principles can be shared across the region to help improve other partners' performance. Data will be reviewed regularly within the quality committee structure

including the Regional Performance Improvement Activity Committee (PIAC) where Members, providers, outside agencies, and other stakeholders have an opportunity to provide feedback on performance, assist in troubleshooting problems identified in the data, and devise creative interventions to improve performance.

Quality and performance improvement activities that use data to improve Member care include multiple integrated projects across the region that are developed, implemented, monitored, tracked, and evaluated based on multiple data sources. Examples of actionable data regularly monitored to inform quality and performance improvement activities include:

- Identifying Members who have not had a well-child checkup and are engaged in behavioral health services with at least five visits in an eight-month period.
- Identifying Members who have both behavioral and physical health conditions and are experiencing some combination of: life transitions, multiple chronic conditions, emergency department utilization, hospital admissions/readmissions, high risk scores, high total cost of care, social determinants of health, and/or engagement with multiple systems.
- Tracking Members who are opioid dependent and/or suffer from chronic pain and are receiving specialized services through a pain management program.
- Maintaining Member registries to ensure special populations or Members with special needs are identified and receive care coordination support.
- Behavioral health performance measures, including:
    - **Outpatient Performance Measures** – Real-time reporting tools identify clients who are not engaging in needed outpatient supports. The tools allow for notification to providers when clients are approaching certain milestones, which allows for proactive engagement strategies to be executed.
    - **Hospital Discharge Performance Measures** – All crisis evaluation information and placement information is recorded in the provider EHR, allowing coordination from the time of admission until discharge.
    - **IPN utilization** – Utilization is tracked monthly to determine gaps in service and identify areas where more targeted interventions are needed, as well as identification of needs for enhanced or new programming within the CMHC regarding inpatient, residential, substance use disorder, and outpatient services to ensure adequate access and care coordination.

The following quality, executive, and strategic analytics are prepared and reviewed monthly:

- **Quality:** We review Member outcome and assessment data (e.g., CCAR, CHPY4, PHQ, Member satisfaction, AUDIT, DAST). For example, using the AUDIT and DAST scores help determine if a Member needs substance use disorder services and then track whether these services were referred/provided. When gaps are identified, we develop intervention strategies.
- **Executive:** Data included in this category provides overall information on organizational health, including penetration, budgeting (i.e., unit cost and Relative Value Unit), adjudication, staffing levels, and other human resources-related information, Members served, and diagnosis information.
- **Strategic Goals:** Goals are tracked to ensure forward progress, including meaningful access to therapy and medical and crisis systems with a specific focus on priority populations (e.g., Hispanics, older adults, developmentally disabled, homeless) to increase access to address health disparities.
- **Crisis Utilization Data:** Data is tracked and reported in real time using an outward facing, Web-based dashboard. Southern Colorado Crisis Connection (SCCC) services are reported monthly, quarterly and annually. Reported metrics include timely response for mobile services, walk in services, respite and crisis stabilization units, pre/post suicidality ideation measures, recidivism,

and Member satisfaction among others. Data is reported by age groups, recidivism, and other demographic breakouts.

These activities are not limited to provider interventions. As the RAE, NHP believes Members also need and can benefit from actionable information. To meet this need across Region 2 and to serve our Members that live in urban, rural, and frontiers areas, we will deploy a Member engagement toolset that allows us to offer targeted bi-directional campaigns around prenatal care, smoking cessation, adult and child prevention, wellness, and diabetes. These text-based programs, which are described in more detail in our response to *Offeror's Response 9* and *Offeror's Response 15*, are augmented with our care management platform that will be loaded with actionable analytics from the BIDM System, our advanced analytics tool, and other information gathered from interactions with providers and Members. This information will be documented in our CONNECTS system and data warehouse to deliver real-time actionable messages to Members for flu shot reminders during flu season, preventative care appointment setting, appointment reminders where providers do not have such technology in place, and other actionable and important events and notifications related to care for a specific Member or the Member's cohort.

Care Coordination Tool (CareConnect)

Our care coordination program is supported by an actionable analytics infrastructure that uses multiple sources of data and information including Colorado interChange, the BIDM System, internal data warehouses, BHO claims, COHRIO, NHP's advanced analytics tool, and statistical methods. When these data sources are combined, they provide sufficient information for care coordinators to devise appropriate outreach and interventions tailored to the Member. NHP will maintain and make available an electronic care coordination tool, CareConnect, to support communication and coordination among network providers and the Health Neighborhood.

CareConnect provides clear, actionable information to providers and care coordinators. The CareConnect application is designed to reduce the administrative burden imposed on providers and care coordinators by providing a platform to gather objective clinical data. Data extracts from CareConnect will be provided to the Department when requested. Several formats of the data can be provided depending on the Department's needs.

CareConnect is the clinical heart of our care management program, offering NHP staff and providers an enterprise-wide collaborative treatment planning and behavioral health record environment. Accessible 24 hours a day, seven days a week by the clinical team, this system enables clinicians to identify, authorize, and manage the delivery of the most appropriate, high quality mental health and substance use disorder services for Members—from the initial point of entry through discharge. The CareConnect application is used for the following processes:

- Creating referrals (i.e., routine, urgent, and emergency)
- Completing and tracking requests for service authorizations
- Performing medication management, inpatient/higher levels of care reviews, and second level reviews
- Managing discharge information and reviews
- Coordinating after-care and follow-up care

Many evidence-based, best practices clinical assessments are embedded in CareConnect and available for use with Members based on identified need. Assessments can be tailored to the specific needs of the ACC Program. An example of some of the assessments currently embedded in CareConnect include:

- SF-12v2 Health Survey
- Mini-Mental Health/Substance Abuse Assessment (Mini MHSA)

- Patient Health Questionnaire 9-Item Depression Scale (PHQ-9)
- Generalized Anxiety Disorder 7-Item Scale (GAD-7)
- Alcohol Use Disorders Identification Test (AUDIT)
- Child and Adolescent Needs and Strengths Assessment (CANS)

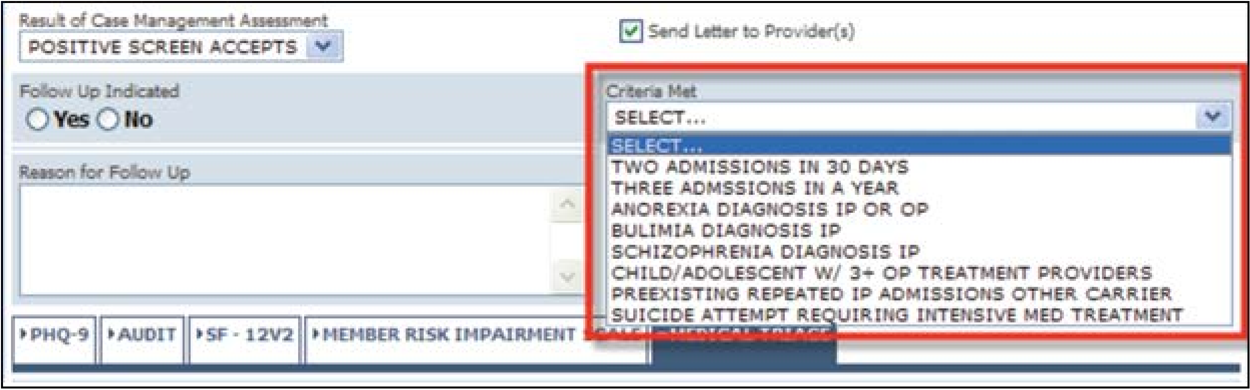
Intensive Case Management Module

CareConnect includes an Intensive Care Management (ICM) program. Comprehensive ICM treatment plans are integrated into CareConnect using the same platform as our authorization/ utilization management program. The ICM program was built in CareConnect taking the following goals into consideration:

- Care management/care coordination documentation system based on industry best practice workflows
- Supports NCQA and URAC accreditation requirements
- Balances different documentation styles including rapid entry via point and click selection of high frequency response items plus customized narrative notes as needed
- Logic incorporated wherever possible to provide decision support and minimize redundant duplication of information
- Data capture fields designed to support mandated reporting requirements and program outcomes
- Integrated health (i.e., physical and behavioral health) focus incorporated throughout
- Links to Achieve Solution health education modules

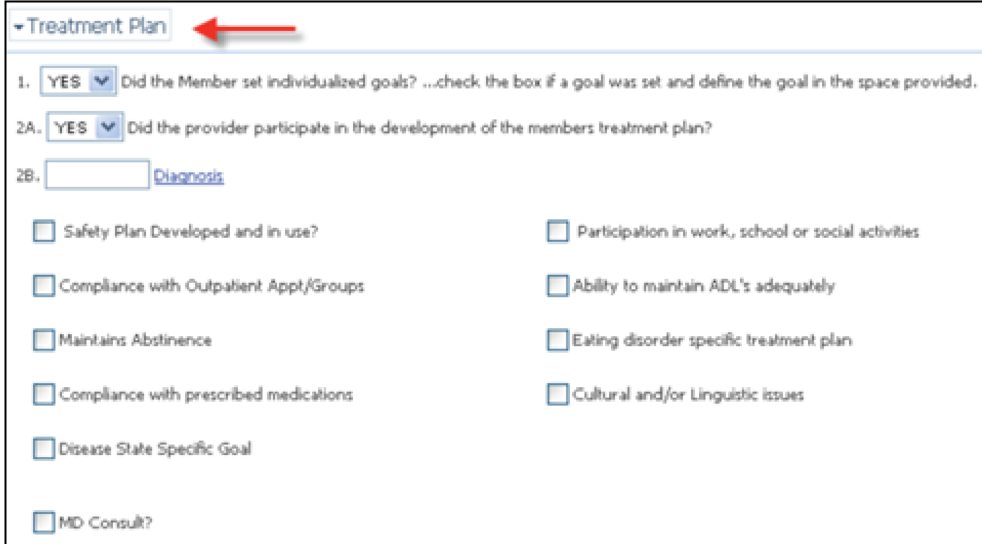
ICM program screens in CareConnect include an assessment process and an ICM referral process. These two processes allow for tracking and trending on the types of ICM referrals received and the risk factors associated with the ICM criteria. The ICM Referral Criteria Screenshot below shows the criteria met for the ICM referral based on the contract, and the indicator/electronic trigger to send a letter to the provider to notify the provider of the ICM assignment. These criteria will be customized for Colorado’s ACC Program.

ICM Referral Criteria in CareConnect



Once the ICM assignment is made, providers can submit treatment plans, authorization requests, and Wellness Recovery Action Plan® (WRAP®) or recovery/crisis plans in the same system. Member treatment needs are coordinated with all involved parties including providers and others as designated by the Member either by phone or in-person at treatment/discharge planning meetings. Once the Member is identified as an ICM participant, a flag is created in the system, improving communication and coordination of care. We have provided a screenshot from our ICM Treatment Plan on the following page.

ICM Treatment Plan in CareConnect



The Acuity Assessment tab, shown on the following page, enables the clinician to complete, score, and save an acuity assessment for the Member. The system automatically determines and displays a tier placement recommendation on the Tier Placement/Stratification Tab for the Member based on the acuity assessment. The clinician can, however, override the system recommendation. Administrative users can maintain tier placement/stratification reference information used by the ICM Tier Placement function.

Acuity Assessment and Tier Placement/Stratification

ICM REFERRAL | ACUITY ASSESSMENT/STRATIFICATION | ICM ENGAGEMENT | CLINICAL ASSESSMENTS | CARE PLAN | MEDICATIONS | CLINICAL PROFILE | MEMBER'S CONTACTS | ICM CONTACT ACTIVITY | DISCHARGE

ACUITY ASSESSMENT

Acuity Assessment Date	Summary Score	Results of Acuity Assessment	Clinician Assessment	Acuity Assessment Notes

No Acuity Assessment history

Date of Assessment

Expand/Collapse ALL Assessment Sections

Current Health Status	Assessment Score	Assessment Score Range
1. Safety - Danger to self/others (SI/HI) in past 6 mos	NOT SCORED	0-5
2. Mental Health/Substance Use Disorder Status ?	NOT SCORED	0-4
3. Medical Condition/Current Health Status	NOT SCORED	0-4
4. Medication: Safety,Knowledge, Adherence, Reconciliation Need	NOT SCORED	0-3
Clinical History		
5. BH/PH IP & ER admits in the past 6 mos	NOT SCORED	0-10
6. Treatment Participation	NOT SCORED	0-3
7. Treatment Resources/Care Coordination Needs	NOT SCORED	0-3
Psychosocial: Resources/Barriers to care		
8. Financial Barriers	NOT SCORED	0-3
9. Legal Issues	NOT SCORED	0-2
10. Transportation Issues	NOT SCORED	0-2
11. Cultural/ Linguistic Issues	NOT SCORED	0-2
12. Social Support	NOT SCORED	0-2
13. Healthcare Benefit/Resource Availability	NOT SCORED	0-2
14. Housing/Stable Living Arrangement	NOT SCORED	0-3
15. Other Disabilities (Vision, Hearing, Mobility, Intellectual)	NOT SCORED	0-3

Score Acuity Assessment | Results of Acuity Assessment for Items Scored to Date | 0 | 0-50

TIER PLACEMENT/STRATIFICATION

Results of Acuity Assessment

Clinician Assessment — SELECT... — ICM Tier Level Description

Expected Intervention Intensity

Expected Duration of ICM Activity

Narrative History

Narrative Entry (0 of 250)

Return to Inquiry | Save Work in Progress | Save Final Version

Examples of Actionable Data Driving Care Coordination Interventions

Examples of data and reports available to care coordinators that drives care coordination outreach and intervention to improve Member care include:

- Identification of children with a primary diagnosis of asthma who have high emergency department utilization. As part of the report that identifies these children, numerous other data elements are included, such as:
    - Condition descriptions (e.g., simple chronic, complex chronic)
    - Inpatient/outpatient/professional and pharmacy costs
    - Total cost of care
    - Risk weights
    - Inpatient admissions and readmissions
    - Emergency department utilization
    - Potentially preventable admissions, visits, and emergency department use
    - Prescription refill information
    - BHO involvement
    - Completed well-child check and are attributed

  This level of detail creates an actionable description of the Member's status to inform care coordination interventions. In addition, we also look specifically at prescription refill rates for control medications versus rescue inhalers relative to emergency department visit dates and PCMP visit dates.

We find that parents are more likely to refill rescue inhalers regularly than control medication. When the dates of emergency department visits versus refill dates are compared, a pattern emerges that parents are likely not giving the child the control medications, run out of the rescue inhaler, and end up in the emergency department. Another issue in this dynamic is that PCMPs repeatedly phone in refills for the rescue inhalers without requiring the parents to bring the children in for check-ups. There is an unsettling pattern of children with chronic conditions like asthma getting rescue inhalers phoned in with no face-to-face medical assessment, including a well-child check. Children with chronic conditions should at the very least receive annual well-child check. We also find that children with chronic conditions who see their pediatrician regularly, sometimes monthly, still go with no well-child checks, which still has a negative impact on the KPI.

- Reports that identify children in foster care, attribution status, who their PCMP is, who the Care Coordination Entity is, the date of their last PCMP visit, and if they have had a well-child check in the past year are important for tracking this population and ensuring outreach to a particularly vulnerable group of our Members. As an example of the importance of this analysis, children in foster care usually run about a 15 to 20 percent well-child check rate versus the general Medicaid population rate of 40 to 50 percent. This necessitates closer tracking and engagement of this population.
- Reports that identify chronic conditions by counties and then by ZIP codes help ensure the best population health management interventions are employed for each geographical sub-region.
- Real-time data from CareConnect to track referrals to ensure engagement of services.
- Use of encounter and diagnosis data to monitor expected utilization within diagnosis areas to determine if services delivered are within expected parameters.
- Sophisticated outlier management to identify under-utilization of less expensive services and over utilization of higher cost services (e.g., emergency department, inpatient). Reports focus on identification of Members needing specific engagement strategies across service providers.

External Data Sources

External data also informs staff about sub-regional needs and differences so that initiatives, projects, and programs can be developed with very targeted interventions and expected outcomes that support the specific geographical or population health segment.

Examples of external data used to help guide decisions at a sub-regional level includes the County Health Assessments conducted and published by County Departments of Public Health. These reports include useful aggregate information such as: age, gender, race, income, housing, health factors, health indicators, barriers to health care, oral health, obesity, prenatal care, smoking, mental health, cancer screenings, chronic disease management, as well as identifies community strengths that can be leveraged in addressing needs.

The Robert Wood Johnson Foundation County Ranking Report also provides valuable data for understanding medical and non-medical issues that are regional specific, such as: mental health, smoking, obesity, low birth weight, preventable hospitalizations, mammography screenings, diabetes screenings, and social determinants such as education, employment, income inequality, housing, drug/alcohol use, access to care and quality of care.

External data sources such as County Public Health Department reports and the Robert Wood Johnson Foundation Rankings are helpful in directing attention to specific issues in areas of the region. This leads to more efficient use of internal data and reporting resources. When external sources are combined with Department's data, internal data, and a robust reporting capability, a repository of actionable information is created that is indispensable for managing and administering the RAE in a way that provides the most benefit for our Members.

Reporting

NHP reporting capabilities enable us to not only identify and understand cost drivers at the regional level, but allows the flexibility to drill-down to the provider/care coordinator and Member levels to determine the best interventions and approaches to support our Members. We identify under-utilization patterns indicating the need for Member outreach and engagement with a PCMP and Health Neighborhood to receive preventative care to avoid costlier health issues in the future. Reports on changes in Member acuity or utilization identify possible gaps in care to be addressed by the care coordinator.

Through our Population Health Management Plan, we will monitor changes and variations in members' health, as well as medical and non-medical transitions that could impact their well-being. KPI reports identify trends as well as performance issues at the practice level. When performance issues are identified, Quality, Provider Relations, and Care Coordination staff work with the practice to trouble shoot and devise solutions. For example, poor performance on the postpartum KPI was isolated to two large regional providers who did not realize they were not billing correctly for postpartum services. Provider Relations staff assisted with redesigning business office workflows to ensure proper billing procedures.

Quality staff provides onsite training for partners/providers/care coordination staff in accessing and utilizing data to improve efficiency and performance. For example, care coordinators were taught how to use well-child check KPI data to identify specific children who had not have a well-child check and have chronic conditions for which they regularly receive medical care. These children should be easier to get in for well-child checks because they are already engaged with the health care system.

Dashboards

NHP uses dashboards to display an extensive amount of data from multiple sources to monitor that we meet the goals of the ACC Program. Dashboards provide data for trending by location and

program. The data is used to measure achievement of goals and identify outliers and negative trends.

NHP has developed a dashboard that tracks enrollment data; KPIs and trends; call center stats; utilization management costs; average population Clinical Risk Groups (CRG), DCG, inpatient, outpatient, and pharmacy costs; admissions; emergency department visits; and behavioral health and substance use disorder utilization. The dashboard provides a high-level view of performance, population health, and utilization. From this dashboard, further information can be distilled by drilling down to practice level and then Member level.

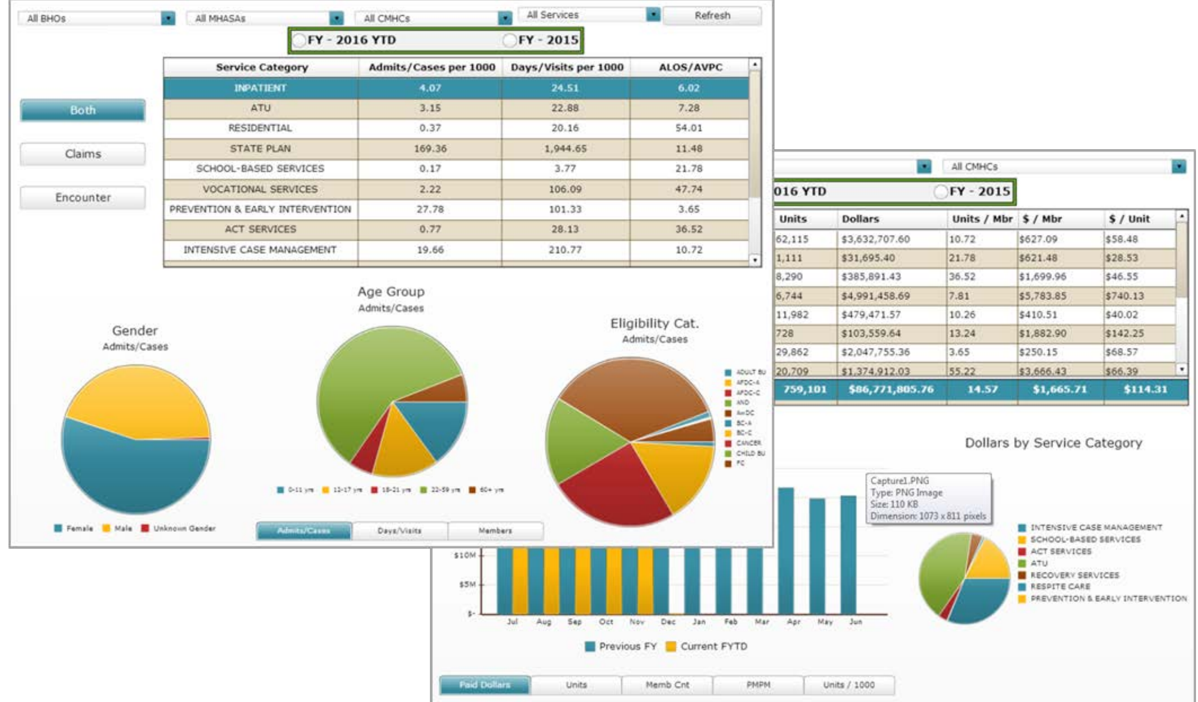
Program dashboards are also utilized to track new programs through startup to ensure program goals are achieved. Drill-down activities are conducted when negative trending is identified related to:

- No show rates
- Service delivery encounters
- Penetration data
- Diagnosis
- Engagement rates
- Budget
- Service mix

SHARING DATA WITH NETWORK PROVIDERS

Once data are gathered, analyzed, and integrated into our systems, they are available for reporting and further analysis. We will separate reporting activity from operational activities using a data warehouse and various data marts. The separation of these activities allows for reporting and analyzing work without impeding such operations as authorizing services, paying claims, and processing eligibility.

An example of an innovative online reporting method is illustrated on the following page. These dashboards provide us with an easy mechanism for accessing and viewing a variety of relevant data including penetration rates, eligibility demographics, utilization reports, and fiscal and statistical reports.



NHP will maintain both a Microsoft SQL Server (local) as well as an Oracle Server (11g) (national). This allows for redundancy in our data storage to ensure that data is always available in the event of system maintenance or other issues. Data from our CONNECTS and other systems are stored as standardized data in a relational database system which allows for data from external sources to be integrated in to the models to enhance reporting capabilities.

We will use a full, state-of-the-art, SAP Business Objects and Business Intelligence Platform which allows us to provide cutting-edge business intelligence. Our Business Objects enterprise server (IntelligenceConnect) will allow us to fully automate production reports and controls granting role driven and row level security access to end users of various applications designed to facilitate on-demand access and manipulation of data. One example of this is our Daily Census reports which uses Crystal Reports to automatically comb our data system to identify Members who are currently authorized for any higher levels or behavioral health treatment. A list of Members and details are sent via secure and encrypted email to the specific discharge planners and care coordinators assigned to work on those member's cases. Additionally, an automated report showing any discharges from inpatient treatment is sent to targeted staff to help ensure that follow up occurs quickly post discharge.

External network providers and partners can securely log into our Intelligence Connect system to access SAP Web Intelligence (Webi) reports. Webi is a simple to use reporting tool to produce reports using a Web browser. Network providers and partners can carry out analysis as well as produce formatted reports and export the results in Microsoft Excel or PDF formats. The data they see is driven by their log in user ID which restricts the data returned to only those Members they are associated with and for which they have permissions based upon HIPPA and 42 CFR Part 2 requirements. SAP dashboards also allow for the ability to share information, analytics and trending on a more aggregate level for identified metrics and measures. Dashboards can be used to track metrics, issue alerts about changes in conditions, and help users analyze current information, trends, or anomalies, at a glance.

