PROPOSAL FOR THE REGIONAL ACCOUNTABLE ENTITY FOR THE ACCOUNTABLE CARE COLLABORATIVE

Region 3 #2017000265

Executive Summary, Technical Proposal, and Attachments

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Executive Summary

EXECUTIVE SUMMARY:
Colorado Access: The Preferred Regional Accountability Entity

COLORADO ACCESS: THE PREFERRED RAE FOR COLORADO'S EAST METRO REGION

For more than 22 years, Colorado Access has driven health care system transformation and delivered improved health and life outcomes for Coloradans. We are the only company with a proven track record encompassing all the functions of a Regional Accountable Entity (RAE). We are fully prepared to deliver advanced models of population management, member engagement, practice transformation, and value-based payment, as well as state-of-the-art health plan operations. What makes us unique is that we have, and will continue to, design and deliver these models in true partnership with the State and with the members, providers and communities in which we also live and work. As a RAE, Colorado Access will build on this in-depth understanding of our stakeholders to ensure accountability, optimize use of financial resources, and enhance whole-person care during the second phase of Accountable Care Collaborative (ACC). In addition, our flexibility and talent for innovation position us to prepare the system for future ACC phases and evolving value-based payment models.

Colorado Access offers the strengths of **an established health care company** that has successfully managed a diverse array of programs for a wide range of populations. Our experience in risk-based behavioral health models (Behavioral Health Organizations), accountable care models (Regional Care Collaborative Organizations), and long-terms services and supports (Single Entry Point) gives us a comprehensive system-level view and an understanding of multiple populations and life stages. This expertise has allowed us to create a more efficient delivery system and seamless member experience within the complex health care environment. As a RAE, our experience, position, and structure will enable us to be **proactive stewards of state resources** by leveraging cross-program efficiencies and regional innovations through a coordinated neighborhood that is more effective than the sum of its parts.

Colorado Access is neither a provider organization nor a for-profit health plan and has no business interests that conflict with the State's shared vision of improving care and outcomes. **As a long-standing state partner,** we have worked to develop the medical and social infrastructure that we know is needed to support member health and wellness. For 22 years, Colorado Access has collaborated with the Department of Health Care Policy and Financing (the Department) to improve Colorado's health care system through both strong and difficult economic climates. This experience has equipped us with an in-depth understanding of state history, the current environment and the challenges that lie ahead. Most importantly, it has prepared us to partner productively with the state to realize its vision for the second phase of the ACC and beyond. While the transition to a RAE may represent an entirely new business venture for other entities, it builds on our own long-standing mission*: to partner with communities and empower people through access to quality, affordable care.*

As a **locally-based, system-level entity**, with experience and expertise that spans the entire continuum of Medicaid services, Colorado Access is uniquely positioned to forward the State's quadruple aim. We have consistently demonstrated our ability to proactively engage and lead Colorado's diverse communities in the transformation process. For more than two decades, we have forged meaningful and effective **local**

partnerships committed to continuous improvement and shared outcomes. We have effectively balanced the need to achieve efficiencies through consolidation and centralization with the importance of local input and control and the imperative to sustain vital community providers. We have invested in creating a strong, flexible statewide network that provides value by moving beyond organizational change to trans-organizational transformation. As a RAE, we will continue to lead and collaborate with local stakeholders, incorporating their ideas, concerns and assets to craft unique applications of the State's vision that are responsive to every community's unique environment and needs.

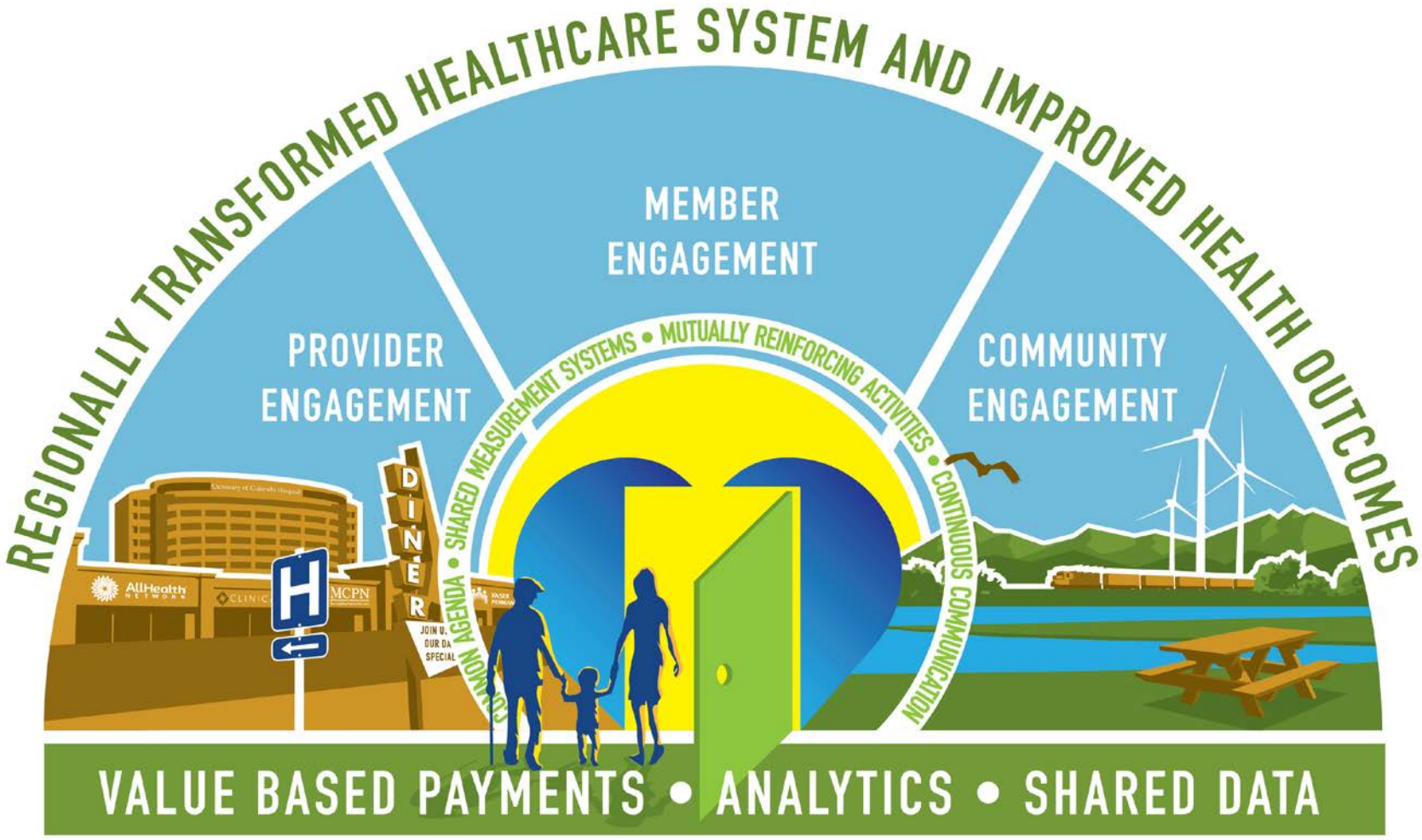
The Colorado Access RAE Model

We will build on our strengths as a results-oriented, community-focused organization, our robust business competencies, our in-depth understanding of the interactions between physical health, behavioral health, and social determinants of health, and our successful history of multi-program integration. **The Colorado Access RAE model aligns our service offerings upon a foundation of data to create a transformed health care system and achieve improved health outcomes**.

As this graphic illustrates, we envision our role as an organizing force, backbone, and gateway that will transform the regional health care system to benefit members and help drive the state's overall health care reform vision. Our change strategies will focus on three primary groups: providers, members and the diverse communities of Region 3. We will work with them to create a common regional vision, develop shared measurement systems, conduct mutually reinforcing activities to attain our goals, and communicate continuously with our partners throughout. To achieve this regional vision, we will perform all the key functions listed in the Department contract and support these functions through alternative payment methods, informative data and analytics, and effective outcome measurement and performance improvement strategies. The foundation for all our efforts will be the statewide agenda and goals for Health First Colorado (Colorado's Medicaid Program).

The Colorado VSS # is: HC00000000013888

Colorado Access Contact Person: Amy Owens, 720 427 8626, Amy.Owens@coaccess.com



The Colorado Access RAE Model uses the *Health Transformation Framework* to align our service offerings upon a foundation of data to create a transformed health care system and improve health outcomes.

The following partners are Region 3 governance council members that exclusively support Colorado Access as the RAE. Leaders from each of these organizations have been attending governance council meetings since 2016, and have actively participated in the planning and design of the Colorado Access Region 3 RAE vision. These partners support the Colorado Access RAE model and look forward to collaboratively transforming health care and improving health outcomes for Region 3 members.

- AllHealth Network
- Aurora Mental Health Center
- Children's Hospital Colorado
- Clinica Campesina
- Community Reach
- University of Colorado Medicine
- Doctor's Care
- Kaiser Permanente
- Metro Community Provider Network (MCPN)
- Peak Vista
- UCHealth
- Rocky Mountain Youth
- Salud Family Health Centers

The following partners have signed letters designating Colorado Access as their preferred Region 3 RAE. These partners support the Colorado Access RAE model and look forward to collaboratively transforming health care and improving health outcomes for Region 3 members.

- Adams Department of Human Services
- Addiction Research and Treatment Services (ARTS)
- Anschutz Campus Community Partnership
- Arapahoe County Board of Commissioners
- Asian Pacific Development Center
- Aurora Health Access
- Aurora Wellness Court
- Boomers Leading Change
- Colorado Children's Healthcare Access Program (CCHAP)
- ClinicNET

- Colorado Cross Disability Coalition
- Colorado Prevention Alliance (CPA)
- DentaQuest
- Developmental Pathways
- Elbert County Interagency Group Connections for Families
- Mile High Behavioral Healthcare
- North Metro Community Services
- Planned Parenthood of the Rocky Mountains Metro East
- Project Angel Heart
- Rocky Mountain Crisis Partners
- Signal Behavioral Health Network
- South Metro Fire and Rescue
- Tri-County Health Department

Mandatory Qualifications

OFFEROR'S RESPONSE 1

Provide documentation demonstrating how the Offeror meets all mandatory qualification requirements.

Attestation that the Offeror meets the requirements of a PCCM Entity and a PIHP.

OFFEROR'S LEGAL NAME AND NUMBER OF YEARS IN BUSINESS UNDER THIS LEGAL NAME

Colorado Access is the legal name of our organization and we have been dedicated to serving the underserved populations in Colorado for the past 22 years.

THE ORGANIZATION'S LOCATION(S), INCLUDING ANY IN COLORADO

Colorado Access maintains three office locations in Colorado.

Our primary physical address is:

11100 E. Bethany Drive
Aurora, CO 80014

Our secondary location address is:

10065 East Harvard Avenue
Denver, CO 80231

We also have an office in northern Colorado:

3001 8th Ave
Suite 120
Evans, CO 80620

TOTAL NUMBER OF EMPLOYEES, INCLUDING CONTRACTED STAFF

Colorado Access currently employees a total of 498 highly competent, talented and experienced staff which includes all contracted employees.

DOCUMENTATION OF THE OFFEROR'S LICENSURE IS NOT SUSPENDED, REVOKED, DENIED RENEWAL OR FOUND TO BE NONCOMPLIANT BY THE COLORADO DIVISION OF INSURANCE

Colorado Access is a licensed entity through the Division of Insurance as proven by the Certificate of Authority which can be found in Attachment B DOI License. Evidence that this license is currently active can be found in the 2017 renewal form titled Health Maintenance Organizations (HMO) Annual Fee Form is also located in Attachment B DOI License.

ATTESTATION THAT THE OFFEROR MEETS THE REQUIREMENTS OF A PCCM ENTITY AND A PIHP

Colorado Access certifies that we meet the definitions and federal requirements for a Primary Care Case Management Entity (PCCM Entity) and Prepaid Inpatient Health Plan (PIHP) as set forth in in 42 C.F.R. § 438.2. We further certify that we have all necessary certifications, approvals, insurance and permits to perform all the services and functions required under this RFP.

Organizational Experience

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. Covering Medicaid covered populations.
c. Administering managed care
d. Managing financial risk for covered services.

MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE

We are pleased to offer our extensive organizational experience and skills working with the Department of Health Care Policy and Financing (the Department) and Health First Colorado (Colorado's Medicaid program), hereto referred to as Medicaid, as we advance to the next phase of the Accountable Care Collaborative (ACC). As a partner to both the Department and Colorado communities, we have successfully: **managed projects of similar size and scope, covered multiple Medicaid populations, administered managed care contracts in a variety of formats, and managed financial risk for both physical health and behavioral health services**. The description below includes our experience and skills as well as program highlights.

Since 1995, we have operated health plans for Medicaid, Child Health Plan *Plus* (CHP+), Medicare, and the health insurance marketplace, providing us extensive experience and skills with a variety of public sector health care programs and formats. This experience, detailed in the table and narratives below, demonstrates our success managing large projects and delivering care for a broad range of populations, including people of varying ages and economic backgrounds, from diverse cultural backgrounds, and those with disabilities, substance use disorders, and other complex and chronic needs.

TABLE 2-1 EXPERIENCE SUMMARY

Summary of Experience Managing Similar Projects				
Program	**Date Span**	**Enrollment** Current/Most Recent	**Contract Type**	**Services Provided**
Regional Care Collaborative Organization	2011 - present	500,000	Medicaid Primary Care Case Management Entity	Coordination of physical, behavioral, and community health services
Medicaid Behavioral Health Organization Access Behavioral Care	1998 - present	580,000	Medicaid BHO Full risk behavioral health capitation	Coordination of specialty behavioral health care, inpatient and outpatient care, residential and community-based services
Access Health Plan Access Health Plan	1995 - 2006	250,000	Medicaid HMO Full risk physical health capitation	Primary, specialty, inpatient, outpatient and ancillary care and full pharmacy services
Colorado Regional	2008-2011	1,800	Medicaid Full risk physical health capitation	Primary, specialty, inpatient, outpatient and ancillary care and full pharmacy services

Summary of Experience Managing Similar Projects				
Program	**Date Span**	**Enrollment** Current/Most Recent	**Contract Type**	**Services Provided**
Integrated Care Collaborative			Administrative services 2010-2011	Coordination of primary, specialty, inpatient, outpatient, and community-based services
Medicaid Single Entry Point Access Long Term Support Solutions	2013 - present	10,120	Medicaid Waivers Administrative services	Case management, care coordination, planning and referrals to long-term services and supports for persons living with disabilities and elderly persons
Wyoming Access	2013 - 2015	165	Medicaid Administrative services	Intensive, collaborative behavioral care coordination for youth who have complex behavioral and emotional health needs
CHP+ HMO	1998 - present	38,000	CHP+ Full risk physical and behavioral health capitation	Coordination of primary, specialty, inpatient, outpatient, and ancillary care; behavioral health (mental health and substance use) inpatient, outpatient, and community-based services; and full pharmacy services
CHP+ State Managed Care Network	2008 - present	4,000	CHP+ Administrative services	Coordination of physical and behavioral health services; primary, specialty, inpatient, outpatient, and ancillary care; behavioral health inpatient, outpatient, and community-based services; and full pharmacy services
Access Health Colorado	2014 - 2015	480	Commercial Full risk, physical and behavioral health	Covered all Essential Health Benefits. Coordination of primary, specialty, inpatient, outpatient, and ancillary care; behavioral health (mental health and substance use disorder) inpatient, outpatient, and community-based services; and full pharmacy services
Medicare Advantage Special Needs Program	2005 - 2015	4,000	Medicare Full risk physical and behavioral health capitation with	Coordination of primary, specialty (including mental health and substance use), inpatient, outpatient, and

Summary of Experience Managing Similar Projects				
Program	**Date Span**	**Enrollment** Current/Most Recent	**Contract Type**	**Services Provided**
Access Advantage			additional dental coverage	community-based services; full pharmacy services
Medical Enrollment and Application Access Medical Enrollment Services Medical Application Solutions	2012 - present	17,000 Applicants served to date	Administrative services	Eligibility determination for CHP+ and Medicaid; process applications

Summary: As has been demonstrated through our 22-year history with Medicaid and other programs, we are experienced and fully prepared to manage the size and scope of the Regional Accountable Entity (RAE) contract. We have the depth of experience, leadership, infrastructure, flexibility, and established partnerships to support the next phase of the ACC. Further, we share and are poised to help achieve the State's vision for ongoing transformation of Colorado's health care system and improved health outcomes for members.

EXPERIENCE SERVING MEDICAID COVERED POPULATIONS

As shown in Table 2-1 on the previous page, our primary focus is serving Medicaid members in Colorado, improving access to care and achieving better health outcomes. The members we serve encompass all Medicaid populations, including children and adults, pregnant women, older adults, people with disabilities, those who are dually eligible for Medicare and Medicaid, and other special populations. Many of these members have multiple, co-morbid diagnoses of serious physical and behavioral health disorders. Many are engaged with multiple care systems such as departments of human services, public school systems, and criminal justice. The narratives below describe our specific Medicaid experience over the past five years.

Regional Care Collaborative Organizations (RCCOs): In 2011, we were awarded three regional contracts by the Department to establish RCCOs: Region 2 (Weld, Logan, Morgan, Sedgwick, Phillips, Yuma, Kit Carson, Cheyenne, Washington, and Lincoln counties), Region 3 (Adams, Arapahoe and Douglas counties), and Region 5 (City and County of Denver). We have been accountable for designing and delivering a person-centered approach and connecting members to medical and community resources, minimizing barriers to access; we have achieved notable results in better health outcomes and lower costs. In coordination with partners and stakeholders, our RCCO model empowers members and providers through increased local accountability and ownership. Since the program began, we have built robust infrastructures and processes that uniquely prepare us to implement the next phase of the ACC, including:

- Strong engagement of major stakeholders, including key providers, organizations, and members. These partnerships create the vision, provide leadership, foster innovation, and offer opportunities for mutual investments and programs.
- A state-of-the-art care coordination model that ensures the right intervention at the right time and setting, providing services as close as possible to the point of care.
- Transformed and engaged primary care practices, ready to move seamlessly to the next phase of the Accountable Care Collaborative.
- Readiness for payment reform. We have developed and/or participated in a wide range of innovative pilots and provider infrastructure supports that prepare the system for future payment models.

Behavioral Health Organizations (BHOs): We have been the BHO contractor for Denver since the program's inception in 1998 and for the Northeast region since 2014. The BHO contract is responsible for the provision of covered behavioral health services to all Medicaid beneficiaries in the Denver and Northeast regions. Over the course of the capitated behavioral health program in Colorado, the BHO role has evolved from providing specialty behavioral health services in inpatient, outpatient, residential and community-based settings to our current accountability for delivering evidence-based practices, improved health outcomes, integrated physical and behavioral health care and significantly enhanced access to care in a variety of settings. When substance use benefits were added to the Medicaid benefit package, we incorporated these services into the full continuum of care offered. As a leader in the field, we have worked closely with the Department and the other BHOs to enhance the delivery of high-quality services, expand access to care, and help members engage effectively in the design and delivery of their behavioral health and substance use services.

Single Entry Point: In 2013, we established Access Long Term Support Solutions to serve as the Single Entry Point (SEP) agency for residents of Adams, Arapahoe, Denver, Douglas, and Elbert counties who need access to long-term care services through Medicaid. We are the state's largest SEP agency and also administer six Medicaid waiver programs. In this role, we provide functional assessments and eligibility determinations, care coordination and planning, coordination of long-term services and supports, and referrals and linkage to other resources. We have piloted innovative care coordination approaches to decrease burden and confusion for members and are a proven leader in person-centered care. After a competitive bidding process in 2017, we were selected as one of four No Wrong Door (NWD) pilot sites in the state. Our NWD partnership will promote alignment with the current RCCO and BHO structures and eventual RAE model. As the RAE, we will seek additional opportunities to integrate long-term services and supports into the ACC program.

Wyoming Access: In 2013, we were awarded a contract with the Wyoming Department of Health to establish Wyoming Access and deliver evidence-based care coordination and other services to youth with Medicaid who have complex behavioral and emotional health needs. Using the High Fidelity Wraparound model, we built capacity, engaged the community, and provided comprehensive, individualized, and cost-effective care coordination for youth and families in seven counties in southeastern Wyoming, including rural and frontier areas. From 2013 to 2015, the program served more than 200 youth and their families. This unique experience has prepared us to deliver Wraparound services in Colorado, should the Department choose to include this program under the RAE.

Access Advantage: In 2005, we became the first Medicaid health plan certified by the Centers for Medicare and Medicaid Services (CMS) as a Medicare Advantage Special Needs Plan through our Access Advantage program. This program was developed in response to the need for a health plan capable of serving the unique and challenging population of members who are dually eligible for Medicare and Medicaid benefits. We subsequently expanded to become a full Medicare Advantage plan, offering plans tailored to Medicare members with significant behavioral health conditions or other chronic or co-morbid health conditions. Our plans were full risk capitated programs requiring the provision of primary, specialty, ancillary, inpatient, outpatient, behavioral health and pharmacy services. Through the implementation of this plan, we developed strong relationships with providers skilled in treating complex members. This provider network had significant overlap with the Medicaid provider network, enabling us to quickly expand the network for the Medicare-Medicaid Dual Demonstration Program undertaken by the Department. The Access Advantage program was terminated after 2015 due to changes in Medicare Advantage funding and risk adjustment methodologies.

Summary: We have a proven track record serving Medicaid covered populations across the lifespan, dually enrolled Medicare/Medicaid members, and those with disabilities and multiple/chronic/complex/ co-morbid conditions. Our broad and deep experience demonstrates our ability to implement programs, deliver outcomes, and partner with the Department and others to achieve the program aims and flexibly adapt to changes and challenges. As the RAE, we will continuously work to understand and meet the needs of the Medicaid population, adapting, innovating, and partnering with the Department, providers, and communities.

ADMINISTERING MANAGED CARE

We have experience within the last 10 years successfully administering managed care programs and developing a robust, state-of-the art infrastructure to support all program requirements: ensuring access to care, building and managing a provider network, paying claims, monitoring and evaluating provider and system performance, and implementing quality improvement initiatives.

Access to Care: We have a strong infrastructure with a proven track record in improving access to care, meeting or exceeding contractual access standards in all programs. We have been successful in meeting access standards even during times of rapid membership expansion or addition of new required services. In all Medicaid programs, we prioritize member choice as an important component of access to care, because limited networks often have the indirect effect of limiting access. We have the largest and most diverse Medicaid physical and behavioral health provider networks in the state and continue to recruit providers who are committed to serving this population. Access to care is increased by strategically recruiting providers with specialized expertise, diverse cultural backgrounds, unique practice settings, off-hours availability, wide geographic distribution, and non-traditional settings. We also support member access to care through outreach and engagement and care coordination to help members overcome barriers. Finally, we do not require authorizations for routine behavioral health care.

Provider Network: We have a large and diverse provider network and a robust infrastructure to recruit, contract, support, monitor, and partner with providers. Our current Medicaid physical health network includes more than 1,418 providers participating as adult or family primary care medical providers (PCMPs), 524 pediatric PCMPs, and 361 advanced practice nurses and physician assistants. This network spans more than 2,200 locations; most

are currently accepting new patients. Our statewide behavioral health network includes more than 1,100 behavioral health provider sites (inpatient, outpatient, and all other covered behavioral health and substance use disorder services) and all 17 of the state's community mental health centers, with multiple locations totaling more than 3,000 behavioral health providers. We have demonstrated the ability to expand provider networks quickly in response to changing membership needs, benefits, or program requirements and to seamlessly expand to new regions. For example, our behavioral health provider network has expanded by 208% since 2011 and by 17% in 2016 alone. As the RAE, we will continue to expand and develop our already extensive network of PCMPs, behavioral health providers, and others.

Claims Processing and Payment: We have more than 20 years of experience paying Medicaid claims (both paper and electronic). This is described in detail in Offeror's Response 22—Data Management and Claims Processing. We have licensed QNXT from the TriZetto Group as our core transaction system. QNXT stores and processes member eligibility, provider contracts, benefits, claims, adjustments, and payments. This best-in-class system is the choice of more than 50 health plans nationally and has been optimized to administer Medicaid programs using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. The powerful claims processing engines within the QNXT system allow for very accurate claims handling. TriZetto processes approximately 1.4 million health plan claims transactions annually for us, with over 90%of these received electronically. We have a robust internal claim quality/audit process to ensure timely and accurate provider payments. We maintain a claims payment accuracy rate of 99% or greater. We routinely participate in State Medicaid audits with consistently positive findings.

We have extensive electronic data interchange (EDI) experience using ANSI ASC X12N 837 formatted encounter data, 834 HIPAA-compliant transactions for reporting eligibility, processing paper and electronic claims/encounters and reporting encounters to the State. We have also submitted encounters in the required flat file format during the years that we have held a BHO contract. We are prepared to be compliant with the changing Medicaid encounter reporting requirements. We were approved by the Department in June 2008 for 837 file submissions, and we have accepted 834 HIPAA-compliant transactions sets for reporting eligibility since 2010. We are actively sending and receiving 834 files with the State and other key trading partners, such as our pharmacy benefit management and dental benefit management vendors, as well with Connect for Health Colorado (the state health insurance marketplace). In addition, we are fully compliant with the ACA Section 1104 Mandatory Operating Rules for eligibility and claims status transactions that went into effect January 2013. We are already compliant with the claims remittance/payment and electronic funds transfer (EFT) mandated operating rules that became effective January 2014. Our sophisticated information systems simplify the tracking and appropriate payment in these and other potentially complicated areas to maximize efficiency and cost savings. We have developed systems that are flexible and capable of adapting to the changing claims payment expectations of the Department and the federal government.

Provider and System Performance and Quality Improvement Initiatives: We have a strong Quality Assessment and Performance Improvement (QAPI) program that has governed our continuous quality improvement processes across all programs over 20 years. This comprehensive program, described in detail in Offeror's Response 23—Quality Improvement, provides a framework, formal methods, and measurable standards for continuous assessment and improvement in all aspects of health care delivery. Our continuous quality improvement philosophy is a core part of our company's work, and that methodology is applied in all departments.

Our quality improvement initiatives include contractually required Performance Improvement Projects (PIP). PIPs target areas of needed quality improvement across providers and systems. Projects have focused on issues such as increasing documentation of body mass index for pediatric patients, improving behavioral health care access for children, enhancing treatment of cardiovascular disease, and increasing colorectal screening rates.

Examples of recent performance improvement projects include:

- **Age-Out Program:** CHP+ members lose coverage when they turn 19. They need to seek new coverage and often-new primary care and behavioral health providers. This project created a series of interventions to help members successfully navigate this transition.
- **Depression Screening:** This program sought to increase adolescent depression screening rates in primary care settings and improve care transitions from primary care to behavioral health when clinically necessary.

MANAGING FINANCIAL RISK FOR COVERED SERVICES

As the Table 2-1 above illustrates, we have successfully managed the full scope of health care financial risk in Colorado for the last 22 years. This includes managing all of the financial aspects and the risk associated with capitation contracts in Medicaid physical and behavioral health, Health First Colorado Substance Use Disorder services (SUD), the Child Health Insurance Plan (in Colorado known as Child Health Plan *Plus* or CHP+), and Medicare Advantage. In these 22 years, we have learned how to adapt quickly and deftly to the changing conditions that are a natural cyclical part of these programs. Recent examples of significant changing conditions include the January 2014 Medicaid expansion and the introduction of the SUD benefit into Medicaid behavioral health. We know through experience that in all of these programs, some years will be financially profitable and some years will not. That is the nature of risk-based health care contracts. We have developed effective models to understand and predict health care costs and therefore are able to anticipate and adjust for new trends using state-of-the art budgeting tools. We know that we need to build financial reserves in the good years so that we can continue to operate as normal in the tougher financial years. This ebb and flow has been a constant for us over 22 years of managing financial risk.

A key element in managing financial risk is participating with the State in capitation rate setting for Medicaid programs. We have worked collaboratively with Department staff and the Department's contracted actuaries over the many years and many rate setting cycles. The collaborative process is a true give-and-take, and the quality of the rates is reliant on the contributions of all parties. This valuable experience allows us to understand where the programs are going in the future, and we provide valuable insight to the Department about how the rates are working to support meeting the needs of Medicaid members.

The experience and financial acumen developed over many years by our stable leadership team has seasoned us to make hard decisions when contractions are necessary, and to know when additional financial investments can be rolled back into our company to further develop our capabilities to serve the members. These investments have equipped us with robust tools to complement our expertise to rapidly address future challenges and adapt whenever necessary. It also has reinforced our long-term vision for Colorado's health care system. We remain fully committed to Medicaid and the other public sector medical and behavioral health programs in our home

state. We intend to continue making mission-driven, prudent risk management decisions that strengthen our ability to provide ongoing support for state health policy initiatives and to deliver quality services for members.

Detailed Description of Experience

We have 22 years of successful managed care experience providing, arranging for, and otherwise being responsible for the delivery and coordination of physical and/or behavioral health through a variety of projects. All of the lines of business listed below are current Colorado Access (COA) contracts. None of these lines of business have experienced any adverse contract actions or project-associated litigation, including termination or cancellation of contract.

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 populations 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/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.

BEHAVIORAL HEALTH ORGANIZATIONS (1998-PRESENT)

We currently serve as the Behavioral Health Organization (BHO) for Region 2 (northeastern Colorado) and Region 5 (Denver). We have held this contract continuously since 1998 in Region 5 and since 2014 in Region 2. This experience includes the delivery of community behavioral health care, as described in more detail in Offeror's Response 2—Experience and Skills and in Offeror's Responses 18-20—Capitated Behavioral Health Benefit.