PRIVACY REGULATIONS

NHP organizational partners have implemented comprehensive controls to ensure they meet all federal and state regulations and policies regarding standards for privacy, security, electronic health care transaction, and individually identifiable health information. These comprehensive controls, as described below, will provide the foundation for the privacy and security controls implemented by NHP.

We will maintain a confidentiality program designed to ensure the integrity and confidentiality of protected health information and sensitive data is maintained in accordance with federal and state laws and regulations. In addition to physical security and the protection of Member data, we will hold organizational information gained through our working partnership in strict confidence, including policies, internal documents, client financial information and other proprietary information.

NHP will maintain a series of policies and procedures addressing Member rights and our obligations under HIPAA, HITECH (including the final rule) and 42 C.F.R. Part 2. All NHP and our partners' employees will be required to complete HIPAA Privacy and Security training and successfully complete post testing, within 90-days of hire and annually thereafter.

In addition to having access to our National Privacy Officer, we will also designate a local Chief Compliance Officer responsible for overseeing compliance with federal and state specific privacy requirements. Privacy Leads will also ensure client specific requirements are met, such as utilization of client specific forms.

If a NHP or our partners' staff member or consultant were to become aware that an improper disclosure of PHI or personally identifiable information (PII) has taken place, they are trained to immediately attempt to secure the return or destruction of the improperly disclosed PHI/PII from the party who is in possession of the PHI/PII and notify the Privacy Lead. The matter would then be thoroughly investigated to determine the cause of the incident and a risk assessment would be conducted to evaluate the possible impact on the individual(s), on operations and the Member. If a privacy breach were to be determined to be a result of actions by our staff or consultants, appropriate management personnel would submit a corrective action plan to our Chief Compliance Officer. The plan is designed to prevent similar occurrences in the future.

If we were to find a privacy breach that was the result of actions by a NHP business associate, the Privacy Lead, or a designee, would document the breach and request in writing that the Business Associate provide a corrective action plan to ensure that similar breaches do not occur in the future. The Business Associate would also be notified in writing that a pattern of breaches may lead to terminating the contractual relationship between NHP and the Business Associate. Further action may include reporting the Business Associate to the Secretary of Health and Human Services.

In situations where NHP is a Business Associate of a covered entity, we would inform the covered entity of the privacy breach or violation as required by the terms of the written Business Associate Agreement.

We will require the protection of the confidentiality and integrity of data. We will constantly monitor all government legislative activity to ensure the organization is aware of any new developing requirements and to ensure compliance with all applicable laws and regulations. NHP will ensure that the integrity and confidentiality of all data is in accordance with specific State and Federal laws and regulations such as the Privacy Act, Drug Abuse Act, and Member confidentiality restrictions.

Security Management

The Information Technology Security Officer (ITSO) and or his/her formally designated alternate control security policy and procedures. A formal request for computer access must be submitted via Security Connect and approved before a user can access any system. Each request must be approved and signed by the user's manager. Access to information systems is determined on a need to know basis and is compartmentalized by job category. Access granted is limited to predefined system platforms (hardware/software), application software, screens, programs, files, and data. The ITSO reviews each request for compliance with submission requirements and authority level. If approved, security is set up for the user. The ITSO is the final approving authority. The Human Resource Department notifies the ITSO when an employee terminates and the ITSO initiates action to immediately disable the user's security accesses to all systems.

Physical Access Control

Visitor access to our facilities during business hours is directed through a receptionist. Logs are maintained to record the entrance and departure of visitors. Access after-hours is based on predetermined work requirements and is authorized at the management level. Proximity locks control entry to the office areas, telecommunication equipment, and computer systems.

Network Access Control

NHP will have two levels of access are assigned at the terminal level:

1. Security access via the local area network (facilities in Windows NT)
2. Security accesses to the CONNECTS System (UNIX and OS/400 level security)

Each staff has a confidential password. We will automatically terminate system access to anyone with a login that has not been used for 45 days. In addition, the system prompts users to change passwords every eight weeks.

If there are any unauthorized attempts to access the system, these are recorded and followed up on immediately. The system administrator is alerted by the system of the location of an unsuccessful login. This could be an attempt to login using a legitimate or illegitimate ID. Access to files is restricted by a security system that allows staff to access only specific programs based on their job function. Further, system users do not have access to data files except through these controlled programs.

Application Security Control

With regard to the CONNECTS system, each staff member's access to the system is designed to accommodate his/her personal job functions. We limit access to different functional areas of the system depending upon job classification. Access to information is also divided into inquiry only or update, which allows certain staff to view pieces of information without the capability to change data. A finite list of security levels is defined for each function and authorized by department managers and all activity against clinical information is logged in an audit trail file. Furthermore, specific departments have a third level of internal security to limit the extent to which certain functions (e.g., claims adjudication) may be restricted. For example, claims processors can pay claims, but cannot build Member or provider files from the system. Claims processors can also view the provider and eligibility files, but cannot update these files.

Virtual Private Network and Email Encryption

Remote access to our information systems and productivity applications such as email is secured using an encrypted Virtual Private Network tunnel during the network session. For email communications, we will use ZixMail secure email plug-in for Microsoft Outlook to encrypt and password protect PHI and sensitive data. With ZixMail, clients, Members, providers, and business partners can safely and securely exchange data over the internet.

Disaster Recovery and IT Business Continuity

NHP will maintain and execute a Disaster Recovery or "IT Business Continuity" plan that offers the best continuity plan in the health care industry. The continuity plan reflects our commitment to ensure compliance of IT requirements in the event of a disaster, which interrupts normal business and IT operations. As described below, we will perform the traditional daily backups to tape and storage offsite methodology as a precautionary measure.

We will perform the traditional daily system backups on all servers to ensure that the content of all production systems can be recovered in the event of a disaster. These backups are performed on both host and local area network systems. Software and production data files are copied to tape. A verification and audit program is then used to confirm that the system backup tapes are complete and accurate. Copies of the tapes are then created and stored off-site. In the event of a physical disaster, the backup tapes that are stored off-site can be used to recover and reload the production systems. System backup tapes are rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems. This traditional backup approach provides a fail-safe for all NHP's data and programs to ensure business continuity.

As the Administrative Services Organization responsible for the CONNECTS system, Beacon's National Data Center, located in Reston, Virginia, houses the IBM i840 production server and supporting hardware. A backup power generator provides backup power to the data center in the event of a power outage. If the building's power generator detects a power outage, the entire building will be back up within minutes. Our computer rooms will be also supported with additional

uninterruptible power supplies to continue operations while the building backup power generator is activated. This procedure ensures a continuity of processing during a local power failure.

Beacon's disaster recovery "Hot Site" is located in Boulder, Colorado, which has identical hardware and software as act as a backup facility in case of a contingency. This backup site is tested annually to ensure full recovery. In the event of a physical disaster at Beacon's National Data Center, personnel will work from alternate work locations at one of the Beacon's Engagement Centers located in Maryland and/or Virginia and/or work from home until the disaster is over. All calls during a disaster/contingency plan are routed to the backup sites based on established telecommunication contingency protocols.

Beacon's National Data Center operates on a 24/7 support schedule. The Data Center was designed to maintain the security and availability of the CONNECTS system by employing the following:

- Lightning protection throughout the perimeter, rooftop, and electrical and mechanical support infrastructure
- 24-hour physical security monitors all cameras, door positions, and badge access areas
- Redundant off-site monitoring of all security systems
- Cameras at each doorway and pan-tilt-zooms throughout the exterior of the facility
- Access to the Data Center requires authentication using pictured role based swipe cards
- 30-inch raised floor rated to support 1,200 pounds per square foot
- Conditioned air is supplied via the raised floor
- Masonry and steel construction, with hurricane wind-rated roof
- Leak detection systems throughout the Data Center and air handlers
- Grounding system throughout the datacenter to provide connections to the raised floor, posts, cages, and cabinets
- Power distribution consists of an A and B side methodology; each side of the power infrastructure has the capacity to support data center load in the event of failure
- 500 Kw diesel generators are regularly tested for added protection
- Generator run time with refueling (currently more than 24 hours of continuous operation without refueling with current load) locked within a sound-attenuated enclosure with guaranteed fuel supply from Foster Fuel (under retainer)
- Critical functions are remotely monitored within Data Center
- A minimum of N+1 configuration at the Computer Room Air Conditioner (CRAC) level and 2N at the back end chiller and cooling tower level for HVAC
- CRAC units maintain temperature and humidity within four degrees and five percent of temperature and humidity set points
- Moisture containment basins and sensors help ensure no moisture enters the Data Center
- Separate and further redundant cooling systems for critical support areas
- Card access control throughout facility

In the case of a disruption in the Colorado Engagement Center, the primary automatic telephone back-up center and the second automatic phone backup Center will provide support. All calls would be automatically rerouted to the backup engagement center. Personnel in the backup engagement center are trained to serve members and have controlled access to the client's data.

OFFEROR'S RESPONSE 22

Describe the Offeror's data management system, including the structure, claims processing system, export capability, and ability to integrate with other systems such as the Colorado interChange and BIDM System. Include a system architecture diagram.

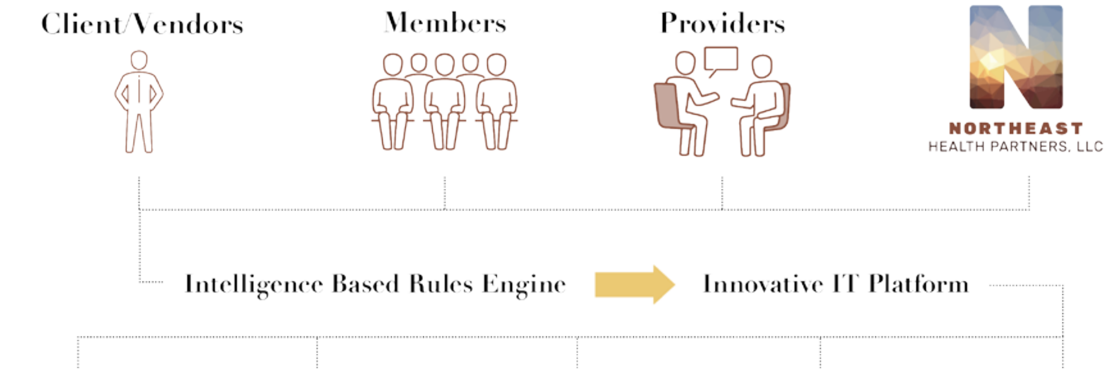
Our claims system processes 22 million behavioral health claims per year.

Northeast Health Partners, LLC (NHP) will fully support the Department's commitment to transparent reporting of on key health and cost measures by establishing a data warehouse that collects, consolidates, and organizes data from multiple sources, and fully integrates Medicaid eligibility and claims data for reporting, analytics and decision support. NHP will achieve this goal by leveraging the existing data management system of its partner organizations to successfully operate the Accountable Care Collaborative (ACC) Program. This claims system is wholly-owned and operated by NHP's partner, Beacon, and used nationally to process more than 22 million claims per year.

DATA MANAGEMENT SYSTEM AND STRUCTURE

NHP will use Beacon's existing enterprise data management system, called CONNECTS, which consists of several layers of fully integrated applications operated by our partner organization, Beacon. This single platform seamlessly interfaces with multiple applications that fully integrate claims, payment, clinical, and Member-related data. These systems are currently integrated with the Colorado interChange, 834 eligibility processing, and 837 claim submissions to the interChange. The CONNECTS system is the front door to data entry and processing for internal staff and external customers such as providers and Members is illustrated below.

Processing for Internal Staff and External Customers



Health Analytics
- Identification & Risk Stratification
- Reporting/Dashboards
- Trending Analysis
- Prescription Drug Intervention Program
- Total Cost of Care analysis (or TME)
- Quality and Outcomes Management

Health & Wellness
- Employee Assistance Program
- Work/Life
- Legal/Financial
- Achieve Solutions Website
- Workplace Services
- Resilience and Well-being
- Prevention Initiatives
- Mobile Apps

Clinical Services
- Utilization Management/ Authorization
- Care Coordination
- Care Management
- Integrated Care
- Person-centered Care Planning
- Discharge Planning/ Aftercare
- Cross System Coordination (Education, Corrections, Child Welfare, etc.)
- Disease/Population Health

Technologies
- Fully Integrated Platform
- Data Warehousing
- EDI Platform
- Telehealth
- CBT/Social Media/ Gaming
- Appointment and Medication Reminders

Administrative
- Call Center/Customer Service
- Eligibility/Enrollment
- Complaints, Grievances, and Appeals
- Network Management/ Provider Partnerships
- Claims processing
- Compliance/Program Integrity/Fraud, Waste, and Abuse

National Data Warehouse: KnowledgeConnect

NHP will incorporate Beacon's national data warehouse into our Regional Accountable Entity (RAE) operations. This warehouse receives imports from the CONNECTS platform and other external data sources to create a large data repository that is used for reporting and analytics purposes. All data is normalized, formatted, and then stored as standardized data in our Oracle relational database system. This data warehouse was created to provide the ability to combine data from internal and external sources (e.g., Colorado interChange) into data models that can be used for efficient and relational enhanced analytics and reporting capabilities. These data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.

The CONNECTS platform includes extensive reporting capabilities. KnowledgeConnect, our data warehouse, receives daily imports from the CONNECTS applications for reporting purposes. This data is formatted and stored as standard data into a relational database system. Reports generated from this data are used to track and monitor pended claims. These systems generated reports provides the claims management team with the ability to measure claims activity on a day basis. This includes claims volume, pended claims, denied claims, processing time, etc. are. The reporting capabilities for pended claims (by processor, by client) assist the management team in performing concentrated follow-up routines to ensure prompt resolution of the claim issue.

The data warehouse currently runs on an IBM® pSeries i5 740® server utilizing an AIX® UNIX® operating system and an Oracle 11g® database, and is specifically configured to support our multiple lines of business and the unique reporting needs of each reporting area and each client. The graphic below illustrates the imports of our data warehouse, KnowledgeConnect.

Imports into KnowledgeConnect

AUTHORIZATION
DW_AUTH

ELIGIBILITY
CATEGORY
CLIENT_SPECIFIC_
ELIG

CLAIMS
(20% of Tx)
DW_CLAIM

ELIGIBLITY
DW_MEMBER

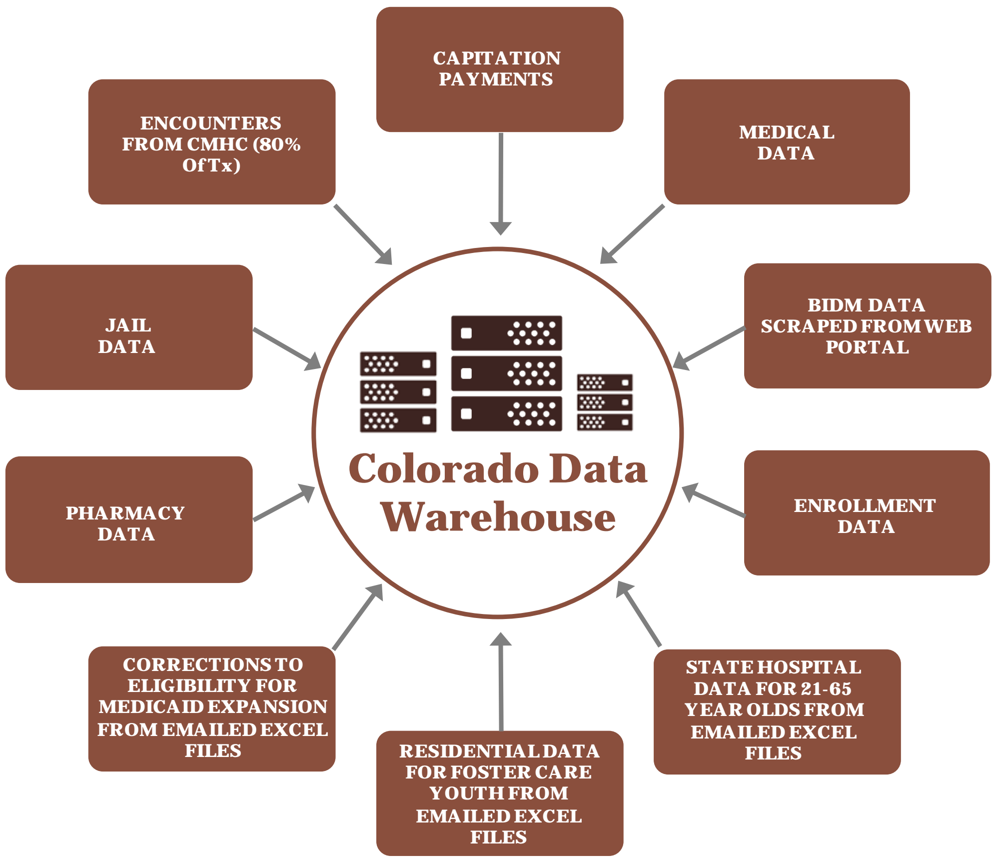
PROVIDER
DW_PROVIDER

KnowledgeConnect
National Data Warehouse

Colorado Local Data Warehouse

Data is propagated from KnowledgeConnect to our local Colorado data warehouse on a weekly basis, with row-count and parity checks between each system in the architecture, for every table sent. To meet our specific RAE duties and business needs, some select data sets are transmitted daily, increasing our ability to manage data outliers (e.g., daily census). Data from the Colorado interChange and BIDM is also loaded into the Colorado data warehouse through automated processes. These automated processes check hourly for 820 Payroll, 834 Daily Roster, 834 Monthly

Roster, and 837 Response Files. The data is stored in SQL Server relational databases. The graphic below illustrates the data imports into the local Colorado data warehouse.



Onsite Systems Expertise for Partners, Providers, and the Department

Each tier of the architecture is under the supervision of onsite staff, which include:

- Business Analysts
- Database Administrators
- Data Warehouse Administrators
- Reporting Programmer/Analysts
- Data Modelers

Automated Error Detection and Notification

Quality checks have been automated with real-time error notification, allowing staff to respond to errors as they occur and before data users are able to access the data. Currently, notifications are sent via email to multiple resources to ensure that our on-call support always has adequate coverage.

Web-Based Data Dictionaries and Entity-Relationship Diagrams (ERDs)

Over the past several years, Beacon has developed and have refined an interactive, web-based data dictionary to assist Reporting Analysts in finding out how data objects may be used to create reports and what data elements are contained within them. The data dictionary includes field-level information as well as ERDs and functional area groupings. These tools not only help in report

creation and documentation, but they are also instrumental in the training of new users by showing them the data elements, what they mean, and how they relate to other data elements.

Use of SAP Business Objects and Business Intelligence Tools

State-of-the-art business analytic tools are available to our staff to allow non-technical business users to explore vast amounts of data, look for outliers, and produce charts and graphs all without the help of IT staff. The result of this investment is that business owners can easily detect outliers, implement policy to correct the outliers, and then measure the outcome/impact of the policy change on the next data refresh cycle. Additionally, when report requests do require the assistance of IT staff, the report requestors are more prepared with requirements which results in quicker turnaround times on the delivery of reports.

CLAIMS PROCESSING SYSTEM: CLAIMSCONNECT

Processing Claims for the Independent Provider Network (IPN)

NHP will use ClaimsConnect as our claims processing system. NHP's partner, Beacon, processes more than 22 million behavioral health claims a year via ClaimsConnect, which is one of the most robust managed care systems in the industry. In Colorado, we estimate that we will process nearly 360,000 claims in 2017; thus far, we have processed 29,900 claims per month for the first six months of 2017. ClaimsConnect provides an architecture that leverages both integration and automation, in addition to being fully integrated with the suite of CONNECTS software systems and technologies. Through the experience of our partner, NHP will be ready to begin processing claims on Day 1 of the contract.

The CONNECTS platform unifies all functions to ensure claims processing and payment is consistent with participation requirements, including benefit design, claims, eligibility, care management, financial management, provider maintenance, customer inquiries, reporting and others. Because all functions are performed within the CONNECTS system, updates are immediately available to all service and functional areas.

ClaimsConnect supports all claims processes involving claims entry, adjudication, payment, and reporting. All provider fee schedules, hospital per diems (contracted rates), and individual client benefit plans are maintained online. Automatic claim suspension routines are also performed for those claims that require further examination. These include duplicate claim submission, Coordination of Benefits (COB), eligibility discrepancies, and authorization edits. Authorizations are used for limiting and/or controlling provider access. Utilization review capabilities are also included to enable the connection between the claim being processed and authorizations in the system. The decision as to whether a claim requires an authorization for payment is part of the benefit set-up logic.

Additional features found in the claims processing subsystem include:

- Online authorization/adjudication capabilities
- Efficient CMS 1500 and UB04 forms screen entry formats for high volume processing
- Specific/generic service authorization capabilities
- Automatic matching of claim activity to outstanding authorizations
- User-defined processing edits
- Online/batch claims adjudication capabilities
- Follow-up capabilities for claims and authorizations
- Split payment and Member reimbursement capability

Claims Submission

ClaimsConnect supports both paper and electronic claim submission. Regardless of how the claim is submitted, we require industry standard CPT codes, HCPCs codes, and ICD-10 and revenue codes. The billing procedure codes specified in the Uniform Service Coding Standards Manual are loaded into a database and are used in helping process claims. Failure to submit the claims using the appropriate codes can result in the claim being denied, resulting in resubmission of the claim with the appropriate information.

Paper claims are scanned, allowing creation of a digital version. Claims submitted electronically and paper claims manually keyed or converted into an electronic format during our scanning process are systematically loaded into the CONNECTS system and then processed automatically applying all systematic edits, including the client-specific benefit requirements.

Electronic Claims. NHP is committed to helping our providers manage their administrative functions more efficiently. We will have implemented and will continue to make electronic claims submission a viable option for all providers and accept HIPAA standard 837 formatted files from any provider's software application or third party vendor. Alternatively, providers without electronic claims software can submit via our web-based Direct Claims Submission. The application is very easy-to-use and provides immediate validation results. Providers who wish to create batch files may also use our free software that can be downloaded to their desktops directly from our website.

To set up this easy-to-use and convenient electronic process, providers obtain a User ID and password from our EDI Help Desk. All electronic batch claims files submitted to us with a valid User ID are submitted through our Electronic Transport System (ETS), FileConnect. FileConnect is a communication system designed for the interchange of electronic data files between subcontracted providers, clients, business partners, or associates. We configure FileConnect for each new provider so that it will to process electronic claims records automatically and seamlessly with our claims processing component of the CONNECTS platform.

FileConnect is the system that will accept electronic claims from providers who choose to use our Electronic ClaimsConnect or their own already established practice management systems to create and submit electronic claims. FileConnect sends electronic files to participating providers, clients, or other business partners or associates. It also includes provisions for file and format verification, enables prompt addition of new file types, and provides notification of file validation results (whether the file was successfully processed or not) via the Internet. FileConnect allows for desktop retrieval of processing results via an Intranet server using any Web browser and Internet Service Provider.

Electronic claims are subject to various audits ensuring that all electronic submission requirements are satisfied. These include verification and validation of data fields such as Member identification number, date of birth, service from and through date, service code, number of units, place of service, amount charged, and diagnosis code. Additional editing and validation requirements occur once the claim is uploaded into the claims processing module of the CONNECTS platform.

Claims Entry/Upload. All claims, regardless of the submission method, are processed against the same business rules for our NHP RAE program. Claims that are uploaded into ClaimsConnect are processed automatically, subjecting them to industry standard systematic edits, as well as customized, client-specific benefits or business requirements. The CONNECTS system enables us to apply client-specific settings for our edits. While we can automatically deny a claim when it fails an edit, and do so in certain situations, many claims can be resolved with additional Claims Processor review. In these instances, the Claims Processor will review all relevant current and historical data pertinent to the claim (e.g., Member enrollment and claims payment history, authorization data, and provider file update history) and take the necessary steps to complete the claim validation for appropriate reimbursement.