Briefly, we have extensive expertise managing care for individuals with serious and persistent mental illness and serious emotional disturbance using a full range of health, social and alternative services such as intensive case management, housing support and medication management. Throughout our history of service to these individuals, we have worked with our partners to implement evidence-based practices and innovative approaches that have moved our system toward a whole-person, recovery and resiliency-oriented approach and substantially improved outcomes. These strategies have included a variety of integrated physical and behavioral health innovations, as well as interventions aimed at improving symptom management, treatment adherence, quality of life and functional status.

a. **Locations**: Denver (Region 5) and northeast Colorado (Region 2) including the counties of Larimer, Weld, Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington and Yuma.

b. **Population served and number of covered lives:** Approximately 372,400 Medicaid members across these regions, including the expansion population.

c. **Type of population**: Medicaid

d. **Primary health care services included in the project:** All behavioral services for the covered diagnoses, including services referred to as b3 waiver services, e.g., clubhouses and drop in centers. Inpatient, outpatient and in home services are authorized, provided and coordinated.

e. **Level of managed care and financial risk**: We serve as a full risk bearing entity through our HMO license and bear the full financial risk for these contracts.

f. **Activities in rural and frontier areas**: The Northeast region has extensive rural and frontier areas, and we have significant experience developing and delivering care in these areas.

g. **Corrective action plans**: None

h. **Adverse contract actions or project-associated litigation**: None

i. **Project Contract Manager and contact information**: Rob Bremer, Vice President of Integrated Care, robert.bremer@coaccess.com, 720-744-5240.

ACC REGIONAL CARE COLLABORATIVE ORGANIZATIONS (2011-PRESENT)

We serve as the Regional Care Collaborative Organization (RCCO) for three regions of the state: Northwestern Colorado (Region 2), East Metro Denver (Region 3), and the City and County of Denver (Region 5). This program connects members to a primary care medical home and provides care coordination services to ensure coordination of care among primary care, medical specialists, behavioral health services and other needed community supports. Details include:

a. **Locations**: Denver (Region 5); northeast Colorado (Region 2) including Weld, Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties; East metro area (Region 3) including Adams, Arapahoe, and Douglas counties.

b. **Population served and number of covered lives**: Approximately 436,400 members; all RCCO enrolled members who reside within the regions.

c. **Type of population**: All Medicaid enrollees including children, adults with dependent children, adults with disabilities, Medicare/Medicaid dual enrollees and the expansion population of adults without dependent children.

d. **Primary health care services included in the project**: Coordination of all physical health services for enrolled members as well as collaboration and shared management of behavioral health and long- term care services for each enrolled member.

e. **Level of managed care and financial risk:** This contract is a Primary Care Case Management contract with no financial risk other than through a value-based contract in which funds are awarded for the achievement of key performance indicators.

a. **Activities in rural and frontier areas**: Virtually all of Region 2 and a large portion of Region 3 are rural and/or frontier. We have significant experience developing and delivering care in these areas.

f. **Corrective action plans**: None

g. **Adverse contract actions or project-associated litigation**: None

h. **Project Contract Manager and contact information**: Patrick Gillies, Vice President of Accountable Care, patrick.gillies@coaccess.com, 720-744-5362.

CHILD HEALTH PLAN *PLUS* HMO (1998-PRESENT)

Our Child Health Plan *Plus* program is the largest CHP+ plan in Colorado, serving members in 43 counties along the Front Range, San Luis Valley, and Northeastern Colorado. Details include:

a. **Locations**: Clear Creek, El Paso, Elbert, Gilpin, Larimer, Lincoln, Logan, Morgan, Park, Phillips, Pueblo, Sedgwick, Teller, Weld, Delta, Eagle, Summit, Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Custer, Fremont, Huerfano, Kiowa, Las Animas, Mineral, Otero, Prowers, Rio Grande, Saguache, Yuma, Washington counties.

b. **Population served and number of covered lives**: Approximately 38,000 children from birth to age 20

c. **Type of population**: CHP+ eligible members including infants, children and young adults.

d. **Primary health care services included in the project**: All inpatient, outpatient and in-home services for physical and behavioral health allowed under the state's CHP+ benefit package.

e. **Level of managed care and financial risk:** We serve as a full risk bearing entity through our HMO license and bear the full financial risk for these contracts.

f. **Activities in rural and frontier areas**: Our CHP+ plan operates in many rural and frontier areas and we have significant experience developing and delivering care in these areas.

g. **Corrective action plans**: None

h. **Adverse contract actions or project-associated litigation**: None

i. **Project Contract Manager and contact information**: Bethany Himes, Vice President of Program Services, bethany.himes@coaccess.com, 720-744-5550.

ACCESS LONG TERM SUPPORT SOLUTIONS (2013-PRESENT)

Our Access Long Term Support Solutions (ALTSS) program is the Single Entry Point (SEP) agency for a metro Denver service area that includes Adams, Arapahoe, Denver, Douglas and Elbert counties. We are the state's largest SEP agency and also administer six Medicaid waiver programs. In this role, we provide functional assessments and eligibility determinations, care coordination and planning, coordination of long-term services and supports, and referrals and linkage to other resources. Other details include:

a. **Locations**: Adams, Arapahoe, Denver, Douglas and Elbert counties

b. **Population served and number of covered lives**: Approximately 10,120 per year; all Medicaid eligible persons within the region who need long-term care services.

c. **Type of population**: Medicaid adults and children needing to be assessed for or qualify for long-term care services.

d. **Primary health care services included in the project**: Assessments, referrals to appropriate programs, completing functional eligibility determinations, case management.

e. **Level of managed care and financial risk:** This is an administrative services contract without financial risk.

b. **Activities in rural and frontier areas**: Large portions of Adams, Arapahoe, Douglas and Elbert counties are rural and we have significant experience developing and delivering care in these areas.

f. **Corrective action plans**: None

g. **Adverse contract actions or project-associated litigation**: None

h. **Project Contract Manager and contact information**: Penny Cook, Director of Long Term Support Services, penny.cook@coaccess.com, 720-744-5236.

Summary: Our long history of achievement in partnering with the Department of Health Care Policy and Financing (the Department) on the programs described above, both Medicaid and non-Medicaid, has allowed us to develop expertise in the delivery and coordination of comprehensive physical health and behavioral health care services that span the continuum of care of outpatient and inpatient services and manage a variety of contract formats: administrative services, behavioral health risk, and comprehensive full risk. We are also experienced in providing services in complex urban areas and in rural and frontier areas with fewer resources and for people across the age span. We are particularly experienced in delivering high quality, evidence-based community behavioral health care and expanding member choice. Throughout all the programs described above, we have used a member-centered approach to whole-person care and worked to integrate physical health, behavioral health, and other services seamlessly for members.

Our track record of strong contract performance is demonstrated by the project descriptions above. We are a trusted partner of the state and the communities we serve and are fully prepared to assume the responsibilities of the Regional Accountable Entity (RAE) and deliver the same level of excellence to help achieve its aims of a transforming health care system and improved health outcomes.

Organizational Structure and Key Personnel

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. INTERNAL ORGANIZATIONAL STRUCTURE

Our internal organizational structure is designed to support a competitive, financially sound health plan that marries high quality managed care operations and functionality with flexible, community based teams to drive results in an accountable fashion. We focus on our core values of compassion, trust, excellence, collaboration, and innovation. Through these values, our highly qualified employees are empowered to do their best work and deliver outcomes at every level of the organization. During our 22-year history, we have demonstrated a commitment to serve the diverse health care needs of Medicaid clients in the state. Our staff members are all located in Colorado and work collaboratively across departments and programs in cross-functional teams that offer traditional experience and fresh perspectives. We are uniquely positioned to demonstrate the efficacies of an integrated care approach through our long history with Medicaid physical and behavioral health and long-term care. Our staff and leaders have deep experience with all of these areas within the Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, system, as well as long standing relationships in the community with providers, stakeholders and members. These relationships are not just professional, but personal. Our work supports our own communities. We work with, and for, our friends and neighbors to improve the health of the residents in our region and the state. We are continually striving to diversify our experience and add services that help us achieve our mission to empower people with access to quality, affordable care. This diversification includes the creation of a subsidiary company to focus on telebehavioral health and technology to increase access and care quality for Coloradans in need.

In recognition of the real life complexity in health care and within the national and state Medicaid systems, our organizational structure uses a matrix model. Under this model, the complexity of our environment is reflected and addressed through our internal structure. We realize that there are many different elements required to achieve the lofty goals of the Accountable Care Collaborative (ACC) 2.0 model – all equally important for transformation success. The achievement of the key performance goals and other measures of success requires multi-faceted efforts that are flexible, powerful and focused. These dynamic efforts require the integration of many different areas of expertise and a combination of strategy and technical skills. Managed care expertise, operational excellence, local relationships, member and family connections and technology are all required; our structure allows each to be balanced and prioritized on a daily basis. The matrix model distributes authority and incorporates accountability both by functional area and by project. In our structure, staff members may have two supervisors, a functional supervisor and a project supervisor. The functional supervisor is charged with overseeing employees in a functional area such as provider relations or utilization review. Project supervisors manage a specific and often temporary project such as a specific key performance indicator (KPI)

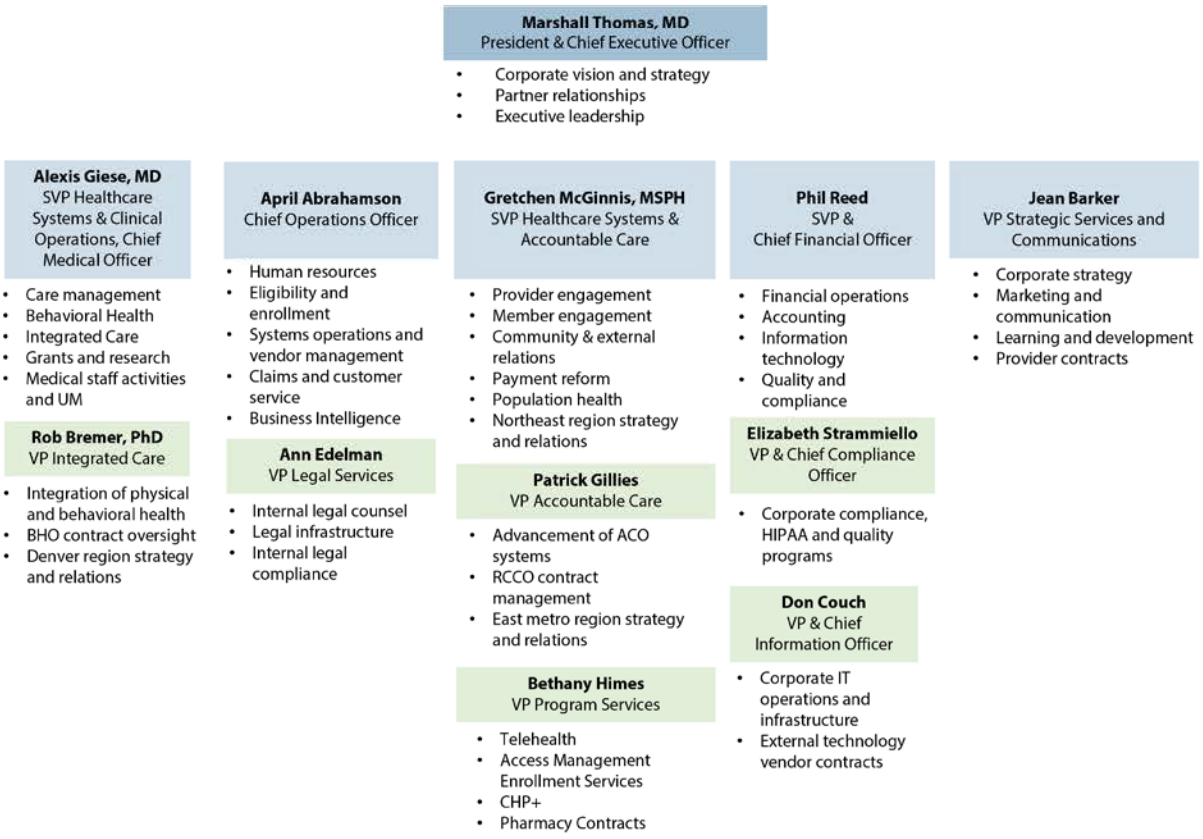
intervention. Our project teams are able to absorb employees from various functional areas to complete their assignment, and then new teams are formed to take on the next project.

The matrix model will be well suited to optimizing performance as the Regional Accountable Entity (RAE) by facilitating creative thinking and innovative solutions. This kind of organizational structure has several advantages, including resource coordination, specialization, and enhanced communication, and also allows a breadth of skills to be deployed in every organizational endeavor. Our staff members are diverse and have deep expertise in their specific roles. That expertise can be leveraged through connections to others with similar depths of expertise in different areas. Our cross functional teams can combine physical with behavioral health expertise, or clinical expertise with technological expertise, in ways that enhance the creativity and flexibility of the entire team. In addition, the natural cross training that occurs during the team process enhances their ability to deliver innovative solutions. Our leadership team at is adept at forming these highly functioning teams, while ensuring that employees have direct connections to their supervisors and understand how their work drives the overall success of the company and the achievement of our goals. This model engages staff at all levels and offers opportunities to learn new skills, to apply skills in a different setting, and to be part of achieving even the most daunting goals. The matrix model has proven to be effective for Colorado Access and its flexibility mirrors what is needed in the region to truly transform the ACC system.

Our executive management team and senior staff members offer significant experience and expertise in clinical and administrative management of complex health care organizations, and of working together on Colorado's relevant health issues. The team has experience in both physical and behavioral health, and all senior leaders have direct experience managing both types of programs. All positions referenced below are located in the region. Our corporate organizational structure and the internal organizational structure are both reflected in the high-level corporate structure diagram below and described in detail on the following page.

B. COLORADO ACCESS ORGANIZATIONAL CHARTS AND DESCRIPTION

EXECUTIVE LEADERSHIP



Colorado Access Corporate Executive Team

Reporting to the board of directors is:

- **Marshall Thomas, MD, President and CEO**: Dr. Thomas has responsibility for executing our corporate mission and oversees all lines of business. He has been with Colorado Access for more than 19 years, with increasing levels of executive responsibility culminating in his appointment as president and chief executive officer in 2006. Throughout his career, Dr. Thomas has worked to develop systems of care that are inclusive, responsive and create synergies between patients and providers. He is a recognized national expert on improving patient health outcomes by integrating medical and behavioral health care. Under his leadership, we have created strong business practices, expanded our client base and reoriented internal practices to support members and providers and strengthen the safety net. Dr. Thomas also

serves as a tenured professor of psychiatry at The University of Colorado Denver School of Medicine and executive director for the University of Colorado Depression Center. He is a practicing psychiatrist and has been involved in system of care development in Colorado since 1980. Dr. Thomas earned his Doctor of Medicine degree from Baylor College of Medicine and his completed his residency in psychiatry at the University of Colorado Health Sciences Center.

Reporting to the president & CEO are:

- **Philip J Reed, Chief Financial Officer**: Mr. Reed provides financial oversight for Colorado Access, and joined the company in 2005. As the chief financial officer, he is accountable for all elements of company accounting, budget and payroll as well as compliance and information technology. This includes assuring that the company meets its fiduciary responsibilities under Division of Insurance, state and federal requirements. Mr. Reed earned a Bachelor of Science degree in business administration from Colorado State University in 1984. He brings an exceptional understanding of the responsibilities of Colorado state agencies and its contractors in providing services under state programs. Prior to joining Colorado Access, Mr. Reed served as the controller for the State of Colorado Department of Health Care Policy and Financing.
- **Gretchen McGinnis MSPH, Senior Vice President of Healthcare Systems and Accountable Care**: Ms. McGinnis is accountable for oversight and leadership of the member, provider and community engagement teams, population health, payment reform, the CHP+, medical assistance, and telehealth programs. She also shares responsibility for the RCCO and BHO contracts. Ms. McGinnis has more than 20 years of health care experience and has been with Colorado Access since 2000. She earned an undergraduate degree from Vassar College and a Master of Science degree in public health from The University of Colorado Denver.
- **Alexis Giese, MD, Senior Vice President of Healthcare Systems and Clinical Operations and Chief Medical Officer (CMO):** Dr. Giese provides executive oversight for the company's care management and utilization management functions and leads the Access Long Term Support Solutions department. She shares responsibility for the RCCO and BHO contracts with Ms. McGinnis. As the CMO, she supervises the clinical leadership and provides day-to-day expertise on behavioral health issues. She is a board-certified psychiatrist and an experienced clinician with more than 20 years of experience working with persons with mental illnesses. She earned her Doctor of Medicine degree from the University of Texas at Houston and completed her residency in psychiatry at Georgetown University Hospital. In addition to her work with Colorado Access, Dr. Giese is the director of community programs for the University of Colorado Depression Center and is a professor in the department of psychiatry at the University of Colorado Denver School of Medicine.
- **April Abrahamson, MBA, Chief Operations Officer**: Ms. Abrahamson is accountable for oversight and overall management of day-to-day health plan operations for Colorado Access including eligibility and enrollment, customer service, claims/encounter processing, system configuration, human resources and business intelligence. Ms. Abrahamson has more than 20 years of employment in the health care industry, which includes a wide range of experiences such as providing personal care assistance in a client's home, supporting physicians in private offices and hospitals, as well as management of large claims, information technology, and provider contracting/configuration departments. She served as the executive director of

Medicaid for Colorado Access and managed the RCCO program in three regions prior to moving into the operational role. Ms. Abrahamson received a Bachelor of Arts degree in kinesiology from University of Colorado, Boulder and a Master of Science degree in health services administration from Regis University.

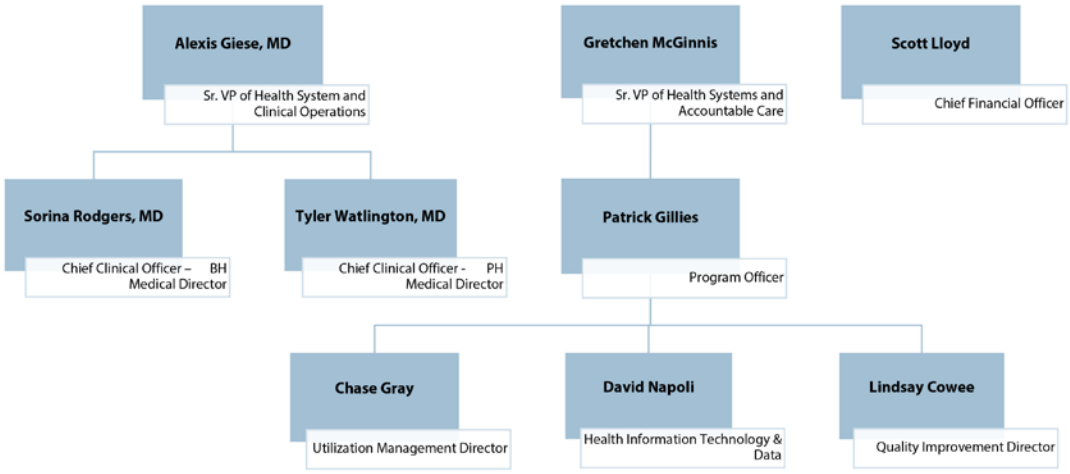
- **Jean Barker, Vice President of Strategy and Development:** Ms. Barker provides executive oversight of strategic initiatives, provider relations and contracting, and marketing. She has extensive experience in the health care industry, having worked for Kaiser Permanente in various leadership roles for more than 20 years. She brings deep knowledge in health plan product development, marketing, strategic planning, sales, and financial planning – both in executive director and consulting capacities. Ms. Barker holds a Bachelor of Science degree in medical technology and a Master of Business Administration degree with an emphasis in finance.
- **Ann Edelman, Vice President of Legal Services**: Ms. Edelman provides a full range of legal counsel and services to the company. Ms. Edelman joined the company in the July of 2012. As vice president of legal services, she is accountable for corporate governance, maintaining and establishing all levels of legal compliance, corporate contracting, and practicing preventive law. She also supervises the company's privacy official.

Our executive management team meets weekly to develop strategy, guide company development, proactively address any issues, and share priorities for the week. The executives meet with the extended senior team, which includes the functional directors and managers across all departments, to discuss current operational performance, upcoming initiatives, clinical and financial reporting, contract compliance monitoring, and to give direction to the extended senior team regarding any issues on a monthly basis. Using this forum, communication is streamlined among the management team and issues can be addressed quickly to facilitate resolution. All participants share information regarding internal and external changes, key events and line of business contract deliverables. Each leader in the organization is expected to meet one on one with their staff members on a weekly basis in addition to regular team meetings. Quarterly management meetings and trainings are held with all members of the leadership team and a variety of other tools are used to share information, provide strategic direction and ensure the company functions as efficiently as possible.

RAE Organizational Structure

The internal organizational structure for the RAE team, including the required positions defined in the RFP, is illustrated in the following organizational chart. Together, this organizational structure offers more than sufficient qualified staff to lead the work required under the contract. The individuals named below are supported by their own teams as well as the shared service functions within Colorado Access (COA).

RAE ORGANIZATION STRUCTURE REGION 3



As reflected in the organizational structure above, the RAE program officer reports to the senior vice president of healthcare systems and clinical operations and the senior vice president of healthcare systems and accountable care. The program officer is supported by the behavioral and physical health teams, including the quality Improvement director, the utilization management director, the health information technology and data director and the chief clinical officers. The RAE program officer is the primary liaison between Colorado Access and the State, with overall accountability for the RAE contract.

In a matrix management role, the program officers work with the Colorado Access clinical, operational, financial and administrative department directors/managers to ensure that all operations and deliverables related to the RAE are implemented timely, run efficiently and are continually monitored for performance reporting and quality improvement. Our department directors and managers are directly accountable to the respective executive management team member who oversees the functional area (as outlined on the Executive Organizational Structure above) for meeting performance and operational requirements for all lines of business. Through the matrix management structure, department directors and managers are accountable to the program officer for the performance, compliance and operations of the RAE contract.

Frequent interaction in senior management team meetings and department meetings ensure that the RAE program officer is involved in and aware of the ongoing performance in clinical, operational, financial and administrative areas of the company as they relate to the RAE contract. The RAE program officer also receives information through data reporting that allows him to monitor performance of operational areas. Examples include weekly customer service call center statistics summarizing RAE calls received, average speed to answer, and abandonment rates. Similar reports and data are shared that address clinical activity, claims activity, member grievances, quality activities and numerous other indicators.

C. KEY PERSONNEL & QUALIFICATIONS

Key personnel responsible for the operations of this RAE contract are listed below. All staff members are currently and will continue to be based in Colorado. All key personnel and other operational staff will be

available to the Department for meetings; will be physically present for meetings unless prior arrangements are made; and will be responsive to Department inquires within one business day. Each individual in a key personnel role will have the appropriate authority and autonomy to perform their role and commit the resources of the company as requested. We will make all necessary personnel, in key positions or other roles, available as needed to meet the requirements of the contract. We are willing and able to comply with the required deliverables and the key personnel approval process outlined in the RFP requirements.

Resumes for key personnel are included as Attachment C. Key personnel to be deployed for this contract include:

- **Program Officer, Patrick Gillies, MPA**: Is the vice president for accountable care and the current lead for RCCO Region 3. In addition, he manages our administrative services contract with Behavioral Health Inc. (BHI) for the Region 3 BHO. Mr. Gillies served for four years as a supervisory public health analyst for the Region VIII office of federal Health Resources and Services Administration. In this position, he promoted national health initiatives, influenced national and state health care policy, and promoted health care system reform. His previous experience includes six years managing health care contracts for the Texas Department of State Health Services, and a total of eight years administering a large integrated behavioral health delivery system in Austin, Texas. Mr. Gillies has a Master of Public Administration degree from Texas Tech University.
- **Chief Financial Officer, Scott Lloyd**, CPA: is a senior financial analyst with COA, responsible for external financial reporting activities, treasury activities, and managing capitation activity for all COA contracts. Mr. Lloyd previously served for 14 years as chief of financial affairs for the Colorado Division of Insurance, where he managed and oversaw a staff of analysts who performed detailed financial reviews of all domestic insurance company financial statements and other filings. He is a Certified Public Accountant, a Certified Financial Examiner and has a bachelor's degree in accounting from Washington and Jefferson College.
- **Chief Clinical Officer, Behavioral Health, Sorina Simion-Rodgers, MD**: is a COA medical director and board-certified psychiatrist. She has more than18 years of experience in clinical management and direct care for individuals with mental illnesses in inpatient, residential and outpatient settings. She has managed services for patients ranging from adolescents to older adults. Dr. Simion-Rodgers received her Doctor of Medicine degree in her native Romania, where she completed a family medicine residency. She subsequently filled psychiatric residencies at the University of Virginia and Long Island Jewish Medical Center – Hillside Hospital.
- **Chief Clinical Officer, Physical Health, Tyler Watlington, MD, MSPH**: is a medical director with COA and board-certified physician in preventive medicine and pediatrics. She recently joined COA after serving for more than 10 years in a variety of quality improvement, analytic and clinical management positions at The Children's Hospital Colorado. Dr. Watlington received the Doctor of Medicine degree from the Medical College of Virginia and a Master of Science degree in public health from the University of Colorado Health Sciences Center. She also completed residencies in pediatrics and preventive medicine at the University of Colorado Health Sciences Center.
- **Quality Improvement Director, Lindsay Cowee, LPC**: is the current director of quality management services for Colorado Access, and served in a similar position for Behavioral Health Inc., for a total of five

years of experience in health care quality improvement. A licensed professional counselor and certified addictions counselor, Ms. Cowee has also provided direct care and managed behavioral health treatment programs for offenders, victims of domestic violence, and others involved in the criminal justice system. She earned a master's degree in psychology from the University of Denver.

- **Health Information Technology and Data Director, David Napoli**: currently serves as our director of business intelligence, where he provides reporting and analytic support for our internal and external (health care practices) customers. He has more than 20 years of experience in health information technology and local health care analytics.

Utilization Management Director, Chase Gray, BSN: is the current program director for care management services for COA, and previously served as regional director, program manager and practice coach more than five years with HealthTeamWorks. When combined with her additional consulting positions with Magellan Behavioral Care and AllCare Home Health, Ms. Gray's experience in utilization management, managed care, quality improvement and care management totals over eight years. She has a Bachelor of Science in nursing degree from Johns Hopkins University School of Nursing.

Sufficient Personnel

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

As the only local, nonprofit health plan in the state, we have been able to attract a team of talented, experienced and committed staff members who will serve The Regional Accountable Entity (RAE) contract. We currently employ more than 400 full time employees (FTE), all of whom live in Colorado and serve our current contracts. We have expertise in customer service, care management, utilization management, member and community engagement, appeals and grievances, leadership and more. Our team includes professional and executive staff members (e.g. attorneys, accountants), clinical staff (e.g. nurses, psychologists), technical experts (e.g. data scientists), hourly employees, and members with lived experience. Our organizational structure was developed with whole person care in mind; our physical, behavioral, and long-term care expertise are integrated and physically co-located within the company.

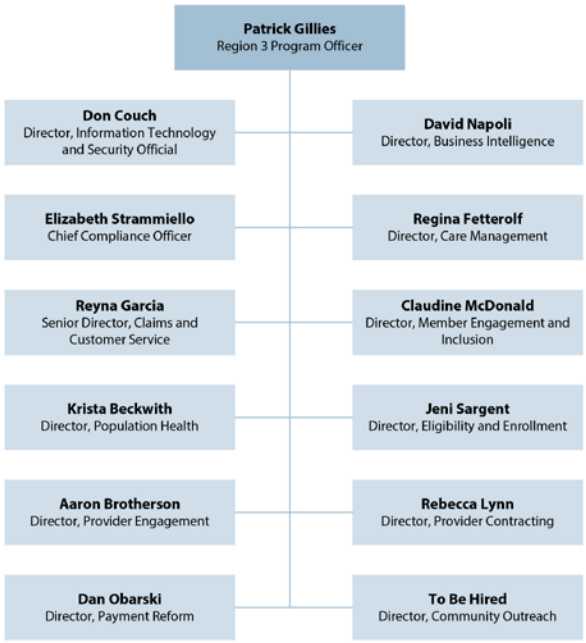
We will ensure adequate essential personnel to perform all of the functions of the contract and to achieve the RAE aims. Our regional RAE team will be comprised of mission-driven employees from local areas. We will regularly monitor the membership and provider counts, as well as other measures of workload, efficiency, and quality, to ensure that our staffing model is more than adequate to meet the needs of members and fulfill the contract requirements. Our focus on serving the underserved attracts employees who are passionate about members and want to provide the best possible care to their neighbors and fellow Coloradans. Recruiting the right expertise and experience is also critical. To meet the requirements of the RAE contract as well as serve the needs of the community, we will employ highly qualified and experienced staff in the areas of customer service, care coordination, utilization management, population health, member and community engagement, provider network management, appeals and grievances, claims processing, quality management, data and technology, finance, communications, leadership and more.