Once entered or uploaded into the CONNECTS platform, claim and encounter batches are reiteratively run through the claims adjudication cycle. This cycle performs the following minimum edits and audits by procedure line item:

- Verifies Member enrollment
- Locates the servicing provider or on-call provider that matches the claim servicing and the claim service date
- Considers transitional authorizations based on the claim service date and number of visits accumulated
- Checks to see if an authorization is required
- Determines if the claim is a duplicate submission
- Applies benefit plan parameters, such as maximums and excluded charges
- Determines compatibility of Third Party Liability (TPL) or Coordination of Benefits (COB)
- Identifies potential fraud and abuse
- Applies the approved amount from the appropriate fee schedule
- Determines if a valid authorization is on file

If adjudication edits and audits cannot be satisfied by information in ClaimsConnect directly, the claim is denied and a summary voucher is sent to the provider indicating the information needed to complete adjudication for payment. If the adjudication edits and audits are ultimately satisfied, the claim is approved for the payment cycle and the check and the summary voucher is sent to the appropriate provider.

The CONNECTS platform is fully integrated taking all elements of the benefit plan and reference codes into account as the claim is adjudicated. Claims receive edits when limits are met or when specific combinations of codes are billed together. The edits can be soft or hard edits, depending on the action that is to be taken.

Hard and Soft Edits. Claims Processors access hard and soft claims edits internally online to ensure the proper handling of claims. Hard edits on ClaimsConnect allow claims to automatically adjudicate based on pre-determined system set-up of specific claim edits. For example, when a claim is entered into our claims system, the diagnosis code is validated against the diagnosis codes in the system reference file, as well as against the diagnosis codes covered by the client in the benefit set-up. If the diagnosis code on the claim is not covered by the client, the claim is automatically denied during batch adjudication. If the diagnosis code is not a valid code in the system reference file, a default value of 'unk' is entered in the diagnosis field and the claim is automatically denied with a request to resubmit it with a valid diagnosis code.

With soft edits, the Claims Processor receives an edit indicating there is a condition that needs to be manually reviewed before adjudication of the claim can be completed. Examples of review required include the possibility of a duplicate claim submission or an eligibility problem in the Member's benefit plan. In these cases, the Claims Processor will determine if the service on the current claim can be paid on the same date as a previously paid service, or they determine if the correct group number is on the claim for eligibility purposes. If it is determined the claim should be paid, the edit is validated and the claim is adjudicated. If the claim should be denied, the Claims Processor applies the appropriate denial code to the claim before completing adjudication. This information is available online to Claims Processors as well as the entire Claims Department.

ClaimsConnect has online capability to code hard and soft edits based on individual client requests. For example, one client may request that we not edit based on 'multiple services on the same day,'; that we pay all claims received. Other clients may have a limit on the number of services that can be

paid on a specific service date. Beacon has the experience, expertise, and flexibility to tailor our services to NHP clients' specific needs.

Duplicate Claims. ClaimsConnect identifies a duplicate claim by comparing the information submitted on a claim to information in the Member's claim history. A claim is denied as a duplicate when there is an identical match. The system detects the duplicate condition when it exists on the current claim or on a previous claim. In situations where the adjudication logic detects a possible duplicate, an edit is applied to the claim and pended for Claims Processor review. This would include claims with different but related service codes.

We use the following criteria to identify duplicate claims submission:

- Member ID
- Date of service
- Provider of service
- Service code

When a duplicate claim edit is received, the Claims Processor reviews the claim history to validate that the service was previously paid to the provider. The Claims Processor also verifies the number of services allowed to be paid per day, and either validates the edit and pays the claim or applies a denial code and denies the claim.

Pended Claims. NHP will pend a claim when there is information required from an internal source to adjudicate the claim. If a claim has been received with missing information, the field with the missing information will be coded as 'unk' and the claim will be denied with a request to resubmit it with the identified missing information. When the claim is received with the identified missing information, it will be processed as a new claim in accordance with existing policies and procedures. Claims are generally pended when there is a question regarding the eligibility of the Member, if there is a question regarding the authorization for the claim, or if updates to the provider file needs to be made based on edits received on the claim.

Denied and/or Disallowed Charges. NHP will follow established guidelines and timeliness standards for notifying providers or Members of denied and/or disallowed charges. Depending upon the day of the week in which a claim is denied and the determined day of the week in which all communications are mailed to the providers and Members, the timeliness of communicating denied claims can range from two to five business days. Traditionally, we decide with our clients upon a weekly mailing cycle in which all communications, including provider summary vouchers, Member explanation of benefits, and claim checks are mailed on a fixed day of the week.

Claims Extract/Encounter Data. NHP will leverage Beacon's demonstrated experience in the development of outbound 837 encounter and pre-priced claims extracts as well as corresponding response files (e.g., 997, 277, and client-specific formats). We currently provide extracts for several public sector and health care trading partners. For example, our health plan trading partners use the 837 extract process as a method of exchanging claims cost sharing data with us for Members with shared medical and behavioral health benefits. We also provide pre-priced claims data to enable finalization of claims by the medical carrier.

Through a core set of standard programs to select and format the outbound data and import response files, data is tracked throughout the transmission process, including submission and response status. We can check compliance of file formatting and data content using nationally accredited compliance checking tools. Each extract is tailored to meet the requirements of the client's companion guidelines in addition to the national HIPAA standards.

Encounter/Claims Processing for CMHCs

Encounter Auditing and Reporting System (EARS)

Using existing processes, we have developed and refined in service to the Department as a Behavioral Health Organization (BHO), we will receive flat files that may be separated by Medicaid, Non-Medicaid, or substance use disorder, or may be combined. We will process those records into our system with a custom written Perl script. During this processing, we assign procedure modifiers to the encounter records based on instructions from provider. Over 100 checks are performed on the data to ensure eligibility and data validation are conducted against each record. The level of action taken on these checks is customizable for each BHO. Frequent eligibility checks also release records previously held for ineligibility. We have an exceptional record of exceeding standards for claims processing, payment, and submission to the Department with 98 percent of claims paid within 14 days. Additionally, Beacon has consistently maintained 98 to 100 percent financial and procedural accuracy through internal audits. Finally, automation within the claims system includes built-in edits to avoid errors, and the system is designed to identify instances of potential fraud or incorrect billings.

We currently have a 98 percent acceptance rate for claims and encounters submission.

CMHCs receive receipt logs with results of the eligibility checks, duplicate checks, and data validation checks so they can correct the records and resubmit the file. We provide an automated on-line 'scrubber' process that lets the centers submit their files into a test system to determine the data validation errors before submitting the file to us formally for processing. We also have separate processes to release records held for ineligibility or if a record is determined to be a duplicate and the center can provide documentation that the record is valid.

We will provide quality reports to providers that give detailed encounter data on errors. This gives them an additional opportunity to address specific errors that are of concern. We can release the encounter held by those errors based on the providers' executives' review.

The report card has been cited as a best practice by auditors.

We will provide each provider with a monthly report card, shown below, that gives summary of the month's and FY's data submissions. There is a reconciliation sheet that breaks down the encounters by each file. At the file level, the center can reconcile the number of records, sum of units, sum of dollars, and break it down to the service category (procedure code modifier) level. There is a summary of errors showing the percentage of records submitted that triggered each error. There is also a graphical representation of their error ranking. There is an executive summary page that shows file timeliness, error ranking, value of records submitted as non-Medicaid where we determined eligibility, and comments toward error trends. This executive summary is used to identify current performance and opportunities for continuous quality improvements and has been cited as a best practice by auditors.

Data Report Card

Northeast Health Partners FY2017 Encounter Data Report Card – Executive Summary

File Timeliness Rankings (Cumulative FY2017)

Providers	Avg Days Late	
Provider1	-1.2	
Provider2	-0.84	
Provider3	-0.21	
Provider4	On time	
Provider5	On time	
Provider6	On time	
Provider7	On time	
Provider8	On time	
Provider9	On time	
* Integrated Program		

Data Quality Rankings (Cumulative FY2017)

Providers	Non-Submittable	MedCap Volume#
Provider1	0.00%	30,821
Provider2	0.02%	20,637
Provider3	0.09%	39,698
Provider4	0.22%	25,212
Provider5	0.23%	171,143
Provider6	0.81%	24,245
Provider7	1.00%	94,743
Provider8	1.77%	1,130
Provider9	4.03%	116,623
# Corrections Included		

Comments and Observations

CMHC	Notes
Provider1	Error rate this month at .1%. Error rate below 1% for the entire Fiscal Year.
Provider2	Excellent data quality. Error rate at 0% entire FY.
Provider3	Error rate at .1%. Four months of .1% or less.
Provider4	Error rate increased to 4.2%. Duplicates and provider credentials are high.
Provider5	Error rate at 1.0% this month.
Provider6	Error rate at 0.0% for fourth consecutive month.
Provider7	Error rate at .2% for the past two months.
Provider8	Excellent data quality. Error rate at 0.3% this month.
Provider9	Excellent data quality. Error rate at .2%. Error rate .2% or zero for the entire fiscal year.

Non-Medicaid Conversion (Cumulative FY2017)

Providers	Rate (Clients)	Charge
Provider1	0.12% (5)	$3,105
Provider2	6.41% (736)	$611,554
Provider3	7.52% (57)	$37,886
Provider4	8.32% (410)	$372,796
Provider5	9.41% (97)	$77,930
Provider6	18.19% (209)	$174,171
Provider7	27.30% (783)	$871,376

Beacon Correction Rate (Cumulative FY2017)

Providers	Corrected	Elig Released
Provider1	0.20%	64.72% of 564
Provider2	0.00%	0.00% of 132
Provider3	0.61%	23.31% of 2741
Provider4	0.00%	9.09% of 11
Provider5	0.44%	20.00% of 25
Provider6	0.14%	95.45% of 44
Provider7	0.00%	0.00% of 5
Provider8	0.40%	76.81% of 138
Provider9	0.33%	84.47% of 219

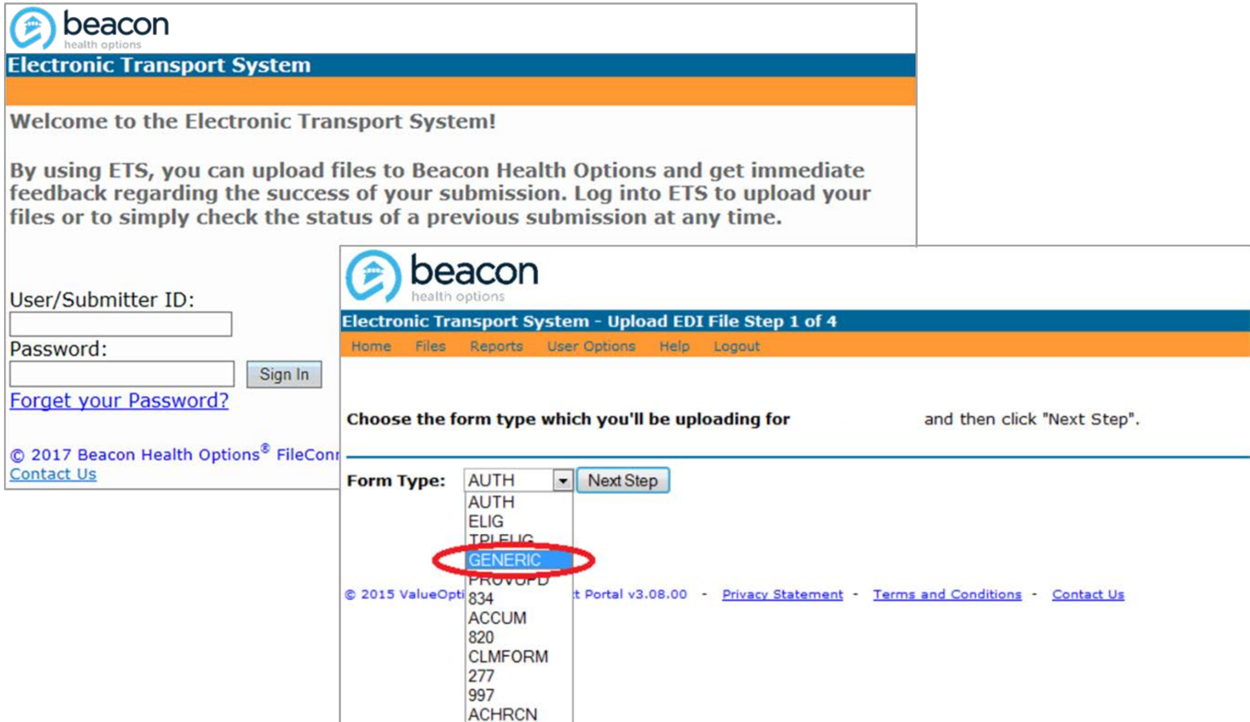
Executive Summary | Errors Summary | Errors Trend | File Reconciliation | File Timeliness

The report's Executive Summary shows:

- **File Timeliness** – Alerts management about potential data submission issues.
- **Data Quality Rankings** – Serves management as a key performance indicator of encounters completed but NOT submitted to the Department.
- **Non Medicaid Conversion** – Describes to management the quantity of provided services Beacon was able to identify as Medicaid eligible and submit to the Department.
- **Beacon Correction Rate** – The number of clients submitted as Non-Medicaid that Beacon's eligibility processes were able to convert to Medicaid eligible.
- **Notes** – A management recap of trending submission errors that identify areas of quality improvement.

EXPORT CAPABILITY

NHP's partners have extensive experience developing Colorado Medicaid-specific data management systems capable of exporting data to create meaningful and actionable information. Automation is the key to delivering high quality data to the Department and our partners. For data exports, we leverage Beacon's internally developed electronic transport system, FileConnect, for the interchange of electronic data files between providers, clients, business partners, and associates.



We support secure FTP file transfers via secure internet connections and site-to-site VPN. FileConnect is highly scalable, and receives, routes, stores, and sends transactions consistent with ANSI X12 standards as well as supporting all HIPAA 5010-regulated EDI transactions and client-specific custom files. This system is fully operational and successfully processes inbound and outbound files on a daily basis.

FileConnect is programmed to receive and process electronic records automatically and seamlessly into our care management system. This interface allows us to provide a reliable, efficient, and uniform process for transferring data. We also maintain a backup system for the EDI so that if one line goes down, we can handle the same job multiple ways.

INTEGRATION WITH COLORADO INTERCHANGE AND BIDM SYSTEM

The Department has provided a secure file transfer server traditionally used to distribute data from the Department to their Contractors. NHP will use automated programs that search the Department's secure file transfer server for new files and downloads them to our EDI platform. The data will then be verified and loaded into our internal databases for reporting and analytics. Each file will have a custom program to support its file format and validation by the programs that load the information into the databases to ensure consistency and accuracy.

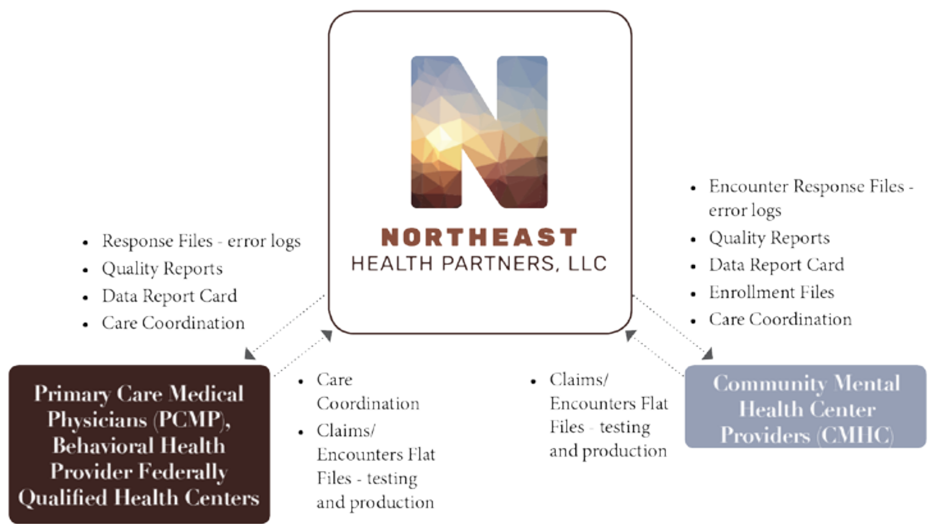
We will load 834, 820, and other industry-standard formats from the State's systems to support our validation of the information received from other sources and distribute information to our analytics section for reporting and trending. Extracts and reports will be sent to those teams that turn the information into action.

We have the capacity to download health population data from the BIDM system and distribute this information to partners and providers per contract via our FileConnect. Our systems are flexible enough to import and export any file format that the data may be provided in including the X12 Medicaid file formats. These data elements are available in a relational database for the analytics, clinical, quality, finance and provider relations groups to process for follow-up, key performance

indicators, audits, reporting, and trending. The data we load is presented in interactive Web tools, reports, and spreadsheets according to industry best practices. NHP will provide training and technical support to partners and providers on what data is available to them, how to access multiple sources of data, and how to use data to manage Members' care.

The following data flows illustrate the various file transfers between NHP, the State data systems, and providers.

NHP Data Feeds to the Colorado interChange



Colorado interChange and Truven Data Feeds to NHP

Truven/BIDM (RCCO Data)

RCCO Claim Data:

- RCCO_AID_DIM
- RCCO_BPLAN_DIM
- RCCO_CASE_DIM_4
- RCCO_CLM_DIAG_FACT_4
- RCCO_CLM_DIM_4
- RCCO_CLM_ERR_FACT_4
- RCCO_CLM_LNE_FACT_4
- RCCO_CLM_SRGPROC_FACT_4
- RCCO_CLNT_BPLAN_ELGB_AID_FACT_4
- RCCO_CLNT_CASE_FACT_4
- RCCO_CLNT_DIM_4
- RCCO_CLNT_ENRL
- RCCO_DIAG_DIM
- RCCO_DRUG_DIM
- RCCO_GEO_DIM
- RCCO_HLTH_PGM_DIM
- RCCO_MTH_ACC_CLNT_SNPSHT_4
- RCCO_PROC_DIM
- RCCO_PROV_LOC_DIM
- RCCO_PROV_LOC_SPCLTY_DIM
- RCCO_SRGPROC_DIM

BIDM:

- Admission, Discharge, Transfer (ADT)
- KPI Trends

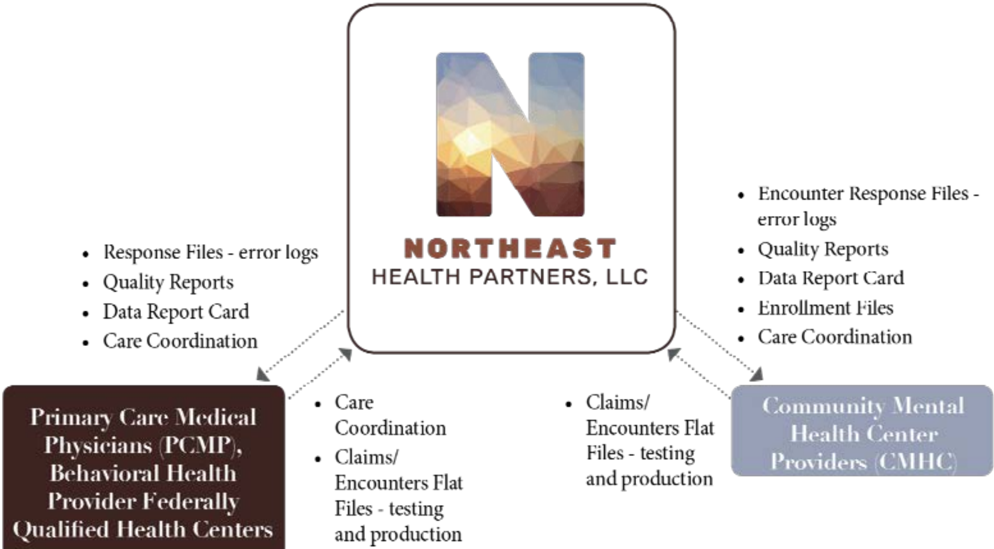
PCMP:

- RCCO_Roster_Report_HCPF
- RCCO_Roster_Report_RCCO4

CORHIO Data:

- RCCO_4_CORHIODATA

NHP Data Feed to Providers



NHP's partners have demonstrated expertise and systems that will be leveraged to implement an effective and efficient data management system to process claims, export data, and integrate with the Colorado interChange and BIDM system. NHP looks forward to working with the Department to continue to move the ACC Program toward more coordinated and integrated care that increasingly rewards improved outcomes.

DATA SYSTEMS ARCHITECTURE

We have provided our systems architecture diagram as **Attachment 9**.

OFFEROR'S RESPONSE 23

Describe how the Offeror will implement and maintain an ongoing Quality Improvement Program, in accordance with the requirements of Section 5.14, and how the Offeror will address quality throughout the administration of the program.

Northeast Health Partners, LLC (NHP) is committed to providing a Quality Improvement Program in accordance with the requirements of *Section 5.14*. Our Quality Improvement (QI) Program will independently study, evaluate and measure the performance of the organization in our service to the Department of Health Care Policy and Financing (the Department), Members and their families, providers, community partners, and stakeholders. We will define QI projects each year that will identify areas for improvement and the resulting action plan will meaningfully enhance the services delivered by the program. We firmly believe that continuous quality improvement is required and while we have a long-standing history of performance, there is always room for improvement.

NHP Quality Approach

Our Quality Management program is committed to ensuring that continuous quality improvement occurs within our organization. By structuring quality operations under a centralized framework, maximum production of best practice quality programming monitored for consistency and applicability will be achieved, and efficiency and effectiveness will be improved.

QUALITY IMPROVEMENT (QI) PROGRAM

NHP's QI Program structure is built from our administrative agents' considerable experience operating both the Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) programs. This structure has been developed and refined in alignment with the Department's quality strategy as well as our partner's existing nationally and locally established processes and best practices. Our Administrative Services Organization, Beacon Health Options, Inc. (Beacon), is a fully accredited NCQA Managed Behavioral Health Organization that functions in accordance with those high standards. Our QI Program structure is designed to ensure:

- Accountability to Members, the State, providers, and stakeholders
- Collaboration and integration throughout the behavioral and physical health systems
- Enhanced physical health and behavioral health outcomes across populations through an integrated program approach
- Increased opportunities for Member, family, provider, and other stakeholder input
- Data driven committees focused on evaluating problem-prone systems, resulting in improved care processes as well as Member satisfaction
- Analytics-based decision making that supports effective interventions and programs -
- Sub-region and community needs are addressed
- Provider support is provided and practices are enabled to meet performance goals through evidence-based interventions and education

The Quality Committee structure is integrated to favor outcomes for whole-person care and consistent oversight, measurement and action across all functions of the Regional Accountable Entity (RAE).

NHP is already well-versed in the federal and state Quality Assessment and Performance Improvement (QAPI) requirements necessary to achieve successful performance and effective outcomes for Medicaid Members in compliance with 42 C.F.R. § 438.310-370. Since FY2007, Beacon Health Options, our administrative agent, received scores of 100 percent on reviews of QAPI program standards under the current BHO/RCCO contracts were scored 100 percent

compliant by the Department's External Quality Review Organization (EQRO). We are proud of these results as they demonstrate the level of program expertise and performance which will be transitioned into the RAE and available on day one to serve Medicaid Members as the RAE in Region 2. Our provider partners have also received accolades for the quality management and delivery of care such as:

- 2017 Enhanced Primary Care Medical Provider award from the Colorado Department of Health Care Policy & Financing.
- 2016 Sunrise Community Health received the GoldStar Award from the Colorado Department of Public Health & Environment, as part of our commitment to increase adolescent immunization rates. Out of 300 Colorado Clinics that were part of the AFIX (Assessment, Feedback, Improvement, and Exchange) program in 2015, Sunrise received the top award for having successfully implemented this program with innovation, collaboration, and sustainable strategies.
- 2015 Shirley Hass Schuett Quality Regional AND State Awards to Sunrise Care Management team.
- 2015 Sunrise recognized as a Project Launch Early Childhood Champion, highlighting childhood screening practices (7,405 kids screened).
- 2014 Five Sunrise Community Health sites recognized by the national Committee of Quality Assurance (NCQA) as Level III Patient Centered Medical Homes.