In addition to the key personnel and executive management described in Offeror's Response 4—Key Personnel, we employ a dedicated and highly experienced team of directors, managers, and other staff members who are qualified and prepared to perform the duties outlined in the RAE contract. With a relatively low level of staff turnover, we have the stable workforce needed to operate an efficient business. We ensure that all personnel meet rigorous requirements appropriate to their roles. This is accomplished through detailed job descriptions that include educational and experience requirements for each position. The hiring process includes rigorous review of background, history, and skills. All positions require in-person interviews; some technical positions also include testing activities. As the RAE, we will continue to use a data-driven approach to monitor the appropriateness of staffing levels and make adjustments as necessary. For example, care coordination workload and caseloads are monitored to ensure that all members are receiving care coordination services when and where they want it. The customer service call center is carefully monitored for metrics such as call volume, time to answer, call abandonment rate, etc. Utilization management is tracked for turnaround time and accuracy (inter-rater reliability). In the claims processing areas, there are standard metrics for claim volumes, timely payment, and auto-adjudication rates. We also use qualitative information to gauge adequacy of staffing levels,

such as member complaints and feedback from the Department, network providers, and community stakeholders.

The table below and the staff descriptions that follow offer a comprehensive picture of the personnel who will perform the work of this contract. The table also illustrates the interoperability of our operations and clinical staff and lists the value add positions, in addition to the required key personnel, that we intend to bring to the Region 3 RAE.

HIGH LEVEL DIAGRAM OF STAFF ENGAGEMENT IN RAE REGION 3



- **Program Officer**

  Patrick Gillies, Region 3 Program Officer, will provide leadership and direction for the region and be accountable to the Department of Health Care Policy and Financing (the Department) and the executive leadership of Colorado Access (COA) for the execution of the RAE contract. His experience is leading the RCCO contracts held by COA as well as serving as the regional lead in Region 3 for the current administrative services contract with Behavioral Health, Inc. (BHI) and provides the right level of knowledge and relationships in the community to achieve the RAE goals. Mr. Gillies has significant experience in managing behavioral health contracts in Texas and brings that experience to COA and the RAE program.

- **HIT/Security**

  Don Couch, Director of Information Technology & Security Official, as the chief information officer for COA, Mr. Couch oversees custom development, business analytics, production and technical support and telecommunications. He also oversees all application development and business analyst functions. Mr. Couch joined COA in 2014 and brings more than 22 years of information technology management and leadership experience in the health insurance industry.

- **Business Intelligence**

  David Napoli, Director of Business Intelligence, provides reporting and analytical support for all COA internal and external customers. Mr. Napoli oversees a team of business intelligence analysts, data visualizers, data scientists and data architects with a combined 80 years of experience in database management, financial and statistical analysis and business intelligence. Business Intelligence team members have expertise in Business Objects, SAS, SQL, Power BI and other tools. Mr. Napoli joined COA in 2016 and brings more than 20 years of experience in local health care analytics to the role.

- **Compliance**

  Elizabeth Strammiello, Chief Compliance Officer, provides oversight and overall management of corporate compliance for COA. She has overall responsibility for all corporate compliance programs and is responsible for RAE program integrity functions for COA. Ms. Strammiello is also responsible for all program integrity auditing activities for the company and provides oversight of the quality improvement department.

- **Care Management**

  Regina Fetterolf, Director of Care Management, employs a team of multi-disciplinary care managers dedicated to coordinating care for members. These care managers are located in the community, at high volume hospitals and within COA. The care management team is comprised of staff with both physical and behavioral health expertise, both licensed and unlicensed. As described in Offeror's Response 15 - Population Health Management, the RAE team will coordinate closely with Access Long Term Services and Supports (ALTSS) case managers to provide a more integrated member experience.

- **Claims & Customer Service**

  Reyna Garcia, Senior Director of Claims and Customer Service, joined COA in 1995. She has held increasingly responsible positions since that time. As the senior director of customer service and claims, she is responsible for the customer service call center and ensures that clients and providers receive accurate information regarding benefits, provider availability and other aspects of the program in which they are enrolled. Ms. Garcia will oversee the integrated call center operations and ensures they are coordinated with, and accountable to the larger RAE program. She is an expert in delivering quality services to a high volume of individuals utilizing call center technology.

- **Member Engagement**

  Claudine McDonald, Director of Member Engagement and Inclusion, has been with COA for more than 20 years during which she has focused on member outreach and communication. Ms. McDonald serves as the ADA coordinator within COA as well as an internal Ombudsman for all member-related issues. She is a recognized and respected leader in the community and works closely with members, advocacy groups and other stakeholders to ensure that our work is person and family centered. Her unique perspective as the parent of an adult child with disabilities provides an additional layer of expertise and experience to her work.

- **Population Health**

  Krista Beckwith, Director of Population Health, joined COA in 2014 with a strong professional and academic background in population and community health. She led the COA work with the Department around the Colorado Opportunity Project and will continue to lead that work in the RAE model. Ms. Beckwith is also a certified professional coder and lends that expertise to our analytic and operational teams.

- **Eligibility and Enrollment**

  Jeni Sargent, Director of Eligibility and Enrollment, is the COA expert on state eligibility and enrollment files and processes. Ms. Sargent and her team manage millions of member eligibility records on a monthly basis and ensure that files are loaded and processed properly, errors are identified and escalated and our system provides accurate eligibility information to support care management, claims payment, customer service and other RAE functions.

- **Provider Engagement**

  Aaron Brotherson, Director of Provider Engagement, joined COA in 2016 and brings more than 15 years of experience in provider engagement, provider relations and value based contracting to the role. He oversees the provider support and practice transformation teams and ensures all provider-facing activities are thoughtful, intentional and coordinated.

- **Provider Contracting**

  Rebecca Lynn, Director of Provider Contracting, joined COA in 2017 and brings a wealth of experience in both facility and contracting. She oversees the integrated physical and behavioral health contracting staff members and ensures contracts are well designed, well implemented, and well monitored. She will play a pivotal role in rolling out the value based payment contracts under the RAE for primary care medical providers (PCMPs) as well as key behavioral health providers.

- **Payment Reform**

  Dan Obarski, Director of Payment Reform, serves as the COA payment reform expert. He oversees a number of payment reform projects within the organization and provides technical expertise on other state and national models. In collaboration with Mr. Brotherson and Ms. Lynn, Mr. Obarski leads the development of the COA Value Based Payment model and will continue to work with providers to evolve the payment models we use.

- **Community Engagement**

  To Be Hired, Director of Community Outreach, oversees our community and stakeholder engagement activities, coordinates with state and local policy makers and supports the regional advisory committee. We are actively recruiting for this position and expect to have it filled by the end of July.

They are not part of the management structure, but we know that care managers will be critical to RAE success. This description of a current Region 3 care manager illustrates the important contributions that these staff members will make to the RAE organization:

Sheryl McCully, RN: *A registered nurse, Sheryl spent many years working in pediatric care and teaching college nursing courses. She currently serves as a transitions of care manager and has provided one-on-one services with more than 500 members. Sheryl's work is largely hospital-based with patients who have complex medical needs. She meets members in the hospital so that she can make an immediate connection at a critical time in which the member is most likely to engage in their care. Because she lives within the communities she serves, Sheryl has built strong relationships and rapport with hospital staff members and community health providers.*

Sheryl recently worked closely with a member who was no longer accepted at a particular practice. The member has a substance use disorder, and the practice believed that providing care for him was too difficult. Sheryl worked to gain the member's trust and, because of her close relationship with the providers, convinced them to give him another chance. She helped rebuild the relationship between the member and the practice by meeting him at appointments, ensuring that he understood his medications and treatment plans, and encouraging him to be his own advocate. Sheryl's patience with the member gave him the trust he needed to follow through with appointments, smart goal setting, and begin his process toward wellness.

B. STAFF TRAINING, DEVELOPMENT, AND SUPPORT

As a company, we offer comprehensive and competitive benefit packages that allow us to attract and retain a qualified workforce. Our active, enterprise-wide training department regularly delivers a robust menu of training options that not only ensure that our contracts are carried out effectively, but also provide employees with an understanding of the company culture and operations, opportunities for professional development and advancement, and wellness and support strategies to optimize their performance. The learning and development team is in regular contact with both management and line staff to monitor for new training needs and gaps. Using a state-of-the art learning management system, new trainings are developed or procured from vendors and systematically delivered to the appropriate staff in a timely fashion. Executive-level leaders and managers also receive training in areas such as change management and performance coaching, as well as content updates related to their areas of subject matter expertise. Our quality team will be responsible to ensure that each department and program is appropriately trained and equipped to carry out the requirements of the RAE contract in an efficient and effective manner. Finally, we have a clearly defined employee performance evaluation process and employee performance compensation program that allows us to identify and recognize top talent and keep them committed to COA.

The Company's organizational processes ensure that staff members have defined responsibilities and competencies embedded in their job descriptions and area desktop procedures and that they are regularly supervised or monitored as appropriate for their roles. While the Company uses a matrix organizational structure as described in Offeror's Response 4—Organizational Structure, there are clear reporting lines for the purposes of employee oversight, support, and performance management.

RAE personnel will be fully trained regarding Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, and other state benefit programs, the RAE aims, structure, and requirements, cultural competence (described in Offer's Response 9—Member Engagement), and other related topics. The training will embrace the concept of whole-person care, with all staff members being trained on physical health, behavioral health, and long term care components. Our staff will be able to offer members, families, and providers an in-depth understanding of the health care system and the benefits of public programs, especially the Health First

Colorado program. Our management team will track legislative and programmatic changes so that staff training on these changes can be implemented promptly.

With our RAE team in place, we confidently assure that we have and will continue to provide sufficient qualified staff members to meet the requirements of the contract. We will work with the Department to ensure that all personnel assigned to this contract have the necessary training to adequately perform their roles, including accessing the Department-provided training described in the contract. In addition to company-wide training for compliance, operations, and URAC standards, each functional department will provide extensive job-specific training requirements to ensure that RAE employees clearly understand the role, responsibilities and performance expectations of their positions.

C. VACANCY MANAGEMENT

High levels of employee engagement are key to a productive, mission-focused workforce and high retention rates. The last two Company employee engagement surveys yielded a more than an 85% response rate. Of those responding, over 95% understood and connected to the mission and values; 87% see how their everyday work supports this mission and vision, and more than 87% understand our strategic priorities. As described above, robust employee training, development, and support activities help maintain this high level of engagement.

To determine the number of qualified personnel needed for clinical and operational functions, we consider the number of members enrolled in our various lines of business, and the percentage of members accessing services. As the current Region 3 Regional Care Collaborative Organization (RCCO) and the administrative services partner for BHI – the Region 3 Behavioral Health Organization (BHO), we have hired the appropriate number of staff members needed to meet all contract requirements. We monitor the ratio of staff-to-members needed on a continual and ongoing basis and make adjustments to staffing when appropriate. As reflected in the organizational structures described in this document, the Region 3 RAE will be staffed by all required key personnel positions, plus value added positions, and is supported by the overall operational and administrative structure of Colorado Access. This will provide the appropriate numbers and types of staff members needed to meet the requirements of the contract and of covered members and guide vacancy management efforts.

Utilizing state-of-the art, data-driven recruitment processes ensures that we fill positions quickly with the right people. This includes having sufficient personnel dedicated to recruitment, using the latest tools and methods, and leveraging in-depth knowledge of the local labor markets and resources. We maintain a position vacancy rate of around 3%, which is low both in the industry and the state. This reflects both a high employee retention rate and a low time-to-fill interval for open positions. The executive team regularly reviews detailed vacancy data and proactively identifies and responds to trends they observe, including recruiting for hard-to-fill positions. We are confident that we will be able to fulfill the contract requirements for the duration of the contract. However, if at any time the Department determines that we do not have sufficient personnel to perform the work associated with this contract, we pledge to rapidly acquire the needed personnel at no additional cost to the Department.

Subcontractors

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.

SUBCONTRACTING WITH TRUSTED PARTNERS

As a managed care organization, we have multiple subcontractors that we leverage for specific expertise and/or system functionality. We strive to maintain knowledge and expertise within the company and will not subcontract major areas of this contract. The following are the organizations with whom we currently subcontract and expect to continue to work with as the Regional Accountable Entity (RAE). While specific vendors are named below, we will continue to evaluate each of these contracts and the functionality we are purchasing to ensure that we are being good stewards of the state's dollars and that the services being delivered are optimized for the needs of members and providers. We reserve the right to change vendors at any time and will follow the Department of Health Care Policy and Financing (the Department) requirements to notify them of any new or changed subcontractors under the RAE contract. We also acknowledge that the State has ownership rights for work products developed under this contract by either Colorado Access (COA) or one of our subcontractors.

All contracts have an assigned vendor lead within COA, and clear service level agreements to ensure the functions we have purchased are being delivered appropriately. Each vendor lead arranges regular management oversight meetings with the vendors to address programmatic changes, upgrades and other functions and to provide a venue to address any issues or concerns. We are in the process of implementing a formalized, enterprise wide, procurement process through which all future contracts and subcontracts will flow to provide another layer of oversight and review for all outsourced functions.

Our current subcontractors include:

- **TriZetto/Cognizant** – Information technology transaction system and processing team used to process claims and encounters; they will process 100%of the RAE claims. This contract has been in place for five years.
- **Scio** – Claims auditing and recoupment vendor that specializes in finding claims payment errors or third party liability scenarios. All non-capitated behavioral health claims will be included in Scio analytics for potential recoupment.
- **Altruista** – Care management tracking and documentation system that also supports utilization management (UM) and grievances documentation and workflow. One hundred percent of RAE clients' UM and grievances will be handled in this system. All documentation for RAE clients where COA is responsible for care management will be completed within this tool. The Access Long Term Support Solutions (ALTSS) long-term care services program will also be tracked and documented within this tool beginning in early 2018, providing a more comprehensive, patient-centered record for all the Medicaid services clients receive.
- **McKesson Interqual** – Vendor who creates and licenses criteria for use in making determinations about UM. One hundred percent of UM decisions use these criteria.

- **Apogee** – Workflow, tracking and documentation system for credentialing activities. One hundred percent of COA credentialed providers are documented in this system.
- **Amitech –** Vendor that provides Enterprise Data Warehouse architecture while partnering with us on best practices around data governance. Their focus is on the transformation of health care through data analytics.
- **Nuna** – Health care vendor that partners with government and health plans to improve quality of care. Nuna is the organization that was contracted by Washington to help overhaul healthcare.gov for the Affordable Care Act (ACA) in 2013. Nuna will be working with us to apply lessons learned from working with nationwide Medicaid data, to drive better outcomes locally for members through data analytic initiatives.
- **CORHIO** – Statewide vendor that provides real time access to a growing number of hospitals' admission, discharge and transfer data. We will be contracted with CORHIO for access to inpatient and outpatient data for our 100% of RAE members.
- **Silverlink** – A member engagement platform that will be used to track and document RAE member communication preferences and manage member focused communications. This tool will offer a full view of all communications members have received from the RAE, allow members to establish a preferred method of communication (e.g., mail, email, texts, phone calls) and provide a mechanism to track various communication activities to support program evaluation. Clinical and population health communications will be managed within this tool and it will be expanded to include all communications with members, such as explanation of benefits (EOBs), customer service contacts, HIPAA disclosures and notifications.
- **Cognizant** – Our information technology (IT) department is outsourced to Cognizant to better allow our organization to adapt IT resources based on ever changing health care needs. This vendor does 100% of our IT programming/development and desktop support and provides onsite teams within COA to deliver these services. Our chief information officer oversees this contract and ensures that all services and functions provided meet the standards of the contract and the needs of the organization.
- **Rocky Mountain Crisis Partners (RMCP)** – Crisis hotline services and after hours utilization management services. These services are available to members and providers when COA is not open. RMCP staff members use our protocols and processes to ensure a consistent experience and decision- making process.
- **South Metro Fire Rescue Authority** - Pilot program to reduce emergency department services for members through South Metro Fire and Rescue Authority and True North Health Navigation. We pay a set administrative fee to cover the transportation of the providers and the expense of the vehicle when a member is seen at their home or other location and not transported in a billable fashion to another facility.
- **Outsourced care management arrangements with regional facilities or other organizations –** UCHealth and Denver Health are trusted partners of our organization. Together, we have entered into contracts that will allow our care managers to work directly within the facility's emergency room departments. We expect these types of arrangements to grow under the RAE contract to meet the needs of the members and providers in the region.