Quality Improvement Program Alignment

Our QI Program aligns with the Department's Quality Strategy and includes activities to evaluate and measure- all functions of the RAE as well as objectives such as advancement of the Quadruple Aim in Region 2. More specifically, it drives improvement in the key performance indicators relating to population health, clinical quality of care, total cost of care and Member and provider experience with the Department's Health First Colorado program. Key activities include evaluating:

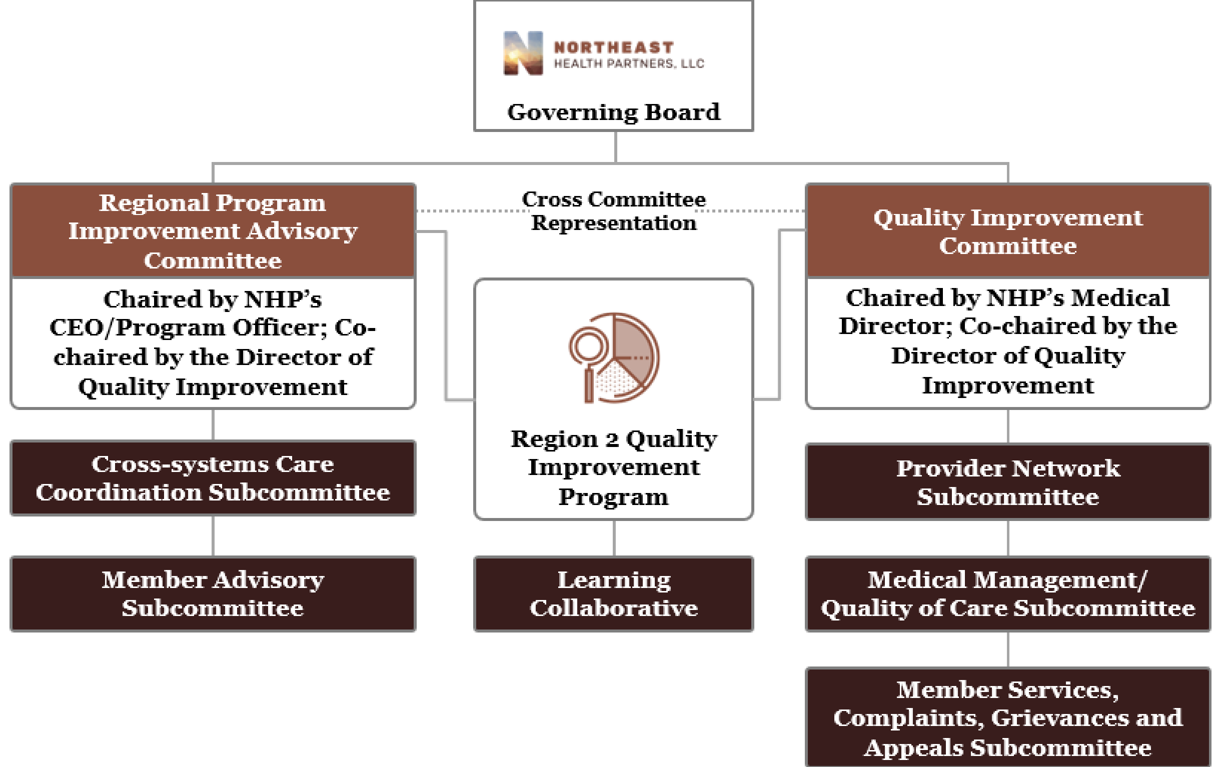
- Performance improvement projects, performance measures and Member experience of care
- Organizational processes for care delivery, coordination and communication to Members, providers and community stakeholders
- Over and under-utilization of care, and services to populations and Members with special needs
- Quality of care and service patterns of care, processes, and concerns
- External quality reviews, results and compliance
- Outcomes of care, under-performance or poor performance

NHP Quality Program Structure

NHP's Quality Program structure will be designed based upon our collective experience and using a thoughtful approach that considers the potential for system-change challenges – that can arise with the implementation of a unified Primary Care Case Management Entity (PCCM Entity)/ Prepaid Inpatient Health Plan (PIHP) program. The QI Program especially recognizes the value of assuring that areas such as cross-system care coordination, Member education and provider support, which may have a higher likelihood of experiencing challenges due to change, would have regularly-established opportunities for problem-solving at the outset. Continued improvement in performance is the primary objective for the QI Program.

Our QI Program structure, administered by Beacon Health Options shown below, is governed by two committees: The Regional Program Improvement Advisory Committee (PIAC) and the Quality Improvement Committee (QIC); both report to the Governing Board of Directors and have cross-representation.

NHP's Governing Board



Regional Program Improvement Advisory Committee (PIAC)

The Regional PIAC comprises Members, family members, and a variety of stakeholders who represent the populations of the region as well as local communities. The role of this committee is to guide and inform program administration including input into performance, with a focus on KPIs, population health, program development, quality of care and service, along with communicating Member, family and community needs and supports improved population health activities for Members. Resource connections include housing, food, peer support, durable medical equipment, financial assistance, clothing, change of provider due cultural or religious preference, transportation and more. The Regional PIAC is chaired by the NHP Program Officer and co-chaired by the Director of Quality Improvement.

Quality Improvement Committee (QIC)

The focus of the QIC is performance and operations, network adequacy and quality of care; the committee is chaired by the Medical Director and co-chaired by the Quality Improvement Director. Membership consists of PIHP and PCCM leadership, staff from all NHP Departments including Data Analytics and IT, providers, and state agencies.

Subcommittees

Our QI Program structure also includes several subcommittees that address performance across systems and several critical areas. These include:

- Cross-systems Care Coordination
- Member Advisory Council
- Provider Services

- Medical Management/Quality of Care
- Member Services, Complaints, Grievances and Appeals

The table below details the participants and purpose of these important subcommittees that will provide NHP with critical feedback on our operations and performance.

Subcommittee	Membership	Purpose
Member Advisory	• Family members • Members • Users of health care services • NHP staff • Member Advocates • Member Services staff	To provide direction in policy and operations, including understanding the Member health care experience, promoting health, health advocacy, and Member engagement, identify health care needs relative to communities, evaluate RAE performance in delivering health care to Members.
Cross-systems Care Coordination	• Care coordinators • Agency and provider staff • Key stakeholders from varied areas across the region	To plan, implement and evaluate system effectiveness and address barriers and needs across the region.
Provider Services	• Provider Relations Director • Representatives from Quality Management, Member Services, and Clinical Departments • Physical and behavioral health practices • Members	To monitor network adequacy across the region, strategize provider recruitment, identify provider education, training and support needs and the most effective forums for delivery.
Medical Management/ Quality of Care	• Chief Clinical Officer or Medical Director • Clinical Director • Clinical Peer Advisor • Quality Director	To review quality of care provided to Members, oversee the investigation and follow up actions for adverse incidents and quality of care issues, oversee UM processes and performance metrics and identify and address treatment needs for the region.
Member Services, Complaints, Grievances and Appeals	• Advocates from behavioral and physical health practices • Hospital provider • Member Services staff • Clinical and Quality Department representatives	To evaluate the service, satisfaction, access and other services, identify trends and recommend system changes and enhancements to improve satisfaction and performance.

To best support providers and practitioners, the QI Program is also adding a provider Learning Collaborative. A major focus of the Learning Collaborative is education. Topics will include detailed information regarding the roles of the RAE, identification of provider support staff and materials, and improving performance with training on the specific details of KPIs and performance measures. The Learning Collaborative is described in more detail in the Performance Measurement section later in this response.

Quality Improvement Plan

Annually, NHP will develop a Quality Improvement Plan designed to guide quality and performance activities throughout the coming year. The plan ensures a high-performing, compliant, patient-

centered healthcare delivery system. The Quality Improvement Plan is developed using the results of the previous year's Annual Quality Report, which details accomplishments, progress on goals, performance on metrics, the qualitative and quantitative techniques used to improve performance, and the impact of those techniques. Also included are the status and results of each Performance Improvement Project, and opportunities for improvement based on performance results. Areas of focus for the Quality Improvement Plan include: Governance, Clinical, Operations, Information Technology, Compliance and other relevant topics as appropriate. NHP Quality Improvement Plan includes processes for working with patient focused collaboratives and HIT exchanges to improve patient outcomes such as: Colorado Regional Health Information Organization (CORHIO), Colorado Department of Public Health and Environment, and Colorado Community Health Network.

NHP will submit our Quality Improvement Plan to the Department for approval 30 days after the effective date of the contract. This plan will outline the implementation of our Quality Improvement Program. Once Department approval is received, we will implement the Quality Improvement Plan. We will review and update the Plan annually and submit by the last business day in September, along with Annual Quality Report.

Within the NHP Partnership, there are active, ongoing internal quality improvement programs and initiatives including:

- 2017 State Innovation Model (SIM)- Quality improvement in clinical quality measures TBD- Beginning in September 2017.
- 2017 DentaQuest- Our safety net solutions dental quality improvement project supports operational and clinical transformation to improve access, patient satisfaction and clinical care processes.
- 2016 NNOHA Dental Dashboard Collaborative- Achieving quality improvement through development and utilization of a dental dashboard to enhance practice processes and ensure positive outcomes which are monitored closely by the Quality team.
- 2015-2017 Colorado Department of Public Health and Environment Quality Improvement Project- by partnering with the Department of Public Health, we were able to implement interventions to improve cervical and colo-rectal cancer screening rates.
- 2015-2016 Comprehensive Women's Health Program in Colorado Community Health Centers – through a partnership with Colorado Community Health Network (CCHN), we developed mechanisms for tracking core services provided to women of reproductive age including: cancer screening, depression screening, HPV immunization, and substance use. Mechanisms for collecting SOGI data and integrating pregnancy intention screenings into the workflow were accomplished as well. We were able to improve access to comprehensive family planning services; and enhance the delivery of team-based care across all participating sites.

PERFORMANCE IMPROVEMENT PROJECTS

NHP's Quality Department simultaneously conducts multiple Performance Improvement Projects (PIPs) in addition to other quality improvement initiatives targeting population health outcomes. As our Administrative Services Organization, Beacon Health Options, Inc. (Beacon) has 22 years' experience in developing successful performance improvement initiatives that have positively impacted Medicaid Member outcomes and improved integration across systems. Current and past PIPs/projects/initiatives are summarized below. These projects are based on performance, State and CMS requirements, and requests or regional needs identified by quality staff and our committees/subcommittees. There is no wrong-door for meaningful feedback that can result in evaluation and establishment of a quality improvement project. These projects focus on improving health outcomes for special populations through increased integration and promotion of health neighborhoods. Many of the projects below reflect some level of integration between physical and behavioral health.

Each project and initiative is designed to improve Member outcomes by promoting collaboration among partners, providers, community agencies, and other stakeholders to create a system of integrated care that effectively addresses all clinical and non-clinical needs of Members through a data driven population health management program carried out under the umbrella of care coordination. Regional quality committees assist in design of projects and initiatives to ensure we get Member feedback about how the projects will impact them as well as gain provider buy-in.

Care coordinators, providers and staff from clinical, provider relations and other departments drive each quality project and initiative, while our quality staff provide data and analytics to support projects and initiatives. The Quality Department collects all necessary data for implementation and execution and shares it with the care coordinators, providers and staff involved in each project. Staff use all available data resources to obtain project base lines, set periodic benchmarks for success, and re-evaluate the overall project impact to determine the effectiveness of the interventions on Member care.

Where possible, quality projects align metrics to streamline processes for providers. In order to ensure project success, providers will have input into the project design. This allows for sub-regional differences, Member population demographics, and best use of community resources. Providers who participate in the projects will receive technical support and education from the quality staff through on-site consultation, written documentation of processes, and discussion within committees, sub-committees, the Learning Collaborative and workgroups where providers are represented. Effective provider education and support functions are based on experience in both RCCO and BHO organizations. Significant quality of care, clinical treatment and documentation, and performance support initiatives were established and based on feedback and the degree of measureable improvement, have been refined over time.

Projects are monitored and reported by quality staff as part of the annual Quality Report, and evaluated using clearly defined objective measures, including, but not limited to:

- Integrated Practice Assessment Tool (IPAT)
- Member Transition Scores (developed internally)
- Claims data
- KPIs
- HEDIS
- Member Health Proxy Scores (developed internally)
- BIDM data including Member risk scores
- RAE Indicators
- SIM Measures
- UDS Measures

The process for developing new initiatives and gaining feedback and direction necessary for significant sustained improvement is a data-driven iterative process based on knowledge of local sub-regional Member needs as well as understanding community resources and capabilities. The prioritization process for new initiatives includes determining the degree to which the activity supports improved healthcare for our Members. Design, implementation, monitoring, and re-evaluation process are embedded in the regional RAE committee structure through:

- **The Regional PIAC:** The Regional PIAC assists in the design of quality projects and initiatives, as well as provides feedback based on on-going evaluation and monitoring outcomes to ensure positive Member impact. The Regional PIAC comprises Members, families, advocates, partners, behavioral and physical health providers, and community agencies. As such, oversight of quality projects through the PIAC ensures accountability to all stakeholders.
- **Sub-committees and work groups:** These committees and work groups are leveraged to bring subject matter expertise to all proposed initiatives.

Projects that have been vetted and approved through the PIAC are presented to the Board of Directors for feedback and approval.

Region 2 Integration of Primary and Behavioral Health Care Activities

For over 10 years, NHP providers, North Range, Sunrise, Centennial and Salud have worked to integrate physical and behavioral health in Region 2 in order to serve Medicaid and indigent populations in rural communities.

SALUD PROJECTS

- **Comprehensive Maternity Care**
  Comprehensive maternity care including prenatal care, patient education, behavioral health screening/intervention; oral health education/assessment/intervention; delivery care; post-partum management. Patients can choose to receive individual prenatal care from our integrated care team or participate in Centering Pregnancy group. Components include: oral health, co-management by Primary Care Provider and OB/GYN, delivery care for both low risk and high risk babies, home visits for high-risk mom/baby pairs, post-partum care and outreach to ensure post-partum visit between 21-56 days of delivery, Pregnancy Related Depression Screening. Comprehensive maternity care is provided through Salud in four rural communities: Fort Morgan, Sterling, Fort Lupton, and Frederick.
- **Integrated Behavioral Health in Federally Qualified Health Centers**
  Individuals with behavioral health needs are served in a primary care setting. The program provides fully integrated behavioral health services in a primary care environment to all patients. We strive to have contact with each patient regarding behavioral health concerns and offer a full scope of behavioral health interventions including psychotherapy, group visits and psychological testing. Salud provides integrated care in four rural communities: Fort Morgan, Sterling, Fort Lupton, and Frederick.

  Salud and Centennial Mental Health Center partnered together to provide quality integrated health care to Medicaid Members in Fort Morgan and Sterling.) Programs include services provided to special populations such as adults with disabilities, older adults and foster children. Salud and Centennial developed and implemented a Primary Care Practice Medical Home which incorporated behavioral health consultations to physicians, transitional care, collaboration, cross referrals, care coordination and co-location of psychiatric and behavioral health services including screenings, assessments, individual and group therapy, case management and physician consultations.
- **Oral Health**
  All Salud patients have access to dental services that are integrated into the primary care environment. Dental services are provided to patients at all ages and include general cleanings and exams, diagnostic imaging, surgery procedures and extractions. For patients ages 0-20 and pregnant women of any age, Salud offers medical dental integration (MDI) where a dental hygienist participates in the medical appointment and provides oral hygiene education and fluoride varnish to lower risk of dental caries among children and pregnant women.
- **Care Management**
  All Salud clinics have Care Managers who are essential Members of the interdisciplinary team and identify high risk ACC patients based on claims utilization data (ER utilization, hospitalization etc.), referrals from internal team members or external community resources. Care Managers complete a Health Needs Assessment (HNA) to identify needs within multiple domains including but not limited to: medical, behavioral health, dental and social determinants of health. When appropriate Care Managers create patient centered care plans designed to identify patient centered goals that leverage patient strengths and assets (i.e. family members, local resources etc.). Care Plans help close the loop in overall coordination of care both within and outside the primary care setting and aim to ensure patients access the right care at the right time in the right setting.

Sunrise Community Health Projects:

The Sunrise Community Health integrated medical, dental, and behavioral health through co-location of physical and behavioral health practitioners in multiple clinic settings. Integrated care teams develop multi-disciplinary plans for driving patient treatment. Sunrise offers comprehensive, quality services including on-site laboratory, radiology, pharmacy, and patient education. Sunrise is a recognized leader in integrated care, advanced Health Information Technology (HIT), safety net collaborations, and professional health education. In addition, Sunrise co-founded the North Colorado Health Alliance, a community collaboration focusing on low-income, under and uninsured people within our service area. Partners include community health, public health, hospital, behavioral health, specialists, local foundations, education, county commissioners, managed care organization, and county social services. Collaborations focus on integrated service expansion; shared HIT infrastructure; community health improvement; regional accountable care activities; and system accountability and efficiencies.

Sunrise Community Health programs include:

- **Shared Electronic Health Record**
  Sunrise and the Weld County Department of Public Health and Environment implemented a shared electronic health record in 2002. A patient's chart is available to clinicians at Sunrise and Health Department clinics thus ensuring safer and more cost effective care.
- **Sunrise Weld Prenatal Clinic**
  Since 2001, Sunrise has embedded primary care clinicians in Public Health clinics for the purpose of providing prenatal care in a community setting. This model facilitates integration and ensures prenatal patients are linked to needed community and public health programs.
- **School Based Health Clinic**
  Beginning in 2004, Sunrise brought primary care medical and dental services to a socio-economically disadvantaged school located in Evans where 95 percent of the children receive free or reduced lunches. These are primarily underserved children and families with limited access to affordable health care. Initially, Sunrise offered services from our mobile health van, and in 2006 a permanent clinic was established on-site. Today, the clinic is open year round, staffed by a NP. Medical, dental and behavioral health services are provided on site as is eligibility screening and care management. Patients have access to pharmacy, lab, x-ray, at the larger Sunrise clinics. NRBH provides the on-site behavioral health services.
- **Mental Health/Substance Abuse Services**
  Partners with the local mental health and substance abuse agencies in our service area to bring co-located and integrated care to our community. Behavioral health team members work within Sunrise clinic primary care teams, jointly creating treatment plans and providing care to patients. Sunrise clinicians are also embedded in the behavioral health setting, jointly creating treatment plans and providing care to patients. Sunrise will continue to focus on fully integrated health care and improving care plans and patient outcomes as well as improving referrals to/from medical and to/from behavioral health.
- **Oral Health Services**
  Sunrise directly provides comprehensive primary oral health services to all ages in our Larimer and Weld clinics. We continue offering one of the most comprehensive programs in the state. Our dental patients average 3.4 visits/year.

Examples of Potential Quality Improvement Projects for the Region 2 RAE

Criminal Justice Transitions

Criminal Justice Transition Projects address challenges of Members released from jail back into the community. Beacon Health Options currently has two projects with one focused on incarcerated

Members with behavioral needs and interventions and the other focused on incarcerated Members with physical health issues. Success for Members can be highly dependent on their transition experience, such as emergency department, admission/discharge/transfer from one level of care or facility to another including Criminal Justice. With the advent of the Affordable Care Act, and aligning with the state's focus on criminal justice, we determined this to be a vulnerable population and especially likely to encounter difficulties, particularly for those with complex medical and/or behavioral health needs. Quality, care coordination and data processes are in place to support these transitions. Members who have a Complex Chronic, Simple Chronic or Critical condition and have been recently released from jail are identified through shared data using proprietary systems we have installed in the community. Care Coordinators outreach to these vulnerable Members to ensure they receive proper medical and behavioral health follow up as well as any other referrals to community resources that may be helpful in effectively transitioning back to the community.

This PIP also targets individuals being released from jails who have had behavioral health treatment in our system. Upon release, providers reach out to inmates to re-engage them in treatment with a re-engagement timeframe within 30 days of release. We continue to see improvement in engagement rates with these Members and our most recent statistics show a mid-year improvement of three percent. Valuable lessons have been learned in the process of executing these Criminal Justice Transition PIPs, including the identification of a need for educational support across systems regarding the availability of care coordination from NHP to support these vulnerable Members and work together to improve health in the lives of incarcerated individuals, along with the importance of data and information sharing.

ADMINISTRATIVE AGENT PROJECTS

Improving the Rate of Diabetes HbA1c Testing for BHO Members who take Atypical Antipsychotic Medications

Individuals treated with antipsychotic medications have a higher rate of Type 2 Diabetes than those who are not treated with antipsychotics. This assertion was the conclusion of Bellantuono et al (2004), who completed a review of 21 studies to assess the risk of Type 2 Diabetes in Members treated with various types of antipsychotic drugs. The American Diabetes Association recommends diabetes testing at least annually for Members taking antipsychotic medications. Studies suggest that less than a third of people prescribed antipsychotic medications are screened for diabetes. To improve rates, Beacon began an improvement project, reaching out to the RCCOs in the services to obtain their support in this project. Each measurement year, the BHO has seen an increase in Member HbA1c testing rates over baseline. The most recent year (2016) shows the HbA1c testing rate for Members who take anti-psychotics improved to 81.6 percent, an increase of 3.2 percent compared to the previous year.

Ambulatory Follow-up within Seven Days of Hospital Discharge

Members who are hospitalized with a mental health diagnosis are a high-risk group, representing the most severely ill psychiatric Member population. During the hospitalization, the Members' symptoms are stabilized and a plan for continuing care becomes a vital step in the recovery process. This project was initiated as a gradual decline in performance over time was identified. Although the decline in the rate of completed follow up visits was simultaneous with steadily increasing membership, the QIC determined it was vital to focus on the transition to outpatient care. Our staff worked collaboratively with providers to identify barriers, develop meaningful interventions, and share best practices. Improvement in rates was gained for some providers; others implemented interventions designed to engage Members using services that do not count toward the rate. These interventions included case management and peer specialist outreach to assist Members with housing accommodations, to obtain medication and other transition supports. No increases in hospital readmission rates occurred. Efforts to improve the rate of completed aftercare visits continue. NHP Partners utilizes multiple interventions to engage Members after discharge including

Care Coordination, transition programs, health navigation and crisis services such as respite care, CSUs, and mobile services.

Emergency Department Visit Reduction

Our staff conducted analysis on emergency department visit data with the goal of reducing emergency department use. Over the last fiscal year, the data showed that a large proportion of emergency department visits were attributed to Members who have not accessed behavioral health services. The rate of emergency department visits is monitored quarterly based upon a rolling 12-month period

In an effort to reduce the emergency department visits regionally, letters are sent to those Members who visited an emergency department at least twice and had not sought services from a behavioral health agency within six months prior to their latest emergency department visit. Included with the letters are reference materials for contacting crisis lines, local mental health providers, and suicide prevention brochures. The aim is to inform Members not only of the crisis services available in their region but to re-direct the Member to contact behavioral health crisis services in lieu of accessing the emergency department. Furthermore, the suicide prevention brochures provide specific information on suicide prevention for adults and youth, an important initiative for Colorado. Behavioral health providers make outreach calls to higher-utilizing Members to actively encourage engagement in services.