- We have a variety of contracts to support basic business operations such as leases, printers, cleaning crew, paper storage and shredding, employee records (UltiPro), accounting systems, telephone system, computer/hardware purchases/leases, internet connectivity, post office box, IT servers, workers compensation insurance, staffing firms to recruit employees, translation services for call center, payroll software, employee benefits, and other services. These contracts are reviewed on a regular basis and are available for review by the Department as needed.

Our legal contracting process ensures that we pass down all state and federal requirements and obligations to our subcontracted vendors, that these requirements are upheld by each of our vendors, and that they are accountable to the same standards as we are for key elements such as timelines and confidentiality. Below is a list of standard contract requirements that are included in our subcontracted arrangements in support of our contract with the Department:

1. Confidentiality and non-disclosure components
2. Member held harmless clause
3. HIPAA compliance
4. Liability – protection for third party liability such that vendors have no recourse with the Department
5. Term/termination language generally aligned with Department contract timelines
6. Immediate termination options
7. Rights to deliverables: they are our property, not the vendors'
8. Independent contractor status: even though vendors are performing services for us, they are not our employee
9. Non solicitation requirements
10. Subcontracting not allowed without our approval
11. Intellectual property protection
12. Department/Colorado Access right to audit and access vendor records
13. Federal fund disclosure: no funds will be deployed to influence an employee or officer
14. Non-discrimination clause
15. Fraud and abuse protections

The RAE: A Single Administrative Entity

OFFEROR'S RESPONSE 7

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

We fully endorse the Department of Health Care Policy and Financing (the Department) vision for the Colorado Medicaid Program and are fully prepared to advance integration of the Accountable Care Collaborative (ACC) Program, Community Behavioral Health Services Program, and Long-Term Services and Supports (LTSS) Program. Building on the successes of these three programs while integrating them more seamlessly will result in several key outcomes for Colorado: more coordinated, higher-quality care experiences for members, a more efficient health care system, and reduced health care costs.

We strongly support the Department's plan to administer the Primary Care Case Management Program (PCCM) Entity and Prepaid Inpatient Health Program (PIHP) as a single program within Region 3 with integrated clinical care, operations, management, and data systems. Our long history of achievement in managing care for Colorado Medicaid recipients, and other populations in multiple contracting formats, has established our ability to implement a wide range of Departmental initiatives with creativity, flexibility, and commitment to the highest quality. Of particular note, we are the incumbent contractor in two current regions for both the Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) programs. While meeting each program's unique contractual requirements, we have also successfully leveraged opportunities to operate them synergistically, reduce complexity for members and providers, streamline administrative processes, achieve better outcomes by aligning clinical programming and incentives, and better understand and meet the population's whole-person needs. Our current work, and our Regional Accountable Entity (RAE) vision goes beyond simply combining administrative structures and operations and instead, integrates the physical health and behavioral health programs in such a way that truly transforms the system. Physical and behavioral healthcare become interoperable components of a holistic system intentionally designed to achieve common goals through a common culture and financially aligned incentives.

As demonstrated throughout this proposal, we are the most experienced and qualified Offeror to be designated as the RAE responsible for administering the ACC in Region 3 as a single administrative entity. We are well prepared and eager to perform all of the functions described in the Contract and will comply with all pertinent state and federal statutes, regulations, and rules, including the Department's 1915(b) waiver for the ACC.

We look forward to partnering with the Department to realize the ACC 2.0 objectives and prepare the system for future advances in the value-based models of ACC 3.0 and beyond.

INTEGRATED ADMINISTRATIVE PROCESSES

As the RAE, we will fully integrate all aspects of governance, leadership, administration, clinical operations, and business operations. We will not outsource, subcontract, or compartmentalize the physical health (Primary Care Case Management Entity) or behavioral health (Prepaid Inpatient Health Plan) components to other contractors or providers or separate them into internal silos. The integrated governance structure and model are described in Offeror's Response 8—Governing Body. Below is a brief description of our plan to conduct the RAE program functions in an integrated administration.

Member engagement and customer service: As described in Offeror's Response 9—Member Engagement Strategy, we will implement a comprehensive member engagement program. Its staffing and diverse array of member offerings—the Member Advisory Council, the onboarding process, cultural competence programs, etc.—will be fully deployed across the entire membership and not segmented by behavioral health or physical health. The programming will be driven by ongoing assessment of the membership's needs, including access to high quality physical health, behavioral health, and other services and supports. Representative member participation will be solicited across subpopulations (e.g. pediatric and adult, persons living with disabilities, persons with chronic/complex medical conditions, persons with substance use).

Grievance and appeals: As described in Offeror's Response 10—Grievance and Appeals, we will maintain a single unit and process to address all grievances and appeals, regardless of source or focus. This provides a seamless experience for members, who may have a variety of concerns; they will not be told to call another organization or number. Grievances and appeals will not be outsourced or subcontracted. Reporting on grievances and appeals will be integrated across programs.

Network development and network provider management: As described in Offeror's Response 11—Network Development and Offeror's Response 12—Network Provider Management, we will continue to maintain and grow a robust network and provide extensive services and supports to both behavioral health and physical health (PCMP) providers. Our provider engagement team is fully prepared to serve a variety of practice types and be a centralized contact point for providers wanting help with a range of issues: credentialing/contracting, claims payment, data, practice supports, etc. Providers will not have to develop separate relationships with two different teams. We will manage the entire population of practices as an integrated service delivery system, allowing for more systematic assessment of RAE performance, needs, gaps, and opportunities, rather than viewing them as two separate networks.

Health neighborhood: As described in Offeror's Response 13—Health Neighborhood, our comprehensive approach to building a health neighborhood in Region 3 is holistic and embraces physical health, behavioral health, specialists, LTSS, local public health agencies, and others. Having a common agenda and shared plan will eliminate duplication, prioritize competing demands, and increase the chances of success. The current system requires both contractors to engage with multiple, overlapping parties. We will use a single health neighborhood team and set of processes to plan, build, and support the health neighborhood.

Community engagement strategy and social determinants of health: As described in Offeror's Response 14—Community Engagement, we will conduct a comprehensive needs/opportunities assessment in Region 3, develop a comprehensive community engagement plan, and implement it jointly with key providers and community partners using a single team and process. We are excited to forward this work by building upon existing relationships we have developed with community entities through our role as the RCCO in this region.

Population health management and care coordination: In Offeror's Response 15—Population Health Management, we describe a comprehensive approach to population stratification that integrates all aspects of members' data: physical health utilization, behavioral health utilization, diagnoses and clinical data, risk factors, demographics, etc. This integrative approach does not segregate members into physical health or behavioral health subgroups or look at them through those separate lenses. The population health department will serve the entire RAE membership, generating a holistic view of members, standard datasets and reporting, and dynamic models to inform clinical and quality interventions. Population stratification will drive member

interventions based on needs, not program assignment. Likewise, RAE care coordination will be planned and delivered to the membership and to subpopulations based on need, acuity, setting, and other factors, not based on program assignment or a dichotomous view of physical health versus behavioral health. In this model, care coordinators are cross-trained; there will be no care coordinators designated as "physical health" or "behavioral health." Staff members are grouped in multi-disciplinary teams to best meet the members' needs, consulting with one another as needed. There is an integrated care coordination leadership and organizational structure as well. This is described in Offeror's Response 16—Care Coordination. Our multi-disciplinary medical director staff works across programs; for example, a regular case conference to provide supervision for care coordinators is staffed by both a psychiatrist and a primary care physician.

Provider support and transformation: Providers frequently complain, justifiably, of "innovation fatigue" from overexposure to multiple entities wanting to partner, conduct pilot program, exchange data, etc. This is exacerbated by the current separation of Medicaid physical health and behavioral health programs. As the RAE, we will implement a comprehensive approach to provider support and transformation using a single department to perform these functions, as described above and in Offeror's Response 17—Provider Support. This structure will be particularly effective in advancing integrated behavioral health care in primary care practices, aligning metrics and incentives, and creating alternative payment models that take into account whole-person care.

Behavioral health services: As the RAE in Region 3, we are fully committed to extending the reach of the community mental health center while at the same time expanding access to a wide range of diverse behavioral health care options and advancing integrated behavioral health care in primary care settings. To accomplish this, we will not delegate oversight of the behavioral health continuum to a behavioral health provider entity. As a system-level entity, we will be able to see the big picture, ensuring that core specialty behavioral health services are preserved while also promoting new models and ensuring accountability to the overall RAE aims. Our administrative structure fully integrates the operational and clinical aspects of behavioral health services throughout, rather than creating a separate reporting line, budget, etc. This is described in Offeror's Response 4—Organization Structure, and other Offeror's Responses.

Data, analytics, and claims processing: Our data, analytics, reporting, and claims processing are managed by the business intelligence and information technology departments, which are fully integrated. Our electronic data warehouse and data processes are unified such that physical health and behavioral health data are seamlessly merged and share standard data elements and reporting tools. We are fully prepared to support all of the data, analytics, reporting, and claims processing requirements in an integrated fashion. We are also prepared to use the power of integrated data and reporting to support health system transformation, improve health outcomes, and support alternative payment models. This is further described in Offeror's Response 21—Data Management and Analytics and Offeror's Response 22—Data Management and Claims Processing.

Quality Improvement: Our quality improvement team is fully integrated across physical health and behavioral health and will support all of our efforts in Region 3. This multi-disciplinary team includes staff members with expertise in both behavioral health and physical health and is experienced in conducting activities that crossover these areas. This is described in Offeror's Response 23—Quality Improvement.

Compliance: Our robust compliance department is fully integrated and will support all compliance efforts in Region 3. Team members' experience includes the full range of health programs and populations, including

physical health, behavioral health (including substance use disorders), and multiple contractual formats. This unified team will conduct all compliance activities described in Offeror's Response 24—Compliance Program.

BEYOND INTEGRATION TO TRUE TRANSFORMATION

Merely integrating or combining leadership structures and administrative processes will be insufficient to achieve the RAE's aims in Region 3. The Department has put forth a bold vision, and we believe that a bold RAE response will be needed to achieve it. Assembling a coalition of participants and reassigning tasks won't suffice. We propose that a **transformative process**, not just structure, is needed to leverage the community's resources and collective wisdom, while truly creating a new vision, a new path to get there, and new, more disciplined and accountable ways to work together in Region 3.

In the winter of 2011, the Stanford Social Innovation Review published a journal article on Collective Impact[1]. It asserted that "Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations." The article defines collective impact as "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem." This seminal article outlined a replicable approach to solving complex social problems. Since publication, it has spawned new collaborative movements within social sectors and new philanthropic funding strategies in Colorado and across the nation and the world.

In preparation for becoming a RAE, we have worked hard to develop an approach to foster regional collaboration and innovation in a thoughtful, effective manner. **The Colorado Access Health Transformation Framework - serves to design and align regional initiatives to forward a shared vision for RAE outcomes.** This framework is built upon the Collective Impact Model and its five conditions for success which, working synergistically, produce alignment and lead to powerful results. They are:

1. **A common agenda:** The partners committed to the Collective Impact Model (organizations, agencies and other stakeholders) have a common understanding of the problems, a collective approach to solving them, and a shared vision for change.
2. **Shared measurement systems:** The partnership has a collective focus on performance management and shared accountability. To bring consistency and clarity to these efforts, participants define and implement shared methods for collecting data and measuring results.
3. **Mutually reinforcing activities:** Through a coordinated, joint plan of action, each participating organization or other stakeholder conducts a specific and differentiated set of activities that support and align with the actions of others.
4. **Continuous communication:** Partners have a forum for consistent and open communication, with a focus on building the mutual trust necessary to succeed.
5. **Backbone organization:** The partnership is led by one organization—the chief support system—that has the staff, resources, and skills to convene, handle logistics, and coordinate the various efforts of

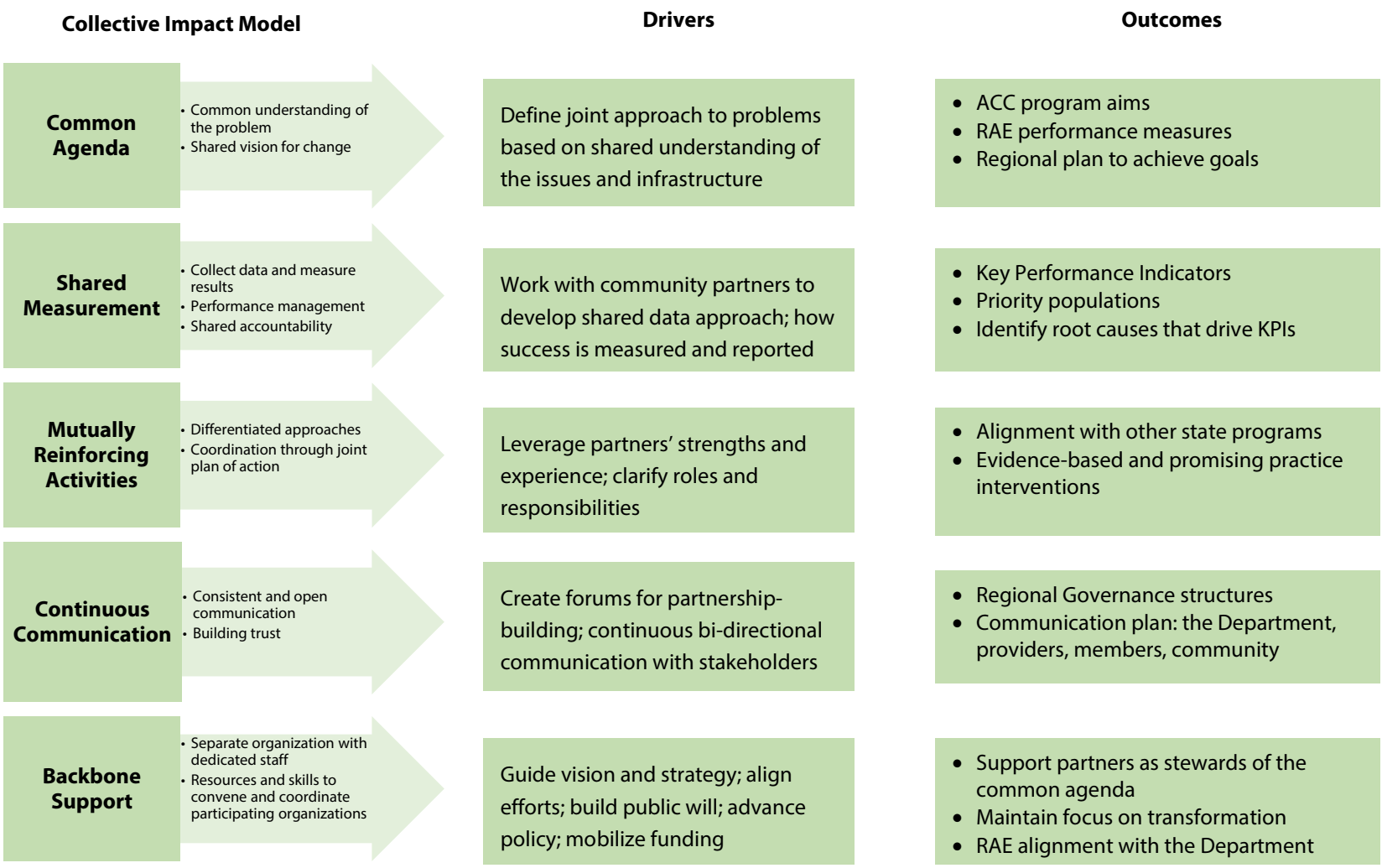
[1] Kania, J. and Kramer, M., "Collective Impact", Stanford Social Innovation Review, Winter 2011, pgs. 36-41.

partner organizations to ensure all are moving together toward a common goal. Truly catalytic backbone organizations instill a sense of trust and urgency and provide the tools, data, and space for innovation that partners need to achieve their shared goals.[2]

Figure 7-1 on the next page illustrates how Colorado Access, as the backbone organization, will operationalize these conditions to transform health in Region 3.