To further demonstrate Beacon Health Options expertise in the delivery of quality projects, additional initiatives include:

- **Integration of physical and behavioral health services for pain management and opioid abuse/dependence:** with measureable outcomes based on OpiSafe, a technology that incorporates best practices from various disciplines. Providers and practitioners from multiple disciplines participate in the program that primarily serves adjudicated individuals, including: substance use disorder treatment, behavioral health counseling, Medication Assisted Treatment, primary care, physical therapy, care coordination and other supportive services as needed.
- **Development of a health neighborhood through an Integrated Treatment Team (ITT) approach:** that utilizes data to identify Members for inclusion based on conditions, risk stratification, risk scores, co-morbid physical/behavioral conditions, emergency department/inpatient utilization, pharmacy data and other relevant data points. The ITT incorporates appropriate providers and agencies such as DSS, local mental health, the local FQHC, home health, and public health. An integrated treatment plan is created to address clinical and non-clinical needs of Members.
- **Integration of behavioral health practitioners and physical health Care Coordinators to increase the percentage of behavioral health service recipients who receive wellness/EPSDT checkups.** Actionable HEDIS gaps will be incorporated such as comprehensive diabetes management. Children who have not had a well visit or are going to need one within 60 days are identified through claims. These children are cross referenced against claims to determine who receives behavioral health services at the local CMHC. The resulting list of children is shared with Care Coordinators who work with behavioral health specialists as the "owners" of that Member relationship to engage the family in services.
- **Member registries for special populations** such as children with diabetes, Members who take anti-psychotics and need HbA1c screenings and Members who over-use opioids. RCCO/BHO Adult Diabetes Integrated Work Group. The goal of this project was to increase education and support for Medicaid adults diagnosed with diabetes as well as treating physicians in the region. The Work Group was initiated due to the high number of adults in the region diagnosed with diabetes, and the associated high costs. The Work Group accomplished the following:
    - Implemented well-attended evidence-based education groups for Members addressing diabetes management

- Ensured that care coordinators were receiving the data necessary to follow up with Members with diabetes
- Coordinated an educational presentation for physicians titled, "Best Practices in Diabetes Management". The presenter was an internal medicine specialist with extensive experience working with diabetes, and included strategies for working with non-compliant Members
- Created an online resource list for Members and providers that included endocrinologists in the area and the latest materials from the American Diabetic Association and Centers for Disease Control and Prevention

NHP Partners have demonstrated our commitment to innovative quality initiatives that produce positive Member outcomes such as:

- Increase in number of women receiving prenatal care to 82.81 percent
- Decrease in low birthweight babies (<2500 grams) to 6.59 percent
- Increase in number of Members assessed for tobacco use to 91.40 percent
- Increase in depression screening to 79.37 percent
- Utilization of Technology Enabled Support including texting programs and telehealth
- Medication Assisted Treatment and support for Members needing opioid treatment

PERFORMANCE MEASUREMENT

Performance measures such as KPIs and BHO Indicators are collected monthly by quality and shared with partners and providers. Measures are tracked through the BIDM system or using other resources when needed. NHP will support network providers in collecting and reporting information that is needed to calculate the measures.

Each measure is reported at the RAE level through the QI Committee structure in aggregate as well as at the partner/provider level to assist practices in tracking their performance. Evaluating performance trends over time at the provider and system levels is a valuable educational process used to determine effective and realistic interventions. Actionable data that is real-time or near real-time will be available to assist providers and care coordinators to allow more immediate response to Member, family and caregiver needs, and to make changes at the clinic level if needed to improve performance and more effectively facilitate care.

Data and measurement are key components of NHP's care coordination model. The Care Coordination subcommittee will use these metrics to evaluate the impact of inpatient and emergency department discharge transitions, Member engagement and care management processes. Based on recommendations from the Care Coordination Subcommittee, NHP will build specific algorithms to warn us when risk increases around certain health issues.

For example, when managing specific health conditions that require a continuous medication regimen for treatment of the condition, quality staff will search for evidence-based gaps in care using the BIDM tool such as HEDIS effectiveness of care measures (e.g., missed compliance medication such as asthma controller or ICS), and will also generate reports identifying descriptive indicators such as medication possession ratio (MPR) or proportion of days covered (PDC). These reports will help care coordinators to determine not only if a prescribed medication has been filled/refilled, but whether the medication is being refilled at the correct intervals, and to intervene to improve care.

At the health delivery system level, the Medical Management Subcommittee would evaluate prescribing behaviors regionally and implement system-wide solutions to this problem such as enhanced reporting to providers through a collaboration with the Department and BIDM system, or distribution of reports and information directly from NHP.

Performance measures are reported out through the NHP Quality Committee structure and specifically the Regional PIAC and QIC. These committees will review performance on a monthly basis and provide feedback to quality staff and recommendations on identified challenges. Sub-committees will review all barriers to performance and make recommendations to the larger Statewide PIAC regarding solutions. NHP's Board of Directors will also review performance measure results quarterly. Other subcommittees will be involved in reviewing performance and analyzing and addressing barriers relative to the role of the subcommittee. Cross-committee work groups will be established when needed to ensure key participants are involved in barrier analysis and intervention development to improve performance.

Accountable Care Collaborative (ACC) Pay for Performance

NHP partners supports the current RCCO in improving KPIs in Region 2 through utilization, analysis and sharing of data identifying Members, populations and performance outcomes. Performance reports will be extracted from the BIDM system and results evaluated through the QIC, Regional PIAC, and relevant subcommittees. Performance Committees will be responsible for identifying methods to improve performance and how best to implement improvement plans.

Key performance indicators currently in place include:

- **Total Cost of Care:** Beacon developed and implemented interventions to address Total Cost of Care using a multi-systemic approach, including Care Coordination, patient outreach and education, utilization of data systems to identify high utilizers, provision of appropriate referrals and special population outreach including prevention for specific populations. Care coordinators outreach Members identified as high utilizers of services, particularly emergency department, and provide Member education and referrals to steer Members towards more appropriate types of services through their PCMP. Member services outreaches special populations such as Members who need breast/cervical cancer screenings, colo-rectal cancer screenings, and well-child checks to ensure Members are getting proper preventative care. Referral protocols are in place to ensure proper utilization of specialty services. Population health management strategies identify groups that could benefit from additional care coordination support, such as those with one or more chronic conditions or Members with co-morbid behavioral/physical health issues. Northeast Health Partners has implemented many strategies for addressing Total Cost of Care from a Population Health perspective, including: Care Coordination, managing transitions, utilizing Community Health Workers, telemedicine, behavioral health and substance use disorder interventions, preventative screening and disease management programs.
- **Emergency Department Visits for Ambulatory Sensitive Conditions:** Admit/ Discharge/Transfer (ADT) data is used by care coordinators to identify Members who have had an emergency department visit or transitioned from one level of care to another. ADT data is real time, so outreach is accomplished in a timely manner to assess Member needs and identify barriers. We have had a positive impact over the past two years working on this KPI, resulting in a decrease from .6 percent in FY14 to -11.1 percent in FY16. Within the Northeast Health Partnership region, decreasing ED utilization is approached through efforts focusing on interventions such as disease management programs and behavioral health outreach.
- **Wellness Visits:** There has been a strong focus on well-child checks for the past five years including a successful Quality Integration Project that leverages both behavioral and physical health resources to engage Members. Member services provides outreach to those who need preventative screenings such as breast/cervical and colo-rectal. Claims data is used to identify Members who have not had a PCMP visit in the previous 12 months so that care coordinators can outreach those Members and engage them in their health neighborhood. Northeast Health Partners have demonstrated successes in providing quality wellness care for their Members as evidenced by: a 79.37 percent Depression Screening rate, hypertension control rate that is higher than both the national and state averages as well as pap test rates that have consistently outperformed national and state rates.

- **Behavioral Health Engagement:** Member engagement in behavioral health care services is an important metric that can link service delivery to the efficacy of outcomes. Northeast Health tracks service engagement using Care Coordinators to actively outreach to Members in an effort to ensure full participation in services. Engagement is defined as a Member attending four services in 45 days. This is a current BHO Incentive Program Measure; intervention strategies are shared across programs. Education and monitoring occur at regular intervals.
- **Prenatal Care:** The Colorado Opportunity Project is being piloted and is currently focused on impacting healthy birth weight in babies born to our Members through referrals to appropriate providers, engagement with their health neighborhood, as well as providing education to OB/GYN providers about engaging with care coordinators to ensure Members receive proper support and referrals. Northeast Health Partners has implemented a successful initiative that resulted in an increase in prenatal visits for their Members. As of 2017, the partners increased the prenatal visit rate to 82.81 percent well above the state and national averages for previous years.
- **Dental Visit:** Northeast Health will use data reports from the BIDM system, as available, to assess the rate of annual dental visits; outreach efforts will be implemented regionally to targeted populations such as youth and families to determine the most effective means of assuring regular visits. Northeast Health will create a dental registry and notify providers on a monthly basis of Members who are due for a dental visit as a part of our approach to ensuring overall wellness for children. Northeast Health Partners has significantly increased the number of children with dental exam at high risk for caries who received sealants from 17.14 percent in 2015 to 36.21 percent in 2017 (YTD).
- **Obesity:** Body Mass Index (BMI) will be used in measuring rates of overweight and obesity unless the KPI specifications differ. In order to align with the Colorado Winnable battle addressing Healthy Eating, Active Living, and Obesity Prevention, Northeast Health will implement evidence based practices that focus on increasing physical activity, dietary education and behavior therapy. In doing so, Members will learn how to lose weight as well as maintain a healthy weight and lifestyle. Northeast Health is evaluating programs that support Members in increasing physical activity through a rewards based system, and the creation community wellness committees. Community wellness committees will spotlight creating connections to healthy food resources and creating community wellness walking/exercise programs. A diabetes prevention program, using pre-diabetes monitoring through BMI measurement will also be considered.
- **Health Neighborhood:** Quality staff support our provider relations staff in implementing the Specialist Physician COMPACT through monitoring and providing feedback on the performance of participating providers. Quality staff will conduct quarterly audits to determine the extent to which providers are using the COMPACT. The results of the quarterly audits will be submitted to the Board of Directors for review. The audit findings will determine if Accountable practices receive all the quarterly incentive dollars or if some will be withheld until performance improves

Additionally, NHP will develop a ninth KPI in collaboration with the Department, other RAEs and stakeholders. We will track and extract performance data monthly through the BIDM System or our proprietary data management and analytics systems with results vetted through our Regional PIAC and published for public viewing on our website.

Flexible Funding Pool

NHP appreciates the opportunity to earn additional performance payments from a flexible funding pool should funds be available. Several of our Quality staff have existing experience participating in the Department's current performance measure work group as well as in the data extraction, measure calculation and validation processes. NHP and these specific colleagues look forward to collaborating with the Department to design the flexible funding pool strategy, payment methodology, and distribution plan. In addition to rewarding providers for the work they will do to advance our Regional performance through the potential measures cited in the RFP, NHP hopes to participate

with the Department and use our internal analytics capabilities to study our Region and communities within the Region for other precision opportunities that may be advanced through this opportunity.

Public Reporting

As the RAE contractor for the region, we are committed to performance improvement on all measures endorsed by the Department. As health care in Colorado continues transitioning to an integrated system of population-based care, it is vital to have consistent metrics that measure our progress and ensure the system changes result in positive outcomes.

We will work to improve network performance on core health and utilization measures that will be reported publicly on a quarterly basis, including:

- Clinical and utilization measures
- Public Health and System Level measures, including obesity, suicide rates and passive tobacco or others as identified by the Department
- Member Experience of Care measures

Public reporting measures may be used to establish a pay for performance program for network providers as determined appropriate based on the measure and QI Program Committee recommendations.

Behavioral Health Base Standards

Experience has shown that improvement in performance begins with network provider education and support. Information regarding behavioral health base standards and the incentive program will be communicated to providers in several different ways, including the provider handbook, website, provider forums, onsite provider visits, and through a learning collaborative, described in further detail in our Advisory Committees and Learning Collaborative section below.

The behavioral health base standards include key health measures that NHP's partners previously worked with the Department to develop and implement through the BHO contract. Over the years, we have come to understand many of the operational challenges experienced by providers allowing us to work with them to deliver more actionable data and effective strategies for improvement. Monitoring includes reviewing performance rates and progress toward improvement both individually and through the quality improvement committees. We have demonstrated strong performance in:

- Reduction of hospital readmissions
- Reducing redundant/duplicate prescription of atypical anti-psychotics
- Reducing preventable emergency department utilization
- Follow up after mental health and substance use disorder emergency department visits

Suicide Risk Assessment - The assessment of Member risk is vital component in the treatment process, particularly for children, adolescents and adults with a depressive disorder. To assure that assessment are completed on every Member entering treatment, risk assessments are required at each initial appointment, and are typically included as a field electronic health records systems. It is also a key element of the tool used in the treatment record review process and provider education. This is a current BHO performance measure; the most recent BHO rate for completed risk assessments documented during initial treatment visit is 92.5 percent.

Hospital Readmissions - The time period immediately following an inpatient stay is a particularly vulnerable time for a Member. It is critical that the Member receive the supports needed to transition back into the community, and care coordination is a critical Member support to ensure stabilization occurs, and to prevent a recurrence of the need for inpatient care. Thus, readmissions to the hospital

are monitored at the seven, 30, 90, and 180-day timeframes to track that the transition process is effective. This is a current BHO standard performance measure; currently, less than 3 percent of BHO Members discharged from inpatient care are readmitted within seven days.

Adherence to Antipsychotics for Individuals with Schizophrenia - Certain psychiatric conditions require the use of psychotropic medications for the successful management of the condition. Antipsychotics are an important part of successful management of Schizophrenia and adherence to these medications are often a direct determinant of that success. Tracking this information provides an opportunity for targeted intervention in order to increase the opportunity for success. This measure was recently introduced by the Department for the BHOs; the adherence rate for the current BHO Region is one of the highest, at just over 60 percent for the initial year's calculation; this compares favorably with national HEDIS rates.

Diabetes Screening - One of the potential side effects of antipsychotic medications is an increased rate of diabetes risk. Tracking Members who take these medications to manage Schizophrenia or Bipolar disorders provides an opportunity to ensure annual HbA1c testing is occurring. It is the goal to build this into standard protocol as a way of supporting good clinical practice for the best clinical outcomes. This tracking provides the data needed to bolster these practices within the provider community. The BHO has a current PIP that measures HbA1c testing for individuals who take antipsychotic medications; an improvement in the testing rate has occurred annually and is now over 80 percent.

Penetration Rates - Working with our administrative agent Beacon, NHP will track penetration rates regularly; assuring Members are able to access services is particularly important with the large increases occurring in the Medicaid population over the past four years. The table below demonstrates Beacon's tracking of their penetration rates for Members in their Colorado program demonstrating that they increased consistently each year.

2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
13.40%	13.36%	13.94%	14.83%	14.86%

Hospital Admissions and Emergency Department Visits and Follow-Up - NHP will continue to track inpatient admissions to identify patterns of care and assure treatment, service engagement and crisis supports are available and effective in preventing hospital admissions as often as possible. In addition, helping Members connect directly with mental health or substance abuse services rather than use the hospital emergency departments as a first point of entry increases the chances of direct engagement and participation with providers who can best address the needs. For Members who do require emergency department supports, it is important to engage them into services quickly in order to assist them in getting the services that would best match their presenting conditions. NHP's partner organizations have initiated the groundwork for this measure; we will continue to work with emergency departments in the region in establishing strong communication and handoff processes to assure follow up appointments are made and completed following emergency department visits.

Our administrative agent, Beacon has had a variety of outreach efforts in place over the past five years to reduce emergency department utilization; the emergency department utilization rates have been consistently low as compared to the weighted average for all BHOs.

Emergency Department Utilization/1,000 Members				
2011/2012	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**
10.18	8.38	8.83	10.22	9.81

Improvement initiatives, such as emergency department visit reduction, are described in the Performance Improvement Project section of this proposal.

Behavioral Health Enhanced Standards

NHP intends to meet the behavioral health enhanced standards required by the Department and described in *Section 7.3* of the RFP. Continued focus toward improving performance rates for the enhanced standards is a QI Program prime objective. Enhanced standards include, but may not be limited to mental health engagement for all Members in need of treatment, including foster care youth, initiation of alcohol and other drug dependence treatment and completion of follow-up appointments within seven and 30 days after hospital discharge with any practitioner for a mental health condition. These measures and others are currently being addressed though several QI Program initiatives. These include:

- Data reports notifying providers of Member hospital discharge to assure a smooth transition back into the community, and to address any immediate Member needs such as medication, transportation or housing.
- Scheduling and availability of flexible aftercare and walk-in appointments
- Targeted Member outreach and exchange of information with care coordinators who can quickly work to address Member needs
- Monitoring, tracking and sharing performance data with providers on a regular basis
- Incorporating the measures, wherever applicable, into the chart audit process
- Consistent education and reminders to practitioners about the value of these measures, performance expectations, and the impact on care
- Establishing expectations, communication methods, procedures, and tracking to ensure coordination is occurring across systems and providers: physical, behavioral, human services, hospital, dental and other community agencies

Our combined organizational experience, innovative programs and unified QI Program will facilitate continued improvements in Member outcomes of care across the region.

Behavioral Health Incentive Program

NHP will participate in the behavioral health incentive program by demonstrating compliance with the Behavioral Health Incentive requirements and contract compliance standards specified by the Department. Achieving improvement goals set by the Department for the Incentive Measures is a priority of the Quality Improvement Program, and its associated committees. Our experience and efforts to assist providers in meeting these goals have been described throughout this section.

Performance measure results are submitted quarterly to the PIAC (Statewide and Regional), QIC and relevant subcommittees for evaluation and recommendations to improve performance for measures that do not meet the targeted goal.

MEMBER EXPERIENCE OF CARE

NHP strives to meet the principals of the Quadruple Aim including developing processes for measuring and tracking Members' experience of care. Our staff assists the Department in administration of the CG-CAHPs and ECHO surveys through offering support to both the Department and the providers who will be participating. Quality and provider relations staff will provide onsite assistance to PCMPs who are chosen to take part in the surveys to ensure that they are able to meet the Department needs/requirements for sampling and Member outreach. Organizational staff have attended and participated in the Health Impact on Lives sub-committee where Member satisfaction surveys are discussed and will continue to attend meetings to offer input and provide support in the development and customization of survey tools administered by the Department.

NHP staff will support the Department in administering ECHO survey according to prescribed protocols and specifications and will continue to lend our administrative support in that effort. We will assist the Department to obtain accurate provider information, update Member information and sample frame creation. Provider Relations staff maintains an updated provider directory which can be utilized for sampling and provider outreach purposes. We will inform the Department of additional surveys used by the RAE and share results through the Operational Learning Collaborative, PIAC, the Member Advisory Committee, through the NHP website, and other venues.

We will maintain a Member satisfaction survey tool on the website that is easily accessible to all Members. Data from the survey is collected and reviewed by the Quality Department and will be incorporated into the information provided to monthly PIAC members for review and comment. Data from the surveys conducted by the RAE will be reviewed by Member Services and PR staff as well. Where there is a need identified for interventions with a particular provider based on survey feedback, quality, and provider relations staff will engage that provider, offer onsite assistance, and try to determine how to effect changes that will result in better Member experience of care.

Member services collects data on Member grievances and complaints and reports it to the PIAC meeting monthly. Calls from Members that identify concerns or complaints regarding quality of care are received in Member Services and are documented then forwarded to appropriate parties such as Quality/Performance Improvement, PR, and administration. Quality of Care Concerns are reviewed regularly by Quality staff and will be presented to the Medical Management sub-committee of the QIC for review and recommendations.

In addition, the Quality Department will utilize various resources for monitoring Member satisfaction such as follow up data from the Nurse Advice Line and responses to Needs Assessments. Beacon's Engagement Center will conduct Member outreach to individuals identified in the Nurse Advice Line data to determine if Member needs were met through resources and recommendations received from the Advice Line. Information obtained through call center outreach will be compiled and reviewed on a regular basis by Quality and the Member Advisory Subcommittee. A positive Member experience is the basis of the relationship between our organization, its providers and our Members. This positive experience increases trust, which in turn leads to Members continuing to access care through NHP. In this way, improved Member outcomes can be realized.

Data and information collected from CG-CAHPS, ECHO, online surveys, complaints and grievances, Member call trends, referral tracking, and Customer Service reports will be collected, analyzed, shared through the QI Program and incorporated into the annual QI Plan along with findings, outcomes and solutions implemented.

MECHANISMS TO DETECT OVER- AND UNDER-UTILIZATION OF SERVICES

Under- and over-utilization of care is monitored through the comparison of specific performance indicators against established benchmarks to assess when utilization falls outside of defined practice patterns. Examples of these utilization review processes include the following:

- Identifying a minimum number of sessions attended within a defined time period to assure the Member is actively engaged in treatment (e.g., mental health and substance use disorder engagement measures)
- Confirming that Members at high risk, such as those recently discharged from the hospital, do not miss appointments. This can be addressed on both a system level (e.g., 30, 60, and 90-day ambulatory follow-up measures) and on an individual Member level.
- Defining the need of high-risk Members for certain types of service interventions (e.g., Intensive Care Management [ICM] services)
- Monitoring Members who discontinue treatment prematurely

- Frequent crisis and/or inpatient service utilization (inpatient re-admission rates)
- High utilization of emergency department services (e.g., identification of Members who have two or more emergency department admissions in a 12-month period)

NHP's Medical Management Subcommittee will review under- and over-utilization patterns with the option to recommend a performance improvement project or targeted provider training. In addition, UM staff may take additional steps, specific to individual providers, to remedy patterns of over- and under-utilization, including meeting with a provider to discuss practice patterns and utilization concerns, recommending specific training programs and/or requiring a corrective action plan.

UM Activities for the Client Over-Utilization Program (COUP)

NHP will partner with the Department in administering the COUP. As the RAE, we will outreach all Members identified through the COUP in order to link them to appropriate and available services. We will continue to coordinate care and monitor service utilization for these individuals until utilization patterns are stabilized and clinically appropriate.

Our administrative agent, Beacon Health Options piloted the COUP project for the Department in 2015/16 and have the processes in place for implementation. Quality staff compiles all care coordination data for this population including information about all outreach, assessment, and referral activities and reports this back to the State quarterly. When we piloted this program, we also returned to the state qualitative information about barriers encountered, Members who should not be included in the program and other anecdotal information that could be helpful to the Department in refining the program. As the RAE, we will continue to provide the State a quarterly report that includes all required information (e.g., outreach attempts, health assessments, interventions, and primary care visits).

As the RAE under the new contract, our quality staff will receive COUP data from the Department, including Members identified for inclusion in the program and those who receive a letter from the Department informing them of their status in the COUP program. Quality staff will apply a data algorithm to determine level of need and whether high utilization is due to a decline in member health or onset of serious health condition, which may account for the higher utilization. Once data and member notification lists are evaluated, quality staff pass the information on to care coordinators who are responsible for Member activation, including member outreach, support and intervention. Care coordinators use a variety of methods to make contact with each identified Member, including scheduling face-to-face appointments through the Member's PCMP, sending letters, identifying contact information through EHRs and other available sources for telephonic contact. Once contact is established, care coordinators will utilize a Patient Activation Measure tool, and perform an assessment to identify Member needs and barriers to accessing appropriate care. Care coordinators will provide Member support through referrals, follow up, and Member education. Every Member is provided with lists of available resources, such as walk in clinics, the call center number, and the nurse help line. Care Coordinators educate Members about the importance of establishing a relationship with their PCMP and using them for health care needs. Care coordinators follow up with Members on a regular basis to determine if the referral and education interventions are working. RAE clinical and quality staff provide support to Care Coordination entities including the option of Intensive Case Managers to assist with outreach and patient activation.

Our quality staff will track COUP Members' utilization of services including pharmaceuticals through claims and ADT data, and forward the ongoing tracking information to care coordinators so they will know if their interventions are adequately supporting the Member. NHP will complete a clinical review for Members who remain on the over-utilization list after a period of intervention. The clinical review will evaluate the appropriateness of restricting the Member to either one medical provider and/or one provider. Our Provider Relations Department will approach the identified practitioners

and educate them about the COUP and all aspects of becoming a lock-in provider and offer the opportunity to do so if the provider is not already a lock-in provider.

The Care Coordination Regional Director will work with care coordinators who are participating in the COUP to ensure they are in contact with the lock-in provider to offer care coordination outreach and support. We will designate appropriate staff to appear as an expert witness in a state fair hearing for a Member who appealed the lock-in status".

Quality staff ensure that providers have the necessary data and Member information necessary to participate and monitors the progress of the program through Member utilization data, including claims and real-time ADT information. A data report will be developed to identify Members who have not utilized their health benefits, and/or have not had a well check. That information would be passed to the care coordinators as well so they can engage those Members and get them in for assessments and services.