[2] Tools for Social Innovators by Spark Policy Institute (http://tools.sparkpolicy.com/). Accessed 5/23/17.

FIGURE 7-1 THE COLORADO ACCESS HEALTH TRANSFORMATION FRAMEWORK



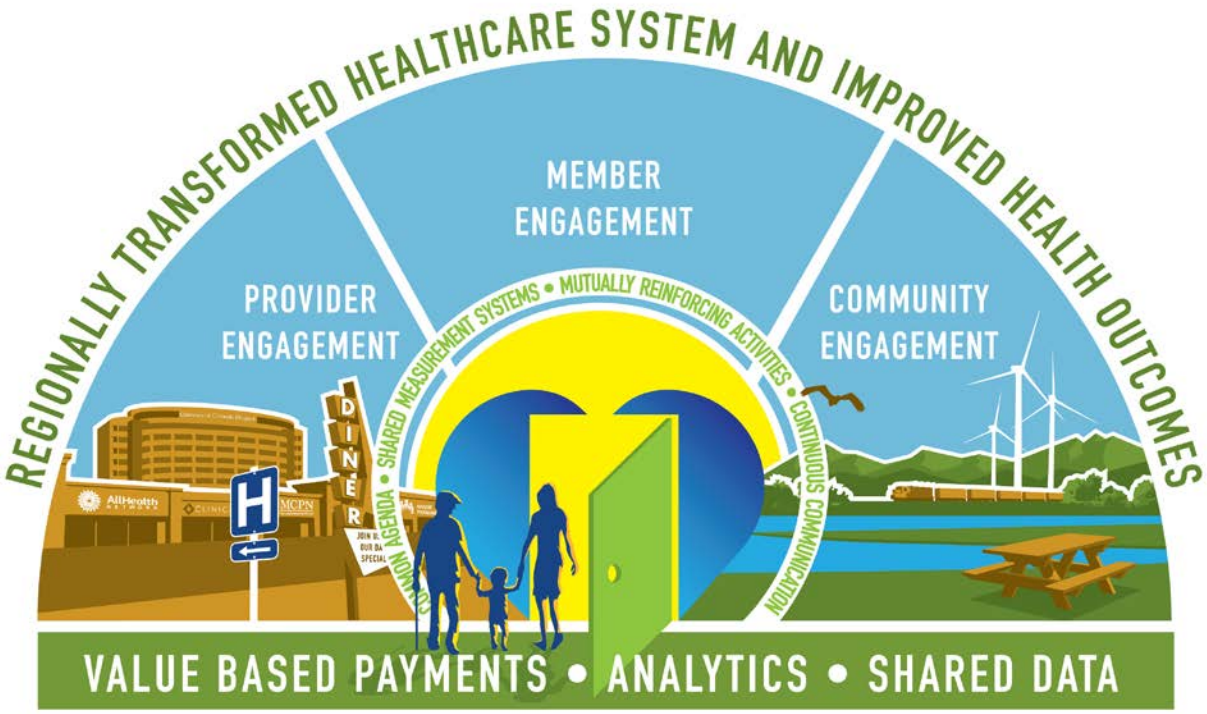
Creating an Action Plan for the Common Agenda

One of the most important RAE functions is the creation of a common agenda that will identify and implement strategies to advance the health care reform efforts in Region 3. The agenda will focus on: using state resources effectively, improving member outcomes, and improving the overall health of the regional population. These general aims and metrics such as KPIs will need regional input, prioritization, and detailed implementation planning to avoid duplication, conflicting models, member confusion, innovation fatigue, and lack of scale to achieve results. For example, addressing a KPI for prenatal care visits might be prioritized based on the region's need, and/or poor performance on this metric. The partners will use data to identify subpopulations of greatest need/impact and agree to share data to support interventions. Mutually reinforcing activities will be selected, and the role of each party clarified across: outreach efforts, member education, social supports, care coordination, etc. Figure 7-2 below depicts the RAE process for creating an action plan for the common agenda. Governance structures and roles are described in Offeror's Response 8—Governing Body.

FIGURE 7-2 DEVELOPING ACTION-ORIENTED PRIORITIES FOR THE REGION 3 RAE

RAE Vision and Structure

We have developed a RAE model to guide regional functions. **The Colorado Access RAE Model uses the *Health Transformation Framework* to align our service offerings upon a foundation of data to create a transformed health care system and improve health outcomes.** Our Region 3 RAE model is shown on the next page:



As this graphic illustrates, we conceptualize the RAE as an organizing force, backbone and gateway for transforming the health care system for members and for contributing to the state's overall health care reform vision. As a RAE, our change strategies will focus on engaging three primary groups: providers, members, and the diverse community of Region 3. We intend to accomplish our vision by performing the key functions listed in the Department contract, which includes: member enrollment and engagement, network development, health neighborhood and community activities, population health management and care coordination, provider support and practice transformation, and integration of the capitated behavioral health benefit. We will support these functions using alternative payment methodologies, data, analytics, outcome measurement, quality assessment, and performance improvement strategies. The foundation for all of these efforts will be the statewide agenda for Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, set forth in the state's 2015 Phase II Concept Paper and in the current RAE RFP.

LICENSING AND INTEGRATED ADMINISTRATION OF THE PCCM ENTITY AND PREPAID INPATIENT HEALTH PLAN (PIHP)

Colorado Access is a Colorado-based, nonprofit 501(c)(4) organization, licensed through the Colorado Division of Insurance since October 31, 1995 as a Health Maintenance Organization (HMO). We have a long and successful history of managing and operating an HMO for the Colorado Medicaid program, as well as for other state and federal programs.

We certify that we meet the definitions and federal requirements for a Primary Care Case Management Entity (PCCM Entity) and Prepaid Inpatient Health Plan (PIHP) as set forth in in 42 C.F.R. § 438.2. We further certify that

we have all necessary certifications, approvals, insurance and permits to perform all the services and functions required under this RFP.

Integration of Clinical Care, Operations, Management, and Data Systems

Through our previous and current contracts with the Department, we have been successfully managing both PCCM Entity and PIHP programs for many years. We are now fully prepared for and enthusiastic about administering both of these managed care authorities as one program by integrating clinical care, operations, management and data systems. Already, we have aligned our physical and behavioral health lines of business in key areas such as customer service, member engagement, provider support, population health, business intelligence, and health information technology. These efforts are intended to set the stage for complete integration of all programmatic functions upon award of the RAE contract.

To support this integration, we have invested in tools and resources that will facilitate the alignment of PCCM Entity and PIHP program performance data. Our robust reporting capabilities will allow us to compile and review integrated performance data for these combined lines of business. The senior management team will review these clinical and operational measures in weekly staff meetings, and will discuss them monthly through the regional stewardship meetings. Benchmarks and service goals will be based on specific contract requirements, state and federal regulations, industry standards, and prior experience. They will be reviewed and approved by the quality committees, which include provider and member input, for final approval by our board of directors.

In addition, our corporate compliance program will maintain independent oversight for contract compliance and for monitoring of internal and external fraud, waste, and abuse. As described in Offeror's Response 24—Compliance and Monitoring, the Executive Compliance Committee reports directly to the Colorado Access board of directors. The executive director and other management team members will use internally developed tracking tools, to ensure that we produce all required reports and other deliverables timely and accurately. With respect to external stakeholders, we have established an objective system for demonstrating accountability through the use of valid and reliable performance measures, member and administrative outcomes, benchmarks and service goals. The management team will emphasize capturing data, monitoring performance and reporting results of clinical and operational processes that reflect and measure our success in achieving the ACC goal of administering the PCCM Entity and PIHP as one program.

Governing Body

OFFEROR'S RESPONSE 8

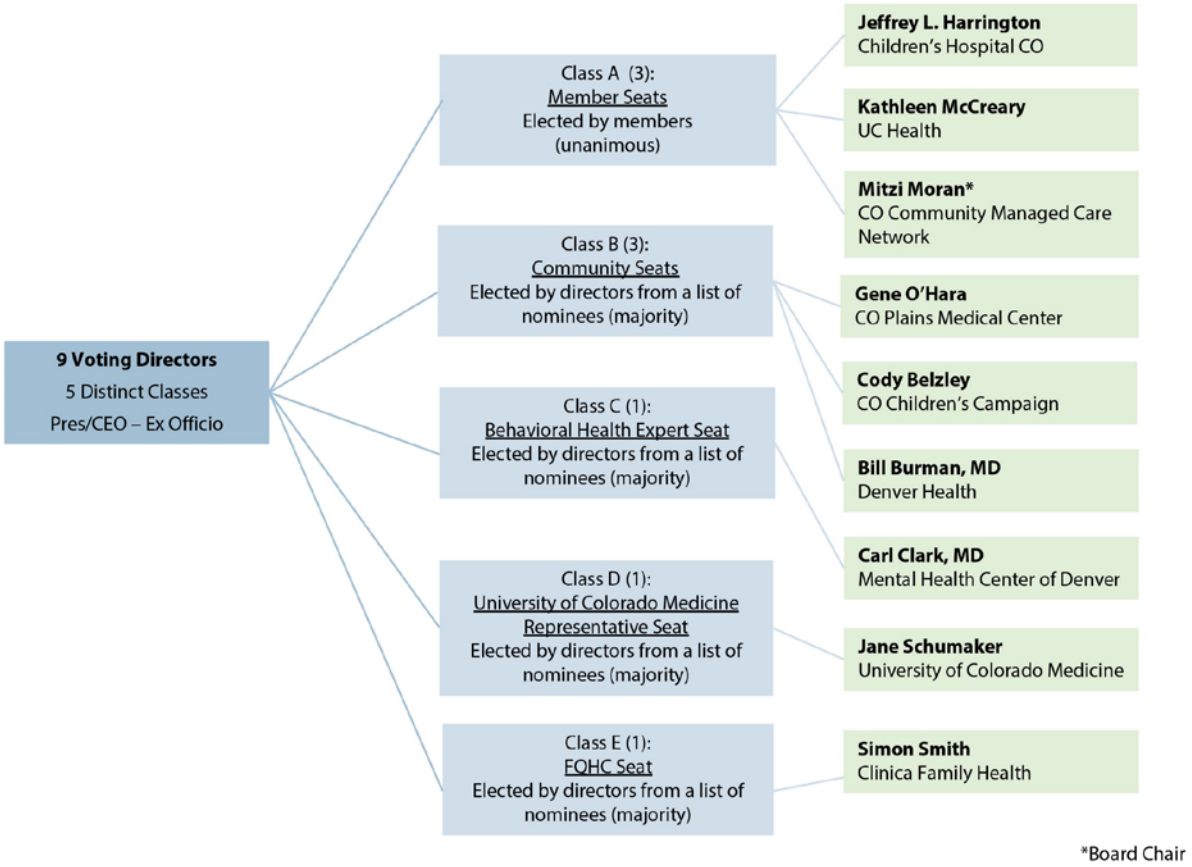
Describe the Offeror's governing body and its responsibilities, including a list of members and their credentials. Include a description of how the Offeror plans to address any perceived conflicts of interest among its governing body.

REGIONAL GOVERNANCE MODEL

The Colorado Access Board of Directors

Colorado Access is governed by a board of directors comprised of nine seats: three held by corporate members, three community at-large seats, and three seats designated for representatives of the federally qualified health centers (FQHCs), behavioral health providers, and University of Colorado Medicine, respectively. The president and chief executive officer of Colorado Access is an ex-officio, non-voting member of the board of directors. The board of directors maintains overall responsibility for the strategic direction and financial success of the company. The overarching organizational structure and leadership are described in more detail in Offeror's Response 4—Organizational Structure and Key Personnel.

COLORADO ACCESS BOARD OF DIRECTORS



Our board of director positions currently include:

- **Children's Hospital Colorado** – a founding corporate member. Jeff Harrington, chief financial officer of Children's Hospital Colorado
- **Colorado Community Managed Care Network (CCMCN)** – a founding corporate member, representing a large number of Colorado's federally qualified health centers. Mitzi Moran, president and chief executive officer of Sunrise Community Health
- **University Health Systems Inc.** – a founding corporate member. Kathleen McCreary, vice president of payer relations & network development
- **University of Colorado Medicine**– Jane Schumaker, senior associate dean for administration and finance at the University of Colorado School of Medicine and executive director of University of Colorado Medicine.
- **Behavioral Health** – currently represented by Carl Clark, MD, CEO of The Mental Health Center of Denver (MHCD)
- **Federally Qualified Health Center** – currently represented by Simon Smith, president and CEO of Clinica
- **Community At-Large Seats** – Three directors representing the community as a whole:
  - **William J. Burman, MD**, physician executive and infectious disease specialist at Denver Health
  - **Cody Belzley**, founder of Common Ground Consulting
  - **Gene O'Hara, Pharm.D.**, CEO of Colorado Plains Medical Center

The individuals who currently serve in these nine director positions all hold (or have previously held) executive or senior level positions with the organizations they represent and/or with other health care related organizations, either in Colorado or nationally. The corporate members nominate their representative to the board and the other corporate members must unanimously accept the nomination. These representatives are class A members and serve without term limits. Representatives for the remaining seats are nominated from a list of nominees submitted by two or more directors, or by a nominating committee of the board, and must be approved by majority vote of the board. These are class C, D, and E members and they serve two-year terms with no term limits. The at-large members are known as class B members and serve staggered two-year terms with no term limits. They are nominated from a list of nominees submitted by two or more directors or by a nominating committee of the board and must be approved by majority vote of the board.