QUALITY OF CARE CONCERNS

The RAE is committed to providing the best possible care and ensuring the safety of our Members. Processes to prevent, evaluate and respond to the safety of Members are fundamental to our QI Program. If there is ever a care-related issue, we want to know about it as quickly as possible so we can address it. The system we have in place to respond to quality of care issues has three main parts: identification, investigation, and solution.

Identification

We rely on a variety of mechanisms to identify quality of care concerns. The most common ways in which quality issues are identified are:

- Through a report that is received from a provider, our staff, the Department, or others
- As a result of reviewing utilization or other treatment or chart audit data
- Through feedback to NHP or advocates
- By means of quality monitoring activities
- Through clinical care managers in the course of their job duties

Adverse Incident Reporting

Regardless of how we become aware of a quality of care issue, we work promptly to investigate the problem so we can determine its seriousness and address it. Immediate action will be taken for any quality of care issues with the potential to create risk situations for Members, as the safety of our Members is our primary concern.

Complaints about care received from Members are processed as grievances. For any complaint that appears to be quality of care-related, an evaluation will be completed through the quality of care process to determine if further action is necessary. An acknowledgement letter will be sent to the originator of the quality of care concern report.

Investigation

The RAE has defined policies on how to proceed in situations in which we identify quality of care issues. These policies incorporate the requirements for Quality of Care Concerns specified by the Department. Individual cases of poor quality of care are referred to trained, experienced QM Department clinical staff to assure Member safety, gather information and initiate an investigation; review with the Medical Director occurs as necessary. Investigation results are submitted to the Medical Management/Quality of Care Committee (QOCC) for evaluation and follow up recommendations. When appropriate, based on the investigation findings, the QOCC may make recommendations for corrective action. Depending on the severity of the issue, other people and

organizations may also participate in the investigation and follow up, including our Medical Director, Clinical Director, providers, and provider relations staff.

Resolution

If the QOCC determines a corrective action is necessary based on the findings of the investigation, their role is to define the corrective action, specify the frequency of monitoring, and evaluate the results. If the QOCC believes more serious action is required in response to the findings, a recommendation is made to the local credentialing committee for follow-up action. It is our policy that practitioners and providers have the right to formally appeal decisions concerning acceptance into the provider network, including corrective and disciplinary actions and changes in network status. We comply with all applicable state and federal regulations related to the provider appeal process. Any quality of care issues that appear to be system-related are referred to the Medical Management Subcommittee for follow-up action; quality of care issues that are provider-related are addressed with the specific provider following investigation. Documentation of quality of care issues, investigations, and findings are documented and tracked using Beacon's care management system; findings are stored centrally in the provider's electronic file. This centralized system allows improved tracking of provider performance issues.

The findings of the investigation may indicate the need for a report to the appropriate regulatory agency and/or Child or Adult Protective Services. If a network provider is suspended or terminated due to a quality of care concern, the appropriate regulatory agency or licensing board will be notified. NHP will comply with all contract and regulatory requirements and notifications necessary as part of quality of care process. It is important to note that investigational findings are used to evaluate systems and processes to determine how to prevent similar occurrences in the future and to improve care across the broader system, as well as at the provider and Member levels.

We will respond to requests from the Department for information regarding a quality of care concern with a response letter within 10 business days of the Department's request. A quarterly report will be submitted to the Department in an agreed upon format that includes a brief description of the concern and the outcome of each review by the specified due date.

Improving Care through the Prescription Drug Intervention Program (PDIP)

In addition to the process described above, we incorporate other mechanisms into our system to promote better care outcomes, and to identify and prevent potential quality of care issues. One mechanism adopted by NHP is Beacon's PDIP. Beacon designed PDIP to integrate and analyze pharmacy data to improve adherence to antidepressants and antipsychotics and prescribing practices among providers. This program combines expertise in psychiatry, psychopharmacology, and analytics to identify medication-related concerns, addressing problems through evidence-based interventions, at both the Member and provider levels. This retrospective drug utilization review program for psychotropic prescribing targets poly-pharmacy, non-adherence, sub-optimal dosing, Suboxone, HEDIS® AMM, and fraud, waste, and abuse through provider and Member interventions.

To ensure Members receive optimal care and providers adhere to best practices, based on our findings, we send notifications to providers and individuals regarding clinically validated medication-related problems. We engage providers and individuals to understand and resolve the most common medication-related issues found among prescribers, such as polypharmacy and sub-optimal dosing. We also address individual non-adherence to recommended medication refills. The use of PDIP promotes the safety of our Members in addition to the support and education available to our providers through this program.

EXTERNAL QUALITY REVIEW

Evaluative feedback gained from objective reviews is welcomed by our staff. We value the opportunity to demonstrate our progress and our programs, technology and focus on improving health outcomes.
Our staff have several years of experience assisting the Department in the execution of external quality review activities. Our leadership and Quality Department staff are knowledgeable regarding the federal PIHP and PCCM requirements, and have structured our programs to meet contractual and other regulatory requirements. In past years, we have audited providers and clinics to ensure procedures and standards are consistent with the relevant PIHP and PCCM requirements.

Each year, Beacon assists providers and partners in preparing for the annual RCCO EQRO audits by reviewing medical records and preparing staff who will be participating in the audit. Beacon prepares requested reports and data for presentation during the audit, arranges for care coordination staff to assist in case reviews with the auditors, reviews care coordination activities and records with the auditors, and ensures all audit requests are met. Results of our efforts are demonstrated in the most recent scores shown on the following page.

Beacon Health Options and our regional partners have consistently received high scores on annual EQRO RCCO audits. Overall scores for each year are as follows:

- FY 12/13: 93 percent
- FY 13/14: 100 percent
- FY 14/15: 100 percent
- FY 15/16: 97 percent

NHP looks forward to participating in the development and design of external independent review studies to assess and assure the quality of care as specified by the Department. We agree to fully cooperate with and participate in all external quality reviews and the associated documentation submission.

ADVISORY COMMITTEES AND LEARNING COLLABORATIVES

An interactive provider learning collaborative focusing on performance will be established by NHP. The learning collaborative will regularly offer training on:

- The fundamentals of performance improvement
- The specifics of performance measures used in this contract
- Incentive program information and how to earn incentives,
- Support tools and recommendations to assist providers in aligning clinic operational practices to achieve improved performance

The collaborative will be interactive to encourage sharing best practices and tips along with challenges, so providers and staff alike can benefit from the experiences of others. The RAE will employ one staff person who is dedicated to the role of educating and supporting performance improvement in the provider network, and will facilitate the collaborative.

Participation in the statewide PIAC, advisory committees and learning collaborative is the most effective way to communicate the current information to RAE members, providers and staff and to learn about the experience of other organizations. Key material regarding the quality of the program overall as well as the most recent program performance updates and initiatives will be conveyed to the regional PIAC, and disseminated to the Quality Improvement subcommittees.
Timely dissemination to providers, families and Members will be accomplished through email updates and website postings. NHP will designate one key personnel staff to serve as a member of

the statewide PIAC to attend monthly meetings, and nominate two representatives from the Regional PIAC to serve as members of the statewide PIAC. We will assure consistent attendance and participation in the Statewide PIAC monthly meetings.

NHP's Regional PIAC consists of Medicaid Members, family members and various stakeholders, including providers, agencies, Health Neighborhood participants and other regional and community representatives. Every effort will be made to engage diverse stakeholders as listed in *Section 5.14.9.2* of the RFP. The role of this committee is to inform and guide NHP leadership and staff about how to improve health, service access, Member and provider satisfaction, costs and identify other essential needs associated with the RAE program.

In addition to reviewing NHP performance data and contractor deliverables, the PIAC agenda will include discussion regarding any program policy changes, proposed and current performance improvement projects and initiatives, Member materials and committee input as well as recommendations for changes.

The PIAC will have a formal budget and a charter that specifies membership and governance structure and is publicly posted on the RAE website. Meetings are planned monthly, however PIAC membership may recommend changes to meeting frequency, location and suggest additional options to solicit feedback. Meetings are open to the public and will accommodate individuals with disabilities; Committee minutes will be posted on the public website within 30 days of the meeting.

Quality Improvement Committee

The Director of Quality Improvement will participate in the Department's Quality Improvement Committee to provide input regarding quality priorities, performance improvement topics, measurement, reporting formats and timeframes and other projects.

Operational Learning Collaborative

NHP will participate in a monthly Department Operational Learning Collaborative to monitor and report on RAE and ACC activities specified by the Department, as well as in annual and ad hoc learning collaboratives to monitor activities and share lessons learned. Minutes and information from the Operational Learning Collaborative will be shared through the QI Program structure and disseminated to providers, Members and other leadership as applicable.

AD HOC QUALITY REPORTS

NHP is able to accommodate all information and data reporting requests from the Department or its agents in a timely manner in the requested format through claims, medical records, internal data warehouses, and internal records such as call center/grievance and appeals.

OFFEROR'S RESPONSE 24

Describe how the Offeror will ensure compliance with the Accountable Care Collaborative Program rules, Contract requirements, state and federal regulations, and confidentiality regulations. In addition, describe how the Offeror proposes to conduct compliance and monitoring activities in compliance with 42 C.F.R. part 2.

The organizations comprising Northeast Health Partners, LLC (NHP) have experience implementing compliance programs designed to ensure full compliance with the Accountable Care Collaborative (ACC) Program and Behavioral Health Organization (BHO) rules and requirements, contract requirements, state and federal regulations, and confidentiality regulations. NHP will also be compliant with major accreditation and quality oversight organizations such as NCQA, HRSA, and RRC. We are dedicated to the highest standards of integrity and conducting business in an ethical and legal manner. Based on our partner organizations' collective experience, we approach compliance from an integrated perspective and seek to integrate that experience into an all-encompassing Compliance Program. We will adopt a Compliance Program to encourage collaborative participation at all levels and to stimulate a culture of compliance. The Compliance Program and Code of Conduct will be tailored and implemented to meet and exceed the Seven Elements of a comprehensive Compliance Program as defined by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS OIG).

The Compliance Program provides foundational oversight of the multitude of requirements by which our organization must abide. NHP will conduct an annual risk assessment to determine the areas that will require compliance attention as an organization. Risk areas are typically evident in audits, performance measurements, patient and partner feedback, and events from the prior year where deficiencies are identified for correction. The goal is to address areas of concern to mitigate and reduce risk factors. Based on our annual risk assessment, we will develop a Compliance Plan to document the Compliance Program and guide our efforts. The Program Officer and Compliance Officer will approve and submit the Plan to the Department of Health Care Policy and Financing (the Department) 30 days after the effective date. The Compliance Program and Plan will be reviewed and updated at least annually; the updated Plan will be submitted to the Department for review by July 31 of each year.

The program structure for the Regional Accountable Entity (RAE) will incorporate all necessary requirements as we move into establishing the RAE operations. This includes ACC Program rules, as well as the Deficit Reduction Act, False Claims Act, Criminal Penalties for Acts Involving Federal Health Care Programs Act. Our Compliance Department also has easy to read reference charts for protected health information (PHI), which includes HIV/AIDS, substance use disorder, and state privacy laws.

NHP'S COMPLIANCE PROGRAM

Our Compliance Program, as described in the Compliance Plan, is defined by HHS OIG and comprises the following seven elements:

1. Written Standards of Conduct and Policies and Procedures
2. Compliance Oversight
3. Education and Training
4. Developing Effective Lines of Communication
5. Conducting Internal Monitoring and Auditing
6. Enforcement
7. Response and Prevention

In the paragraphs on the following page, we detail each element of our Compliance Program.

1. Written Standards of Conduct and Policies and Procedures

NHP will develop written policies and procedures based on established policies and procedures of our partner organizations. These policies and procedures will ensure that all officers, directors, managers and personnel know and understand what is required to ensure that NHP observes and maintains high standards of ethical conduct in its business and operational practices. Policies and procedures will be accessible to staff as they provide guidance on key clinical and operational processes as well as compliance related topics that impact daily management of Members during service delivery. We will submit copies of policies and procedures to the Department within five business days of the request.

An important component of the Compliance Program is a Code of Conduct, which sets out basic principles which all personnel must follow. This Code of Conduct applies to all business operations and personnel. Non-personnel representatives of NHP, such as external advisors and consultants, will be directed to conduct themselves in a manner consistent with this Code of Conduct when they are acting on behalf of NHP.

The Compliance Program and this Code of Conduct are not intended to and shall not be deemed or construed to provide any rights, contractual or otherwise, to any personnel or any third parties. This Code of Conduct is not intended to conflict with any employment policy contained in the Employee Handbook which applies to all employees of the organization. This Code of Conduct and the Compliance Program does not alter in any way the employment-at-will status of all employees of the organization.

The Code of Conduct explains our commitment to ethical standards and sets expectations for all employees in achieving and maintaining these standards. Employees are trained on the Code of Conduct upon hire and, at a minimum annually thereafter. Training includes review of the Code and the Compliance Program; various compliance related case studies, and the opportunity for clarification and questions. At the conclusion of training, employees are required to attest that they have read and understand the Code, agree to abide by its principles, and report any suspected or possible violations. The Code of Conduct may be updated periodically and establishes the ethical standards employees must uphold in critical areas and aspects of the Company's operations. The scope of our Code of Conduct includes, but is not limited to, the following:

- Information privacy, confidentiality, and security
- Conflicts of interest
- Detection, correction and prevention of noncompliance and fraud, waste, and abuse
- Timely and accurate reporting
- Open communication and non-retaliation
- Ethical and accountable behavior
- Continuous quality improvement

NHP maintains and enforces policies and procedures that define and support the compliance program and address, at minimum, in the following areas:

- Reporting potential incidents of non-compliance or fraud, waste, and abuse
- Protecting the confidentiality of Member identifiable health information
- Providing security for access to and transmission of protected health information
- Compliance risk assessment and mitigation
- Compliance training for employees, contractors and volunteers
- Conflict of interest
- Screening for exclusion or suspension from federal programs
- Anonymous compliance reporting

We review and update policies annually or as needed off-cycle, in order to ensure compliance with applicable federal, state and local laws and regulations.

Distribution of our policies and Code of Conduct to employees begins upon hire, through orientation and a mandatory training program. The mandatory training program must be completed within the first 90 days and annually thereafter.

We have provided an example of a current Code of Conduct policies and procedures from NHP's partnering organization North Range as **Attachment 10**, and, as needed, we will develop new or revise existing policies in response to audit findings or new or revised federal and state regulations.

2. Compliance Oversight

NHP will maintain oversight of the Compliance Program through multiple levels of the organization including designation of a Compliance Officer responsible for administering the Compliance Program in conjunction with other key Executive staff, a Compliance Committee to serve as the primary oversight body for tracking and trending compliance indicators, and Network Management as the immediate resource for compliance issues and follow through at the network level. This multi-leveled approach to overseeing compliance in our system is effective and achieves individual as well as systemic levels of impact.

Compliance Officer - NHP will have a designated Compliance Officer to serve as the coordinator of all compliance activities who will be accountable to our Program Officer. The Compliance Officer will have direct access to the Board of Directors and to Executive Leadership as needed to report any findings. The Compliance Officer will oversee day-to-day activities related to the Compliance Program and will guide development of the Compliance Plan and policies and procedures.

The Compliance Officer has unfettered access to the NHP Program Officer and Board of Directors. Additionally, the Compliance Officer will be available to assist partner organizations with state or contract specific compliance needs. The Compliance Officer has a direct line of communication to the Corporate Compliance Department. This enables the Officer to learn about best practices and current fraud trends from across the country. The Compliance Officer will be responsible for developing and implementing compliance policies, procedures, and practices that assure compliance with contractual requirements.

The Compliance Officer functions independently and objectively and has several responsibilities, including, but not limited to:

- Establishing and maintaining all necessary policies and procedures to support the Compliance program
- Creating a compliance plan
- Overseeing the day to day functions of the Compliance Department
- Reporting findings to the Program Director and Board

The Compliance Officer's primary responsibilities will include:

- Creating, overseeing and monitoring the implementation of the compliance program
- Creating a compliance plan
- Establishing and maintaining all necessary policies and procedures to support the Compliance program
- Overseeing the day-to-day functions of the Compliance Department

- Reporting on a regular basis to NHP's Quality Committee, Executive Leadership, and Governing Board as needed and assisting these governing authorities to establish methods to improve NHP's efficiency and quality of services, and to reduce NHP's vulnerability to fraud, abuse, and waste
- Periodically revising the program in light of changes in the needs of the organization, and in the law and policies and procedures of government and private payer health plans
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and Colorado standards
- Ensuring that independent contractors and agents who furnish services to NHP are aware of the requirements of NHP's Compliance Program with respect to coding, billing, and marketing, among other items
- Coordinating personnel issues with NHP Human Resources Department and Credentialing Office to ensure compliance requirements in these arenas are being met
- Coordinating with the NHP's Program Managers and Supervisors regarding internal compliance reviews and monitoring activities
- Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all departments, providers, related facilities, agents and, if appropriate, independent contractors
- Developing a culture that encourages personnel to report suspected fraud and other improprieties without fear of retaliation

The Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities, including, but not limited to Member records, billing records, and records concerning the marketing efforts of NHP and NHP arrangements with other parties, including employees, professionals on staff, independent contractors, suppliers, agents, and physicians. The Compliance Officer can review contracts and obligations, seeking the advice of legal counsel where appropriate, that may contain referral and payment issues that could violate the anti-kickback statute, as well as the physician self-referral prohibition and other legal or regulatory requirements.

Compliance Committee - NHP will establish a multi-level Compliance Committee structure. The NHP Board of Directors is responsible for appropriately resourcing and directing the Compliance Program, Regulatory Compliance Committee activities, and overall program compliance with contract and regulatory requirements. The Compliance Committee consists of Executive level management, including the Executive Program Director and Compliance staff from the Regional Care Collaborative Organization (RCCO) and BHO. In order to capitalize on the knowledge from each organization, RCCO and the BHO will maintain separate Compliance Workgroups with leadership for their respective organizations. The COC will review the minutes and activities and performance of the workgroups to ensure consistent implementation of an effective compliance program throughout the partnership.

The Compliance Committee will report directly to the RAE Board; a Compliance Plan will document the program and guide our efforts. The Executive Program Officer and Compliance Officer will approve and submit the Plan to the Department 30 days after the effective date. The Compliance Program and Plan will be reviewed and updated at least annually; the updated Plan will be submitted to the Department for review by July 31 of each year.

The COC's functions related to the Compliance Program will include:

- Analyzing the organization's requirements with which it must comply and specific risk areas;

- Assessing existing policies and procedures that address specific risk areas for possible incorporation into the Compliance Program;
- Working with appropriate NHP departments to develop standards of conduct and policies and procedures to promote the Compliance Program and the Code of Conduct;
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations;
- Determining the appropriate strategy to promoting adherence to the Compliance Program and the detection and reporting of potential violations; and
- Addressing other functions where compliance impacts operating structure and daily routine of NHP's service delivery.

Network Management - Network Management provides an avenue for compliance actions led by the Compliance Officer as it relates to the provider network. Actions may include provider education regarding the Compliance Program, provider reporting of potential compliance issues, and interventions to respond to compliance related issues with providers.

3. Education and Training

Our training program supports compliance awareness and understanding across all levels of the company. It provides training on our mission, business, and individual job functions. We require all employees to complete specified new hire and annual trainings as a condition of employment. Topics include, at minimum:

- Our Code of Conduct
- Confidentiality policies
- Fraud, waste, and abuse
- Federal and state laws
- Our compliance programs
- Confidentiality policies

In addition, how to report potential non-compliance and fraud, waste, and abuse issues and whom to contact with compliance or policy and procedure questions is also provided.

Training is delivered via an eLearning platform that enables us to produce evidence of training when requested. The Compliance Officer will also be available to create and deliver location and department specific compliance, contractual and program integrity training not only to our staff, but also to the provider network. Providers will receive training on general compliance requirements and fraud, waste and abuse activities, including, but not limited to, how to successfully conduct and comply with an audit, the seven primary elements of an effective compliance program and the need to have a compliance plan.

NHP staff, including Members of the Board of Directors, who are involved with the administration or delivery of the ACC Program, complete the following training within 30 days of the beginning date of employment:

- Embracing a Culture of Compliance
- Compliance Laws, including State-specific training on fraud, waste, and abuse laws and whistleblower protections
- Fraud, waste, and abuse
- HIPAA Privacy and Security
- The Code of Conduct
- Conflict of Interest and Confidentiality, Privacy and Security policy requirements

Staff are required to complete annual training that includes False Claims Act training, which highlights state and federal requirements; the Deficit Reduction Act, the Fraud Enforcement and

Recovery Act, the federal Anti-Kickback Statute; and the Stark law. Through this annual training program, staff is educated on the False Claims Act and its pertinence to fraud and abuse in Medicaid programs. Staff is alerted to specific provisions for whistleblower protections and are provided with resources to help them remain compliant with federal and state False Claims Act laws.

4. Developing Effective Lines of Communication

Effective lines of communication between employees and the Compliance Officer will be in place and incorporated into employee training. Written policies and procedures are available to all employees who may want advice on certain policies and procedures, or who wish to report actual or suspected violations of law or the Code. A system designated for routine internal monitoring and auditing for compliance risks will be available. The Compliance Officer interacts regularly with functional areas in order to conduct investigations, monitor and support business operations and respond to inquiries. Reports of potential non-compliance, suspected fraud, waste or abuse, privacy incidents or general compliance concerns come into the Compliance Officer through several avenues including, emails to the compliance inboxes and in-person conversation with compliance staff.

All staff is encouraged to ask questions and report any problems or concerns about the organization or our operations. NHP maintains a Compliance and Ethics Hotline and other procedures to foster an open atmosphere for employees, providers and Members to report issues and concerns, anonymously. We contract with a third party for reporting compliance concerns via mail, online, or by telephone. The staff may also direct any questions or concerns to their supervisor, manager, operating unit executives, the Compliance Officer, or Human Resources. Concerns made by staff may require investigation to assure compliance with the requirements of the contract and applicable laws.

Effective lines of communication are also maintained between NHP, agencies, subcontractors, providers, and Members operating under the scope of this contract. Communication shall be conducted using the best and most appropriate means available, such as, direct mail, telephone, email, website and Committee meetings.

5. Conducting Internal Monitoring and Auditing

In addition to proactive reviews, NHP also maintains a Compliance and Ethics Hotline that allows employees, contractors, Members, and providers to anonymously report issues related to compliance or fraud, waste, and abuse. Hotline contact information is published in a variety of places, including external newsletters and the company website. Identified compliance risks will be investigated and addressed promptly to assure that the risk of future recurrence is reduced. The routine internal monitoring system will include:

- Processes to monitor Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing
- Processes to screen provider claims collectively and individually for potential fraud, waste, or abuse
- Processes to identify overpayments to providers including upcoding, unbundling, of services, services that were billed but not rendered, inflated billing, and other improper payments
- Processes to monitor for and promptly resolve other compliance risks identified

The purpose of internal monitoring and auditing activities is to ensure the organization is meeting expectations and the contract requirements of the RAE, and state and federal regulations. Additionally, NHP's Compliance Officer will monitor and review reports issued by the various operational and business departments of NHP to validate adherence to the Compliance Program.

Concerns reported to the Compliance Officer or through other communication sources that suggest substantial violations of compliance policies or regulations, will be documented and investigated promptly to determine their veracity. The Compliance Officer will document all reports, including the nature of any investigation and its results. As appropriate, such information will be included in reports to the Program Officer, Board of Directors, or the COC. Issues will be reported to the Department as appropriate.

6. Enforcement

Response to non-compliance must be enforced to have an effective Compliance Program. Disciplinary actions are consistent with the action regardless of a staff's position across the organization and response to non-compliance is contingent with the level of finding. Decisions about actions are a collaborative effort between compliance, legal, human resources, and supervisory staff to assure proper action occurs following incidents that impact compliance.

NHP will establish clear expectations of compliance through our Code of Conduct and Compliance Program policies and procedures. The Code of Conduct and Compliance Program policies and procedures will require staff to report issues of non-compliance; fraud, waste and abuse; and unethical behavior. Disciplinary guidelines are provided to staff in the Code of Conduct and other organization polices, including but not limited to the Disciplinary Action and Sanctions for Violating HIPAA Privacy and Security policies.

Violations may be grounds for termination or other disciplinary action, depending on the circumstances of each violation as determined by the Human Resources Department in consultation with the NHP Compliance Officer or designee.

7. Response and Prevention

It is important that NHP respond to an incident or report as a way of continual process improvement. The response will occur at the employee/supervisor level or higher depending on the incident. Investigation of reports is a necessary component of a Compliance Program should the report warrant such action. Investigations may involve human resources, legal, and/or the Compliance Officer based on the incident to ensure a thorough assessment of the incident and potential follow up.

Investigation findings are reviewed to assess if modifications are necessary to prevent future incidents. Modifications may include revisions to policies and procedures, staffing adjustments, or implementation of new/modified audits or protocols.

At the end of the fiscal year, the Compliance Plan is reviewed and a report completed regarding successes and opportunities. Compliance indicators are continually assessed and updated to ensure current relevance. Policies with compliance components are updated as standards change.

If an investigation identifies fraud, waste, or abuse, misconduct, violation of applicable laws or regulations, or noncompliance with ACC Program requirements, NHP will take prompt appropriate action, including but not limited to, the following:

- For staff, when warranting an investigation, the Compliance Officer consults with the Human Resources department to determine appropriate action in accordance with the Code of Conduct and other applicable policies and procedures
- For providers, corrective action plans may be required based on investigative findings designed to correct underlying problems that resulted in program violations and prevent future program violations or misconduct. Depending on the circumstances, corrective action plans may involve repayment of overpayments, disciplinary action or other remediation in response to the violation.

Each corrective action plan is tailored to address issues identified in the investigation, provide structure and timeframes for completion, and is monitored and tracked by to ensure that the improvement is fully implemented in a timely manner

- Training and education to prevent recurrence of program violations or misconduct may be provided as needed to staff or providers
- The Compliance Officer and affected business areas will monitor and audit to ensure effective resolution of issues identified during an investigation
- Voluntary self-reporting and referrals to law enforcement, governmental authorities and/or the County will be enforced, as appropriate. NHP will report instances of potential fraud, waste or abuse, misconduct and/or noncompliance related to the Department as applicable

INSPECTION AND AUDITS

As the RAE, NHP agrees to allow the Department, CMS, the U.S. Department of Inspector General, the Comptroller General, and their designees to inspect and audit any NHP records or documents, or those of our subcontractors, if applicable. We agree to allow inspectors and/or auditors to inspect the premises, physical facilities, and equipment where Medicaid-related activities and/or work is conducted at any time. This will include Department staff access to our claims system and data for audit program integrity activities. In addition, the entities listed above will retain inspection and audit privileges for 10 years from the final dates of the contract period or from the date of completion of any audit, whichever is later.

Further, we agree to allow CMS or its agent or designated contractor and the Department or its agent to conduct unannounced, on-site inspections for any reason. If right of access is requested, we will make staff available to assist in an audit or inspection, and provide adequate on-site spaces to reasonably accommodate the Department, state, federal contractors, or their designees' personnel conducting all audits, site reviews, or inspections. NHP also agrees to allow Department staff access to our claims system and claims data for program integrity activities.

We agree, in consultation with the Department, to participate in compliance monitoring activities and respond to any Department or designee request for information related to compliance monitoring, including Encounter Data analysis and Encounter Data validation, and other information or analyses needed for compliance monitoring. We will submit copies of existing policies and procedures to the Department with five business days of request. NHP staff will have previous experience in the preparation and timely submission of compliance monitoring documentation preparation, on-site visits, and other monitoring activities. NHP will also submit copies of existing policies and procedures to the Department within five business days of request.

Exclusion Screening

It is NHP's policy not to employ, contract, or conduct business with individuals or entities listed by a federal agency or state law enforcement, regulatory or licensing agency as excluded, suspended, debarred, or otherwise ineligible to participate in federally funded health care programs, or who have been identified as potential terrorists or having connections with terrorists. To do this, we will screen employees, the Board of Directors, vendors and providers against state and federal lists such as:

- The General Services Administration (GSA) System for Award Management (SAM) list
- HHS OIG List of Excluded Individuals and Entities (LEIE) for Medicare/Medicaid sanctions
- The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons List (SDN) for individuals and/or entities involved with terrorists and/or terrorist activities
- State exclusion lists

Our Human Resources Department also screens all individuals with an ownership or controlling interest of five percent or more on a monthly basis. Provider Network Operations screens all individual providers, clinicians within a group practice and any owner of more than five percent of any participating provider during credentialing and re-credentialing and monthly thereafter or consistent with the reporting entity's publishing cycle if the publishing cycle is greater than monthly. If we discover an employee or provider on any of the exclusion lists, we will notify the Department within five business days of discovery.

This information will be disclosed by NHP at the time of executing the RAE contract with the Department, at contract renewal or extension, and within 35 calendar days of either a change of ownership or written request by the Department.

FRAUD, WASTE, AND ABUSE

NHP Compliance Plan described above will articulate our Compliance Program designed to detect and prevent fraud, waste and abuse. The experience of our organizational partners will be leveraged for the NHP Compliance Program, including methods to identify potential fraud, waste and abuse. These methods include:

- Member or family member reports of services billed but not provided
- Claims review using algorithms designed to detect unusual billing practices
- Medical record audits
- Claim and encounter data validation processes
- Provider or other agency reports
- Quality of care evaluations

NHP supports good stewardship of state funds and promotes efforts to educate staff and providers on appropriate practices to avoid fraud, waste and abuse. Our fraud, waste and abuse efforts consist of four major functions: prevention, audit and detection, investigation, and resolution. Effective prevention efforts are built on provider education, training, communication, monitoring, and industry partnerships. Specific examples of prevention mechanisms include:

- **Provider Communication:** Providers can find information relating to their roles and responsibilities in ensuring compliant practices in their Provider Handbook. Additionally, information in the handbook informs the provider of the reason and nature of audits we've done and how an audit is triggered.
- **Training and Education:** Annually, we conduct training programs focused on detecting consumer, provider, and facility fraud, or abuse cases. This training is provided to NHP staff, including quality management, provider relations, credentialing, compliance, utilization, and clinical management staff. As part of its Provider Monitoring Program, these staff members monitor providers through a variety of measures, including chart audits, service calls, claims analyses, clinical reviews, and care authorizations. Our training programs detail current federal and state regulations concerning NHP's obligation to actively work to identify and stop fraudulent activity and educate stakeholders. Our training program also includes examples of simple claims billing errors that may trigger a fraud investigation and provides an overview of the False Claims Act and other applicable laws, fraud reporting and referral processes, and whistleblower protection. Identified cases of potential fraud or abuse are reported to our Compliance Officer, as described in the section on reporting fraud, below. Additionally, all NHP employees receive CMS-compliant anti-fraud training when first hired and annually thereafter, while information is available on our website for Members regarding identifying and reporting suspicious activities. All training is documented and verifiable.
- **Provider Profiling and Credentialing:** NHP requires all providers to register with appropriate types and categories of service, and to be credentialed prior to contracting. As part of our

credentialing process, we screen providers through databases such as the Federal LEIE and GSA Debarment List to ensure that they are not sanctioned or excluded from participation in federal programs.

- **Fraud and Abuse Hotline:** NHP disseminates our toll-free Compliance and Ethics Hotline number through Member materials and Provider Handbooks to give Members and others a confidential means for reporting fraud and other issues.
- **Claim and Encounter Edits:** Our system has edits in place that automatically deny claims for reasons such as duplicates, unknown service, unknown or ineligible Member, and ineligible providers. Knowledge revealed (e.g., emerging patterns) by data validation audits and trend analyses are used to design new rules/edits to prevent improper payments.

Audit and Detection Mechanisms used by NHP to identify suspicious provider activity include:

- Member or family Member reports of services billed but not provided
- Claims review using algorithms designed to detect unusual billing practices
- Medical Record audits
- Claim and encounter data validation processes
- Provider or other agency reports
- Quality of Care evaluations
- Program Integrity audits and investigations
- Fraud and abuse hotline
- Annual verification of services mailing to Members

We will implement a systematic medical record review process for conducting audits on a regular basis. Auditing procedures were refined over several years and have proven useful and effective in improving documentation according to feedback received from providers. This process will include clinical oversight from the Medical Director.

The medical record review process includes education, corrective actions, recoupment of funds for unsubstantiated services and reporting for potential fraud when repeated patterns of improper billing are identified.

Our process will begin with education up front. During new provider on-boarding, each provider is required to review material about documentation requirements and encouraged to ask questions. Documentation requirements are also available in the Provider Handbook. During a provider’s first year in the network, a medical record audit is typically completed.

NHP will conduct several types of medical record audits over the course of the contract. At times, focused audits are completed. These audits may be associated with performance measures, quality initiatives, service types, grievances, quality of care, and/or validation of services or content. Examples of types of audits that may be conducted include:

- Medical record content documentation for mental health and substance use disorders
- Quality of Care
- Evaluation and Management Codes
- Coordination of Care
- Inpatient and Residential Treatment
- Encounter/Claims Validation Quality Review (411 Audit)
- Risk Assessment and Evaluation

Non-medical record audits include:

- Contract Compliance
- Enhanced Primary Care Medical Provider (PCMP) Standards
- Performance Measures
- ADA Disability Assessment

Medical Record Audit Procedures

Selection

Providers may be selected randomly for routine audits or may be audited for a variety of other reasons, such as grievances, quality of care concerns, retrospective claims review, and requests by the Department. Providers selected for audit will be asked to provide a record for each Member chosen. For routine outpatient audits, the selection pool consists of Members who had three or more services from the provider. Claims review will be done at the same time as the medical record audit on at least four claims for each record. Providers will be re-audited when six months have passed after a previous failed audit.

Audit Procedures

Providers who submit records to us have three weeks from the date of the request letter to submit their materials. A two-week extension may be granted on request for special circumstances. Beacon's audit staff will complete the medical record audit and claims review within 30 days after receiving the charts. Claims reviews that were done along with chart audits will be submitted to the Compliance Officer for review and action, if necessary. Such decisions will be made according to compliance policy. Providers will receive a letter stating the audit results and a copy of each audit form completed. The letter will contain recommendations for improvement, as needed, and a time line for future audit. Sample forms for provider use or tip sheets for complying with problem areas may also be included. Contact information is included and the provider is invited to call the auditor with questions regarding the audit results.

Scoring

There may be items at the beginning of the audit that are monitored but not scored. These are typically new audit items. Each audit comprises five scored sections, and each section is scored separately. In the case of a claims audit, a claims audit consists of 14 question for each claims. A passing score is 80 percent in each of the audit tool section; there is no aggregate score.

Re-audit Procedures

Providers who have a score of 80 percent or better in each section of the audit will "pass" the audit and no further action will be taken. The provider will be placed back in the pool for random selection for their next audit in two years. Providers who score between 60 and 80 percent on one or more sections of the audit will "fail" the audit and receive education and recommendations for improvement. They will be re-audited in six months. If the provider receives failing scores at the second audit, they will be asked to submit a Corrective Action Plan and will be re-audited again in six months.

Providers who score below 60 percent will "fail" the audit and be asked to submit a Corrective Action Plan for the relevant items within three weeks of receiving their results. Provider who fall into this category will also be re-audited in six months. Providers who do not improve significantly after a Corrective Action Plan will be referred to the Quality of Care Committee for quality concerns.
In cases where the documentation does not substantiate the service billed, a recoupment is initiated and education is provided. A follow up audit is scheduled within six months. In the process of auditing, the auditor may encounter information that appears potentially fraudulent. In those instances, auditors are trained to report the potential fraud to the Compliance Officer for further

action. Continued instances of audit results indicating the documentation does not support the service billed will result in a program integrity referral to the Compliance Officer.

Provider Education and Training

We will offer documentation training to providers to support and assist them in meeting documentation requirements. Education is offered several times each year; topics may vary by treatment type. Round table discussions are also offered on specific topics and discussion may include documentation and other procedural and compliance-related questions. These sessions are always available by webinar for those providers who are unable to attend in person. NHP also presents documentation training in-person open to all providers and available by webinar at least semi-annually.

Another method we will use to communicate compliance expectations to providers is via email. Tip sheets for medical record documentation, Member engagement and other topics are brief and structured so providers can keep the information at hand. Emails are also sent to notify and remind providers of events and procedural, contractual, or regulatory changes.

QUALITY IMPROVEMENT INSPECTION, MONITORING, AND SITE REVIEWS

NHP agrees to make staff available to assist in any audit or inspection under the RAE contract. We agree to fully comply with all requirements regarding site reviews conducted by the Department or its designee at ours or our providers' locations. We agree to:

- Allow the Department or its designee to conduct site reviews at least annually, or more frequently as determined by the Department
- Cooperate with Department site review activities to monitor NHP's performance
- Allow the Department or the State to inspect and review our operations for potential risks to the state of Colorado operations or data
- Allow the Department or its designee to conduct an emergency or unannounced review for instances including but not limited to Member safety, quality of care, potential fraud, or financial viability
- Fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department
- Participate in the preview of the monitoring instrument to be used as part of the assessment for a routine site review
- Submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's desk audit prior to the site review
- Make available to the Department and/or designee and its agents for site review all records and documents related to the RAE contract, either on a scheduled basis or immediately on an emergency or unannounced basis

We understand that site reviews may include a sample of our network providers to ensure that providers have been educated and monitored by NHP about the requirements under the RAE contract. In the event that the site reviewers wish to inspect a provider location, we will ensure that providers make staff available to assist in the audit or inspection effort, and that providers make adequate space on the premises to reasonably accommodate the Department, state, or federal personnel conducting the site visit.

Various system checks, described below, are built into our claims and encounter processing systems to detect errors, inaccuracies and overpayment, and prevent upcoding, unbundling of services, services billed but never rendered, inflated charges for services, miscoding or other improper payments.

Claims

Part of the adjudication process of paying a claim through our system involves matching incoming claims to existing service authorizations. If a claim does not have a matching service authorization, the claim is not paid.

Encounters

Upon receipt of monthly encounter data files, checks are performed on all encounter data received before being reported to the State. Specially developed software programming is used to perform these checks. Among the errors that could trigger the identification of questionable service coding or inaccurate CPT billings are:

- Place of service is not provided or is invalid
- Procedure code supplied by provider does not match the one derived by the RAE
- Number of units is not provided
- Duration is invalid or not provided
- Invalid core service code
- Invalid program code
- Number of units does not match that calculated by the RAE
- Procedure code is not on State-approved list
- Number of units is not numeric
- Start time is invalid or not provided
- Provider credential is invalid or not provided
- Invalid modality code
- Procedure code is not provided
- Procedure code is not on state approved list for service date

The types of errors are then compiled into a report and returned to the provider submitting the file for resolution. A monthly data report card is then produced to show the overall health of our encounter submission for the month. A summary of this report is presented to the NHP Board monthly to ensure the required corrections and follow-ups are completed.

Encounter Data

Having performed the encounter data certification process many times under the previous BHO contract, our administrative agent, Beacon is very familiar with the importance of attestation of accuracy and completeness of the data delivered to the Department. Incoming claims and encounters are subjected to more than 80 different edits to test for completion and accuracy, including several specific checks for eligibility. A data report card process has been in use since 2006, and it will be used by NHP to provide positive feedback to submitters of encounter data about the quality of their data submissions and where opportunities may exist for improvement. Data certification will include certification that data submitted are accurate, complete, and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members. Prior to the monthly submission of encounter data to the Department, the raw data is reviewed by our Health IT Director for completeness and accuracy and compared to previous submissions' totals as a reality check. Once the encounters are submitted to the Department and no questions are raised, the letter of certification is then sent.

Data quality submitted by our staff through the BHO contract was monitored through the use of a monthly data report card, which Health Services Advisory Group (HSAG) described as a "best practice".

Beacon has extensive experience submitting Encounter Claims Data electronically, consistent with the Health First Colorado Program policy rules and the Medical Assistance Manual of the Department. They typically submit multiple encounter data files to the Department every month, in the ANSI ASC X12N 837 format. We have a robust Electronic Data Interchange (EDI) system and proven experience in working with the ANSI ASC X12N standards. Since 2009 we have reported over 5.8 million services to Medicaid Members, averaging about 645,382 unique services per year. Our EDI system successfully completed the X12

migration from version 4010 to 5010 in 2011. In October 2015 our EDI system successfully completed the migration from ICD-9 to ICD-10. NHP participates in monthly meetings with the Department to discuss encounter data submission quality, as well as to help prepare for the future of these data submission standards in an integrated environment. NHP represents the partners and providers during the meetings with the Department.

NHP makes full use of the enrollment reports provided by the Department to identify and confirm Membership and as a basis for payments, adjustments, and reconciliation of claims and encounters. We use these files to drive almost all of its system processing, including, but not limited to, authorizations, claims payments, Member mailings, recoupment/payment recovery activities, quality improvement, provider contracting, financial planning, reporting, and auditing. Data provided by the Department has been key in our ability to provide care and monitor performance. By using the data extensively in everything that we do, we have been able to provide clarity and confidence of decision-making to the State, providers and Members.

Member Services Verification

NHP conducts a Member services verification process as a key component of its efforts to detect and deter fraud, waste, and abuse. This plan is designed to validate Member service delivery and ensure Members are receiving the services for which billing occurred. The plan involves randomly selecting a sample of paid claims/encounters on an annual basis and sending Members written correspondence that requests the Members identify if the services did not occur as billed. We investigate every response received and potential outcomes include:

- Requesting progress note documentation from the billing provider to ensure the service was documented and billed appropriately
- Following up with the Member to discuss the service in more detail
- Recouping claims/encounters that were billed incorrectly
- Expanding to a Program Integrity audit to determine if other services billed by the provider are affected
- If fraud is suspected, reporting to the Department within the timeframes specified in the Medicaid contract and to the Medicaid Fraud Control Unit (MFCU) as directed

Data related to the Member services verification process is maintained and reported as needed, including notices sent, responses received, follow-up actions taken, whether fraud was suspected and when it was reported to the Department, and overpayments recovered.

Investigation

On behalf of NHP, Beacon conducts alleged fraud and/or abuse investigations of providers. Beacon maintains a Compliance Department staffed with Certified Fraud Examiners, Certified Internal Auditors, Certified Professional Coders, Accredited Healthcare Fraud Investigators, and licensed clinical staff.

NHP, in compliance with the Office of Inspector General (Medicaid and Medicare), Insurance Fraud Bureau (Commercial), and Office of Personnel Management (Federal Employee Health Benefits Programs), has put in place a fraud and abuse program designed to meet regulatory requirements and protect health plan Members, providers, and staff. Beacon's Program Integrity Department is dedicated to detecting, investigating, and preventing all forms of suspicious activities related to possible health insurance fraud and abuse. This includes any reasonable belief that insurance fraud will be, is being, or has been committed. The online interactive Fraud and Abuse training fulfills our responsibilities defined under the Deficit Reduction Act to provide training for all NHP staff about the Federal False Claims Act, the rights of employees to be protected as whistleblowers, and our policies and procedures for detecting, reporting, and preventing fraud, waste, and abuse.

Responsibilities of the Compliance Department include:

- Examining and identifying billing trends through a set of “data mining” tools that include regular reports for (internal use only) examining:
    - High volume of sessions
    - High volume of dollars paid
    - Family groupings of sessions
    - High volumes of unduplicated Members reports (high quantity of Members)
    - Duplicate claims submission
    - Matching surnames (providers and Members with matching surnames)
- Following up on all referrals from all sources to determine if fraud and/or abuse is occurring
- Coordinating the education of providers, staff, and enrollees about the incidence and types of health care fraud
- Generating fraud guidelines for handling claims when fraud issues are involved
- Requesting from the managed health care system special handling flags for those providers suspected of aberrant activities and reviewing the reports generated from these flags
- Proposing to senior management ongoing revisions of policies and procedures in claims payment and case management practices resulting from fraud investigations
- Maintaining documentation on all cases referred for investigation
- Coordinating with state fraud agencies on investigations and findings, as directed
- Performing all preliminary background investigation of claims history and previous interactions with suspected aberrant providers
- Creating and maintaining a central reporting database on all providers under investigation to generate to the Department’s fraud unit
- Acting as a resource to provider relations in procedures of disenrollment of participating providers
- Being prepared to testify at any hearings or trials resulting from fraud investigations
- Recovering improper payments made on fraudulent or abusive claims, when approved by the Department
- Coordinating with NHP staff to suspend provider payments, when requested by, or in consultation with, the Department
- Participating in joint meetings held by the Department and the MFCU
- Providing reports on Fraud, Waste, and Abuse activities per contractual requirements and when requested by the Department

Reporting Fraud

Potential occurrences of fraud or abuse are reported to the NHP Compliance Officer, who conducts an initial investigation of such reports, involving other staff as necessary. If the findings of the initial investigation support potential fraud or abuse, notification of the potential fraud or abuse is made to the Department within the timeframes specified in the Medicaid contract and to the MFCU as directed. Referrals include cases that involve potential fraud or abuse by employees, practitioners, Members or family members, community mental health center partners, or other organizations or facilities involved in the provision of mental health services to Members. We will work collaboratively with the Department and MFCU to conduct or assist in investigations and to make available all documentation and records pertaining to the fraud investigations upon request. Upon completion of an investigation, the following steps may be taken in collaboration with the Department and MFCU:

- Reversal of claims/resubmission of encounters
- Recovery of overpayments
- Recommendation of a corrective action plan
- National Credentialing Committee review for credentialing issues, or possible disenrollment and suspension of referrals

- Provider education
- State agency notification
- Initiating a provider and/or Member flag for monitoring claims/encounter activities

NHP's partners have a track record of reporting potential fraud to the State in accordance with the requirements of our contract. Through investigative efforts, funds were recouped based on inappropriate billing and documentation practices and corrective actions and monitoring were put in place to ensure accurate billing and documentation in the future.

The Compliance Officer will attend and participate in joint meetings held by the Department and MFCU to discuss issues related to fraud, abuse, and misuse of Medicaid funds and resources.

NHP will submit a fraud, waste, and abuse report to the Department every six months and annually that contains the following information:

- All audits or reviews which have been started, are on-going or completed in the previous six months (or annually)
- All instances of suspected fraud discovered and reported to the Department during the past six months (or annually)
- The number of notices sent to Members to verify and report whether services billed by providers were actually received by Members

Monitoring Members for Improper Prescriptions for Controlled Substances, Inappropriate Emergency Care, or Card-Sharing

NHP will deploy the Prescription Drug Interaction Program (PDIP) to identify the use of improper prescriptions or prescribing patterns. The program combines expertise in psychiatry, psychopharmacology, and analytics to identify medication-related concerns and address problems through evidence-based interventions, at the individual and provider levels. The use of PDIP will allow NHP to obtain regular reports detailing controlled substance prescribing and dispensing that include Member, as well as prescriber detail. We will use these reports to initiate follow-up with the State and appropriate authorities.

Corrective Action Plans

NHP agrees to respond to the Department for any required actions with a corrective action plan that will be submitted to the Department for approval within 30 calendar days of the final report, specifying the action to be taken to remedy the deficiencies and time frames. We agree to make all changes to the plan as required by the Department and resubmit the plan for the Department's approval. Once approved by the Department, we also agree to implement the plan and continue progress until we are found to be in compliance by the Department. In addition, we agree to ensure that Covered Services are provided to Members during corrective action periods that affect the provision of covered services to Members.

PROHIBITIONS

NHP will comply with the requirements defined in Section 5.15.7 of the RFP. We will educate our Network Providers and monitor for adherence to requirements for Network Provider participation in the Accountable Care Collaboration Program including the following:

- Provider identification of provider-preventable conditions
- Enrollment with the state as a Medicaid Provider
- No payment will be made to an entity or individual who has been excluded from participation in federal health care programs

- Prohibited affiliations regarding any entity of individual who has been debarred, suspended or otherwise excluded from participation in procurement activities or non-procurement activities in accordance with applicable federal or state regulations
- We will create and submit a Provider Preventable Conditions Report to the Department annually, and by July 31 of each year.

Further, we understand that the Department will not make any payments to NHP should any of our ownership partners be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual, or an entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services and are debarred, suspended, or excluded from participation from federal health care programs, or have a prohibited affiliation as delineated in *Section 5.15.7.4* of this RFP. We will provide written disclose to the Department for any prohibited relationship with a person or entity within five days of discovery.

Network Providers not meeting these requirements will not be eligible for payment for the delivery of services. Upon discovery, we will report to the Department and the HHS Secretary, as applicable, any non-compliance issues with these requirements.

SCREENING OF EMPLOYEES AND CONTRACTORS

NHP routinely performs initial and monthly exclusion checks of our staff and network providers. Prior to hire or contracting, we screen staff to ensure they are not debarred, suspended, or otherwise excluded from participation in federal health programs by checking against Officer of Personnel Management (OPM), the Office of Inspector General's (OIG) List of Excluded Individuals (LEIE). Staff are then screened monthly throughout the duration of their tenure. Likewise, during initial credentialing, we screen all potential network providers against the above databases, and will not accept any provider into the network that is excluded from participating in federal health programs. Once accepted into the network, providers are screened monthly for continued compliance.

If during the course of the contract that NHP determines that one of our staff, subcontractors, or network providers has been excluded, we will take appropriate action in accordance with federal and state statutes and regulations, and will report the discovery to the Department. This report will be delivered within five days of discovering the excluded provider.

REPORTING

NHP will return any overpayments to the Department within 60 days (or earlier upon identification). We will work collaboratively with the Department to keep each other informed of any anomalies or errors in the capitation payments, underlying data received, and cash paid by the Department. An example of our collaboration is reflected by how closely our staff worked with the Department during the new MMIS system transition.

NHP will promptly notify the Department about changes in a Member's circumstances that may affect eligibility. We will report all adverse licensure or professional reviews it has taken against any provider, according to 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the State regulatory board. We will immediately notify the Department of information that may affect a provider's eligibility to participate in the managed care program or in the ACC program as required.

NHP will immediately notify the Department upon receipt of information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the managed care program or in the Colorado Medicaid program, including a change in provider licensing, ownership or control, elimination from the provider network, or the conviction of a crime related to the provider's

involvement in any program under Medicare, Medicaid, or Title XX service program of the Social Security Act.

At times, it may be necessary to terminate an existing provider due to non-compliance with contract requirements, quality or performance issues. We will notify the Department in writing of a decision to terminate an existing network provider at least 60 calendar days prior to services being terminating, except for quality or performance issues as appropriate. For provider termination due to a quality or performance issue, we will notify the Department in writing and will submit with the notice of termination a description of our plan to provide or secure services following the termination. In such instances, we commit to submitting the notice of Network Provider Termination within two business days of the decision to terminate.

FRAUD, WASTE, AND ABUSE COMPLIANCE REPORTING

For all covered services included in the RAE contract, NHP will create and submit a Fraud, Waste, and Abuse Compliance Report every six months. This report will contain all audits/reviews from the past six months that were either started, in process, or completed, and all issues of suspected fraud discovered and reported to the Department during the past six months. Information included in this report for either audit/review or suspected fraud issues will include the provider legal name and trade name if any, NPI, and location of the provider.

For fraud, waste, and abuse audits specifically, the report will include the:

- Issue(s) being reviewed or audited
- Amount of the overpayment identified if any, and the amount recovered, if any
- Status of the review or audit
- Start and end dates of services covered by the review or audit
- Start date of the review or audit and the date of recovery, if any

For issues of suspected fraud, waste, and abuse audits specifically, the report will include the:

- Suspected fraud issue
- Start and end dates of the services suspected to involve fraud
- Approximate amount of the claims affected
- Date of fraud report to the Department

The report will also include the number of notices sent to Members to verify and report whether services billed by providers were actually received by the Member; the number of responses received; number of responses warranting further action; whether a review or audit was conducted or fraud report was made regarding responses warranting further action; and the amount of overpayments recovered.

The Fraud, Waste, and Abuse Compliance Report will be submitted to the Department within 45 days of the end of the reporting period, with an annual summary report for the past year that includes all the information of the semi-annual report by July 31.

ADMINISTRATIVE REPORTING

NHP is very familiar and has in-depth understanding of the administrative and financial data that underlies the Administrative Report. Our accounting systems can readily provide the data covering the requested period to meet the 10-day turnaround timeframe for this deliverable. We understand that the Department may change or terminate any fixed submission schedule it creates by notifying NHP in writing of the change or termination.

NHP's Administrative Report will contain all information regarding our staffing, expenses, and revenues relating to the scope of work under the RAE contract as directed by the Department for the period that the report covers. The report will include, but is not limited to:

- Number of FTEs per position category, as determined by the Department, and total salary expenditure for that position category
- Operating expenses broken out by category, as determined by the Department
- Number of staff that were newly hired/terminated and number of vacant positions, broken out by position category as determined by the Department
- Administrative revenues, such as payments by debt and interest revenues, broken out by source as directed by the Department
- Administrative expenditures, such as payments to subcontractors, if any, and providers, broken out by source as directed by the Department
- Remaining cash-on-hand at the end of the period

FINANCIAL REPORTING

NHP is very familiar and has in-depth understanding of the financial data that underlies financial reporting. Our accounting systems can readily provide the data to meet the specified turnaround times for each deliverable. We have experience and has previously submitted quarterly internal financial statements, trial balance, crosswalks, and other relevant financial data to the Department both quarterly and annually. All financial reports were submitted timely and were accepted by the Department.

As the RAE, NHP will submit financial information to the Department quarterly and annually, and attend in-person quarterly meetings to review and discuss our financial information. We will compile financial information that will include, but not be limited to:

- Quarterly internal financial statements, including balance sheet and income statement
- Quarterly trial balance listing all account numbers, descriptions, and amounts
- Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the quarterly financial report

We will submit the quarterly financial report using a template that has been mutually agreed upon by NHP and the Department. The report will contain a detailed accounting of the total revenue received from the Department during the quarter and how payments were spent, including but not limited to the amount and percentage of PMPM payments spent during the reporting period, and a breakdown of how the PMPM payments were spent to support the following work categories:

- PCMP network provider support, with a break-down of administrative payments made to PCMPs based on the payment strategy used (e.g., PMPM, other payment arrangement)
- Care coordination, with a break-down of dollars spent on contracted care coordination and provided by NHP
- Practice support to include specific information about the types of practices supported
- Administration
- Network development
- Community infrastructure and Health Neighborhood participants
- Systems support and capital infrastructure investments
- Subcontractors, if any
- Any additional categories that may be expanded

NHP will submit Quarterly Financial Information to the Department no later than 30 days from the end of the state's fiscal quarter.

Annual Financial Statement

NHP's partners have previously submitted audited financial statements to the Department on an annual basis. The audited financial statements are also provided to and required by the Colorado Division of Insurance. Audited annual financial statement will be complied by NHP and will include, but not limited to:

- Annual internal financial statements, including balance sheet and income statement
- Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP)

The audited annual financial statements will certified by an independent public accountant and NHP's Chief Financial Officer or their designee. Our audited annual financial statements will be submitted no later than six months form the end of the fiscal year to the Department in a template provided by the Department and modified as needed.

Quarterly Financial Meetings

NHP's Chief Program Officer and CFO will participate in quarterly meetings with the Department to formally present and review the quarterly financial reports submitted to the Department. The Contractor shall submit other financial reports and information as requested by the Department or its designee, and assist the Department in verifying any reported information on request. If the Department determines that there are errors or omissions in any reported information, NHP will produce an updated report that corrects all errors and includes all omitted data or information. The updated report will be submitted to the Department within 10 days from the date of request.

HEALTH INSURANCE PROVIDERS FEE REPORTING

NHP's staff have previously prepared and submitted the IRS Form 8963, both preliminary and final calculations by the IRS, and all relevant additional information to the Department by the required due date. NHP will produce and submit a Health Insurance Providers Fee Report to the Department as applicable.

In the event that NHP is subject to any Health Insurance Providers Fee under 26 C.F.R. § 57 and required to file IRS Form 8963, we will create and submit a Health Insurance Providers Fee Report to the Department that contains all of the required under *Section 5.15.13* of this RFP annually, and no later than October 1 of each year in which we filed IRS Form 8963.

DISPROPORTIONATE SHARE AND GRADUATE MEDICAL EDUCATION HOSPITAL REPORT

Our administrative agent, Beacon has previously produced and submitted this report Disproportionate Share and Graduate Medical Education Hospital Report to the Department in a timely, accurate, complete, and truthful manner. This certification will be signed by either NHP's Chief Program Officer or CFO, or their designee. We will continue to meet the requirements for this deliverable as specified by the Department and submit this report quarterly on July 31, October 31, January 31, and April 30.

MAINTENANCE OF RECORDS

NHP commits to maintaining a complete file of all records, documents, communications, notes and other materials that pertain to the operation of this Program and work and delivery of services performed under this contract sufficient to disclose the nature and extent of services/goods provided to each consumer for 10 years or longer as required according to the requirements in *Appendix B* and federal regulations.

We will maintain all records related to the work performed by Subcontractors required to ensure proper performance of that work. Records will be maintained by NHP until the last to occur of: (i) the date 3 years after the date this contract expires or is terminated, (ii) final payment under this contract is made, (iii) the resolution of any pending contract matters, or (iv) if an audit is occurring, or we have received notice that an audit is pending, the date such audit is completed and its findings have been resolved (the "Record Retention Period").

We will retain and require all subcontractors to retain enrollee Grievance and Appeal records, in accordance with 42 C.F.R. subsection 438.416, base data in accordance with42 C.F.R. subsection 438.5(c), MLR reports in accordance with 42 C.F.R. subsection 438.8 (k), and the data, information and documentation specified is 42 C.F.R. subsection 538.604, 438.606, 438.608 and 438.610 for at least ten years.

NOTICES AND DISCLOSURES

NHP will create policies and procedures for handling all of the notices and disclosures referenced in Section 5.15.16 of this RFP. Our policies and procedures will require responding within 10 business days of the Department's request. These policies and procedures will cover the following:

- **Security Breaches and HIPAA violations.** In the event of a breach of the security of sensitive data, NHP will immediately notify the Department of all suspected loss or compromise of sensitive data within five business days of the suspected loss or compromise and will work with the Department regarding recovery and remediation. All HIPAA violation will be reported in accordance with the Business Associate Addendum.
- **Ownership or Control Disclosures.** Ownership and control disclosure information specified in *Section 5.15.16.3* of this RFP will be disclosed to the Department regarding ownership or control interests in NHP at the time of submitting a provider application and when executing, renewing, or extending the RAE contract with the State. Disclosure information will be submitted in a Department approved form and within 35 calendar days of either a change of ownership or a written request by the Department.
- **Disclosure of Information on Persons Convicted of Crimes.** NHP will notify the Department of the identity of any individual who has ownership, controlling interest, or managing employee in NHP who has ever been convicted of a criminal offense related to that individual's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act. We will notify the Department at the time of submitting a provider application and when executing, renewing, or extending the RAE contract with the State, and within 35 days of written request by the Department.
- **Business Transaction Disclosures.** We will submit full and complete information concerning the ownership of any subcontractor with whom NHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between NHP and any wholly owned supplier or subcontractor during the five-year period ending on the date of the request. This disclosure will be submitted within 35 calendar days of the date of a request by the Department or by the Secretary of the Department of Health and Human Services.

CONFLICT OF INTEREST

NHP's organizational partners have experienced identifying potential conflicts of interest and providing full disclosure statements to the Department with the details that create the appearance of a potential conflict of interest. We will comply with the conflict of interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors. We will submit a full disclosure statement to the Department that sets forth the details that create the appearance of a conflict of

interest within 10 business days of learning of an existing appearance of a conflict of interest situation.

SOLVENCY

NHP will notify the Department upon becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards specified in the RAE contract. We will not hold any Member liable for our debt in the event of insolvency. The Department will be notified within two business days NHP becomes aware of a possible solvency issue.

SUBCONTRACTS AND CONTRACTS

NHP will disclose copies of any existing subcontracts and contract to the Department within five business days of request. We will further ensure that Members are not billed by a subcontractor or provider for any amount greater than would be owed if the contractor provided the services directly or in violation of 25.5-4-301(1)(a)(I), (II), and (II.5), C.R.S.

WARRANTIES AND CERTIFICATIONS

We will disclose to the Department if we are no longer able to provide the same warranties and certifications as required at the effective date of the contract within five business days of becoming aware of the inability to offer the warranty and certifications.

ACTIONS INVOLVING LICENSES, CERTIFICATIONS, APPROVALS, AND PERMITS

NHP will notify the Department within two days of being notified of the following situations:

- Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Title 10, Article 16, C.R.S.
- Any action on the part of the Colorado Commissioner of Insurance suspending, revoking, or denying renewal of NHP's certificate of authority
- Any revocation, withdrawal or non-renewal of any necessary licenses, certifications, approvals, permits, etc., required for NHP to properly perform this contract

NHP will notify the Department within two business days of a notification of any of the actions above.

OFFEROR'S RESPONSE 25

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Accountable Care Collaborative: Medicare-Medicaid Program scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

Northeast Health Partners, LLC (NHP) fully supports the Medicare-Medicaid Program (MMP) and attests our willingness and ability to perform the work described in the proposed Accountable Care Collaborative (ACC) MMP scope of work and will negotiate with the Department of Health Care Policy & Financing (the Department) in good faith providing the establishment of actuarially sound funding. As of May 2017, Region 2 had 6,707 ACC MMP enrolled Members. It is the highest regional population of MMP Members in the state compared to other Regional Accountable Entity (RAE) regions. Therefore, our demonstrated expertise and support of this program is essential for RAE Region 2 Members' success.

NHP currently has staff that began participation in the development of the Full Benefit MMP since the draft Dual Demonstration Contract Proposal was released in 2012. This staff includes a dedicated (Long Term Services and Supports (LTSS) Director that works in the region and with the Department to further promote transitions and care with the LTSS population. Additionally, we have dedicated physical and behavioral health care coordinators, provider relations and quality staff, member services, a Systems Integration Coordinator, and operations staff to participate in the following MMP meetings and workgroups:

- Medicare Medicaid Stakeholder Meeting
- Accessibility Workgroup
- Protocol Development
- Member Communication
- Service Coordination Plan Workgroup
- Training – video, town hall, regional
- Plan of Care
- Alliance – Ombudsman Program

We have also established community relationships that help meet key MMP objectives, including:

- Improving Member experience in accessing care
- Promoting independence in the community
- Assisting Members in getting the right care at the right time and place
- Improving transitions among care settings
- Promoting person-centered planning
- Improving quality of care
- Reducing health disparities
- Achieving cost savings for the federal and state government through improvements in health and functional outcomes

MEDICARE-MEDICAID PROTOCOL MEETINGS

Pursuant to MMP contract requirements, NHP's partners will facilitate community stakeholder meetings throughout the 10 county region that comprises RAE Region 2. These meetings will provide a quarterly forum where community agencies can collaborate and coordinate the medical, behavioral, and social health care needs for Members with Medicare-Medicaid benefits. The meetings will be held in various locations and rotate through Region 2 counties. Each meeting will comprise various community stakeholders, and all meetings are generally attended by representatives from:

- Skilled nursing facilities
- Hospice agencies
- Disability Service Organizations
- County Public Health Departments
- County Nursing Services
- Area Agencies on Aging
- Single Entry Point Agencies
- Hospitals
- Home health agencies
- Behavioral Health Organizations
- County Departments of Social Services
- FQHCs
- Community Centered Boards

OFFEROR'S RESPONSE 26

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Wraparound Program scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

Northeast Health Partners, LLC (NHP) attests to our willingness and ability to perform the work described in the proposed Wraparound Program scope of work and will negotiate with the Department of Health Care Policy and Financing (the Department) in good faith, providing the existence of appropriate funding.

Some examples of the wraparound services we currently provide include the following:

Wrap-Around Services for Adults

Through the agency's community support program ("Journey") adult clients are provided with wrap-around supports, enabling them to maintain stability in the community and benefit from a multi-disciplinary team approach to service provision. Clients receive intensive case management services (care coordination, resource acquisition), therapeutic and medical services, and internal/external referral for housing and employment support. Peer services are also a key component to this program, including one-on-one support, recreational/social programming, and Warm Line services. All services are planned and implemented using a strengths-based recovery philosophy.

Wrap-Around Services for Youth

Using County Interagency Oversight Groups as a vehicle, youth clients are provided wrap-around services, incorporating families, schools, treatment providers and other community resources to support youth and their families in their behavioral health recovery. Comprehensive, strengths-based, individualized plans of care are developed for youth referred through the IOG program, and care coordination is provided by Centennial Case Managers.

OFFEROR'S RESPONSE 27

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed PASRR scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

Northeast Health Partners, LLC (NHP) attest to our willingness and ability to perform the work described in the proposed Pre-admission Screening and Resident Review (PASRR) scope of work and will negotiate with the Department of Health Care Policy and Financing (the Department) in good faith providing the existence of appropriate funding. Our belief is that the benefits of PASRR are achieved through meaningful, Member-centered recommendations directed at ensuring that each Member's outcome with placement and identified services is successful. To accomplish this, we:

- Identify Members with mental illness or intellectual and/or developmental disability, or both
- Collect thorough and accurate information in a timely fashion
- Place an emphasis on a person-centered approach
- Understand the community and resources available for placement options
- Articulate useful determinations of outcome

We endorse the use of a quality assessment model that reinforces state and federal guidelines, centered on extracting historical and baseline information, Member-centered goals, psychopharmacologic interventions, and specific interventions needed to support a Member's success in skilled nursing facility level of care and the potential for successful community-based placement. Our staff have improved provider compliance with status change reporting through ongoing education and team-decision meetings to enhance service delivery.

NHP's clinicians have a high regard for the goals and functions of the PASRR process. Our depth of experience and resulting insights make Northeast Health the natural choice for managing these services for the Department. We have a proven history of expertise regarding the three key PASRR elements (i.e., Level I screens, Level II evaluations, and Resident Reviews). We also have an established record of

- Identifying mandatory triggers (MDS requirements) targeting status change evaluations
- Making identified amendments that have contributed to the development of specialized service definitions
- Implementing successful strategies to solve PASRR conundrums (e.g., ICD-10 changes, provider education on Level I documentation, reviewing protocols for transitioning between skilled nursing facilities)

We underscore the value of clinical expertise and make continual efforts to capture appropriate treatment recommendations that are responsive to Members' needs.

OFFEROR'S RESPONSE 28

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Brokering of Case Management Agencies scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

Northeast Health Partners, LLC (NHP) attests to our willingness and ability to perform the work described in the proposed Brokering of Case Management Agencies scope of work and will negotiate with the Department of Health Care Policy and Financing (the Department) in good faith providing the existence of appropriate funding.

We place high importance on the availability of an unbiased and independent coordinator that can connect Members applying for, or receiving Medicaid Long Term Services and Supports (LTSS) to a Case Management Agency (CMA). Our service delivery system is based on the need for optimal systems integration and alignment, as well as care coordination for our Members through a comprehensive and well-organized service delivery model. We assist Members in successfully navigating complex systems and ensure that they receive services in a person-centered manned, respecting their preferences and choices.

NHP already has contracts with providers across the state of Colorado, and specifically in the Regional Accountable Entity (RAE) Region 2, to provide a full continuum of services for Medicaid Members including Primary Care Medical Providers (PCMPs), psychotherapy, medication management, case management agencies, substance use disorder treatment, intensive in-home services, consultation to Members in long term care settings, school-based services, oral health, and integrated behavioral health in primary care settings. Out of respect for Member choice, we provide Members with a wide variety of options with providers and agencies specializing in case management services. Our network has been carefully crafted and comprises the professionals who are committed to helping Members develop individualized service plans, arrange for services, chose the right provider(s), monitor health/safety and the welfare of Members, and supervise the delivery of services.

OFFEROR'S RESPONSE 29

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Health Information Exchange Connectivity Assessment scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

Northeast Health Partners, LLC (NHP) attests our willingness and ability to perform the work described in the proposed Health Information Exchange (HIE) Connectivity Assessment scope of work and will negotiate with the Department of Health Care Policy and Financing (the Department) in good faith, providing the existence of appropriate funding.

The HIE Assessment and Evaluation Request from the state of Colorado charged the Regional Care Collaborative Organizations (RCCOs) with evaluating all providers servicing Members within their region regarding effective service rendering. There are two phases to this project. Phase 1 involves interviewing all providers and gathering their responses to the State's questionnaire. Phase 2 is the development of a strategic plan that addresses the results of the questionnaire and the State's criteria for defining the overall strategy for HIE services. The RCCOs were responsible for interviewing each provider and answering all questions from the State. Detailed below, we describe our level of effort associated with completing Phase 1 of this project.

Beacon managed the project by hiring staff to reach out and educate individual providers on the purpose of the project, and solicit answers to the State's 76 questions. As provided by the State's guidelines, 50 percent of the providers were interviewed in person, and 50 percent were interviewed over the telephone. Once the provider completed the survey, results were input into an online form and then imported into the SQL server database. The results were verified and then exported into a Microsoft Excel spreadsheet as requested by the State. A test file was submitted to the State for formatting verification. The test file was approved and subsequently, the project file was submitted to the State, which completed Phase 1 of the project.

In managing this project, Beacon has established a number of efficiencies that will allow NHP perform a HIE Assessment and Evaluation Request from all providers in our network annually, or as directed by the State. For example, using the SQL database will allow for future reporting on the data and assist in improving the provider's ability to maintain continuation of care for Members. The data gathered can be used to determine which providers are capable of using the HIE system to its fullest capacity, and identifying providers that may need assistance to improve their use of the system and integration into their operations.

OFFEROR'S RESPONSE 30

Provide a description of a capitated payment reform initiative the Offeror seeks to implement in Region 1 or Region 5 that describes:

a. Payment methodology, including:
   i. The rate structure and logic model.
   ii. Performance and/or quality measures that are incorporated into the proposed value payment model and how they affect payments.
b. Policy innovation goals or targets that may enhance the Medicaid program and support the Accountable Care Collaborative's goals to improve Member health and life outcomes and to use state resources wisely.
c. Mechanisms for cost neutrality or cost savings, and the estimated amount of projected cost savings, if applicable.
d. Population and geography, including:
   i. Regions or counties in which the capitated payment reform initiative will operate.
   ii. Approximate number of Members included in the capitated payment reform initiative.
   iii. Eligibility categories included in the capitated payment reform initiative.
      a) Any limitations on who may participate.
e. Provider network, structure, and value-based payment arrangements.
f. How the proposed capitated payment reform initiative structure will foster communication, cooperation, and alignment with the Contractor's Accountable Care Collaborative structure.

The Offeror's response shall include a Letter(s) of Support from the local system of care (Denver Health Medicaid Choice or Rocky Mountain Health Plans Prime).

Northeast Health Partners, LLC (NHP) is submitting our proposal for the Regional Accountable Entity (RAE) Region 2 only. Therefore, Offeror's Response 30 is not applicable to our submission.

OFFEROR'S RESPONSE 31

Provide a statement that the Offeror agrees to:

a. Operate the Accountable Care Collaborative, as described in Section 5, irrespective of whether or not the Department exercises its option for implementing the Offeror's proposed capitated payment reform initiative.
b. Accept the actuarially certified Capitated Rate developed after the award based on the Contractor's proposed capitated payment reform initiative if the Department chooses to exercise its option to implement the Offeror's proposed capitated payment reform initiative.

Northeast Health Partners, LLC is submitting our proposal for the Regional Accountable Entity (RAE) Region 2 only. Therefore, Offeror's Response 31 is not applicable to our submission.