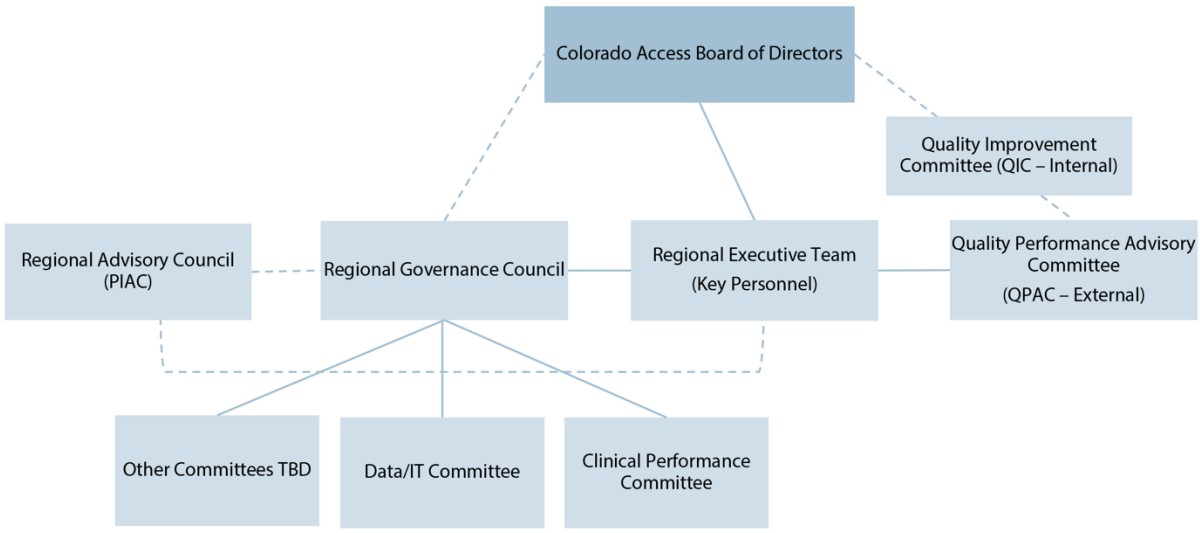
Collectively, the board of directors offers a diverse background of clinical, financial and health care operations experience. The board of directors meets bimonthly, and regularly receives information from the president and CEO, and members of the executive team as appropriate, regarding company financials, operations, quality initiatives, legislative updates, industry trends, and other strategic issues. Performance, compliance, and quality measures are reviewed with the board as specified in our quality program description and corporate compliance program. The executive committee of the board meets monthly. Additional ad hoc board meetings can be called at any time to address urgent or emergent issues. The board is encouraged to challenge each other and engage in healthy conflict in order to provide the strongest possible leadership for Colorado Access. Board members and corporate officers receive formal conflict of interest training, complete a conflict of interest declaration and

formally agree to abide by the board conflict of interest policy annually. This policy is available for review upon request. A current listing of board members can be found at coaccess.com/our-board-of-directors.

Regional Governance Model

We, along with our board of directors, believe that strong, functional and accountable leadership at the regional level is critical to the Accountable Care Collaborative (ACC) and that the participants in the local system of care must work together in new and different ways in order to achieve the Regional Accountable Entity (RAE) aims. We have long recognized that all health care is local and that the power to achieve transformation lies in our communities and the providers who serve them. With the support of our board of directors, we have formed an effective regional governance model for Region 3 that brings together the strength, experience, and resources of the health care components in a new and accountable way: not merely to represent our own organizations but to develop the common agenda and drive transformation across the regional health care system as a whole. This governance model enables members, providers, and stakeholders to be directly involved in regional health care decisions. The regional governance model is depicted in Figure 8-1 below, and its components are further described in the following sections.

FIGURE 8-1 REGIONAL GOVERNANCE MODEL



The Region 3 Governance Council

The Region 3 Governance Council has been designated by our board of directors to participate in decision-making and oversight to assist us in creating and implementing an effective RAE. The Council's goals are to improve the member experience of care, improve population health, and reduce the per capita cost of health care. Voting members of the Council accept a fiduciary responsibility to the RAE and agree to make decisions in good faith and in a manner believed to be in the best interests of RAE aims and members. Current members are listed below. These partners have actively participated in the RAE model development, have collaborative partnerships with Colorado Access (and, in many cases, each other), are major Medicaid providers, and have a critical role in achieving RAE aims. Upon award, we will reassess the size and membership of the Council to

ensure that it has adequate and appropriate representation to achieve the RAE aims and the contract requirements. The addition of community representative seats is planned. The membership of the Governance Council will be posted on the Colorado Access website.

Current Region 3 Governance Council Members:

- Patrick Gilles, Colorado Access RAE program officer
- David Pump, deputy director Peak Vista
- Annie Lee, senior director, Medicaid strategies and programs, Children's Hospital Colorado
- Austin Bailey MD, medical director, Colorado Health Medical Group, UCHealth
- Charles Baumgart MD, chief medical officer for population health, UCHealth
- Ben Wiederholt, chief executive officer, Metro Community Provider Network (MCPN)
- Bebe Kleinman, MNM, chief executive officer, Doctor's Care
- Tina Finlayson MD, associate medical director, CU Medicine
- Jessica Dunbar MSPH, executive director, Rocky Mountain Youth
- John Santistevan, chief executive officer/president– Salud Family Health Centers
- Keith Larson, chief financial officer, AllHealth Network
- Simon Smith MHA, president and chief executive officer, Clinica Campesina
- Rick Doucet, chief executive officer, Community Reach
- Randy Stith PhD, chief executive officer and executive director, Aurora Mental Health Center
- Rick Rush, executive director, Kaiser Permanente

Governance Council members have endorsed the following core set of principles to guide their work:

- We strive to ensure access to efficient, high quality, integrated health care in the region.
- We mutually accept responsibility for the management of the ACC program, the collective performance of all providers in the region, and the collective health outcomes of all ACC members in the region.
- We acknowledge that our partnership transcends the ACC program and that our success in working together will lead to achieving the desired outcomes we all seek in Region 3.
- We place great emphasis on our long-term, respective roles in the region and how we will mutually work within our partnership, as well as with other providers and stakeholders in the region, to improve the health care delivery system.
- We actively work toward payment models that share risk among Colorado Access and providers in the region.
- We act as good fiscal stewards of finite health care resources, consistent with the Quadruple Aim. We support and work towards fair compensation for all parties in our region.

- We engage in direct, transparent, conversations.

Committees and Ad Hoc Work Groups: The Governance Council may establish, oversee, and dissolve additional advisory committees and working groups as needed to address specific operational issues.

Responsibilities of the Governance Council:

- Collaborate across the health neighborhood to assure an effective clinical delivery system in the region, intervening as needed to address system-level issues.
- Collectively work towards addressing the social determinants of health and achieving the Quadruple Aim in Region 3: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.
- Collectively accept accountability to achieve the goals of the ACC program and attain the established key performance indicators (KPIs) in Region 3 by engaging providers, Colorado Access, and the broader community.
- Support individual providers to make improvements that enable them to participate effectively in the ACC and contribute to its goals by disseminating information and sharing best practices.
- Provide regular reporting to the Colorado Access board of directors on RAE performance.
- Develop and make recommendations regarding financial issues such as (1) value-based payment models and sharing financial risk; (2) setting criteria and mechanisms for determining administrative and incentive payments (base rates, adjustments for quality ratings, etc.).
- Inform policy decisions that would affect RAE network providers and contractors.
- Participate in structured communications between the Department and Colorado Access regarding strategic and policy issues related to the RAE program.

The Region 3 Advisory Council

In addition to the governance council, we will convene and charter a **Regional Advisory Council**. This Council is a broad and inclusive stakeholder group of members, providers, community-based organizations, and other organizations that participate in the health community and neighborhood. Membership in the Regional Advisory Council is by invitation from the Governance Council and will include, at a minimum, the following stakeholder representatives required to fulfill the Performance Improvement Advisory Committee (PIAC) requirements:

- Members
- Members' families and/or caregivers
- Primary care medical providers (PCMPs)
- Behavioral health providers
- Health neighborhood providers (specialists, hospitals, long-term services and supports (LTSS), oral health, nursing facilities)

- Individuals representing advocacy and community organizations, local public health agencies, and child welfare interests
- Regional health alliances

Responsibilities of the Regional Advisory Council:

- Review the Contractor's deliverables and program performance data.
- Inform program policy decisions.
- Provide two representatives to serve as members of the statewide PIAC.
- Inform the development of member materials.
- Provide feedback to the Governance Council regarding operational and quality issues related to RAE implementation.
- Conduct reviews and provide input as requested by the Governance Council regarding key performance indicators, performance data, and other issues; make recommendations for new or enhanced programming.
- Develop priorities for community investments (e.g. incentive payments or new funds).
- Review and provide input regarding regional infrastructure or external vendor investments.
- Collaborate with population health teams to review analyses and prioritize focus areas.
- Implement processes for obtaining and evaluating member and community feedback.
- Coordinate with other entities that have conducted community or regional needs assessments, including LPHAs, CDPHE, nonprofit provider systems, and other agencies.
- Coordinate common elements of policy priorities and shared lobbying/engagement efforts among partners.

Upon award of the RAE contract, we will formally seat the Regional Advisory Council to meet the membership requirements and execute the responsibilities described above. The following organizations have already provided letters of support and are already committed to participation on the Regional Advisory Council:

- Adams Department of Human Services
- Addiction Research and Treatment Services (ARTS)
- Anschutz Campus Community Partnership
- Asian Pacific Development Center
- Aurora Health Access
- Aurora Wellness Court
- Boomers Leading Change
- Colorado Cross Disability Coalition

- Colorado Prevention Alliance (CPA)
- DentaQuest
- Developmental Pathways
- Elbert County Interagency Group; Connections for Families
- Mile High Behavioral Healthcare
- North Metro Community Services
- Planned Parenthood of the Rocky Mountains; Metro East
- Project Angel Heart
- South Metro Fire and Rescue
- Aurora Wellness Court/ Aurora Municipal Court
- Colorado Children's Health Access Program

CONFLICT OF INTEREST

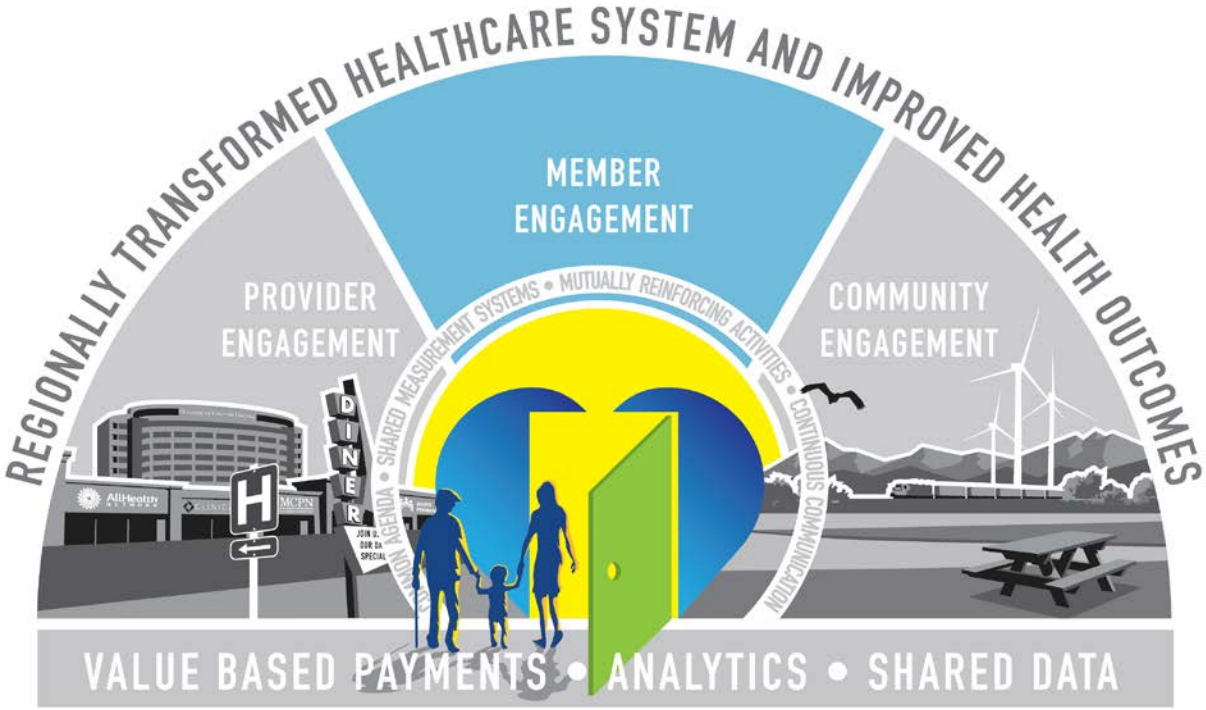
All of our board members and company officers currently receive annual training on our conflict of interest policy and sign a conflict of interest disclosure. The Region 3 Governance Council members will also participate in these processes. The identification and resolution of conflicts of interest are required under IRS Code, Treasury regulations, and Colorado state law. They are also matters of ethics, corporate responsibility and sound management practice that afford protection to all involved parties in cases where there are dual interests. Our conflict of interest policy requires the disclosure of any actual or possible conflict to the members of the Governance Council, which include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the contractor and their immediate families, members of the governing body, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons. If a member fails to disclose a conflict, the Council may take appropriate disciplinary action, which may include removal of the person as a Governance Council member. The conflict of interest policy also prohibits any Governance Council members from participating in or seeking to influence the provider contracting process. This policy is available for review upon request. Members selected for participation on the Governance Council are prohibited from having direct participation in contractual negotiations with Colorado Access.

Member Engagement

OFFEROR'S RESPONSE 9

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

With more than 20 years of experience in the Colorado Medicaid market, we have developed a member engagement strategy that successfully meets the needs of members at all levels of self-sufficiency and at various stages of acculturation. Our overall strategy for a successful member experience emphasizes member informed choice, streamlining our system for efficiency and effectiveness, to meet members "where they are" and offering support and assistance according to member preferences. We developed our successful strategy by seeking the voices of members, family members, and caretakers in all aspects of our work and incorporating their feedback into our programs and departments at every level.



PERSON-AND-FAMILY-CENTERED APPROACH

Engaging Members in Their Health and Well Being

We support member self-determination and offer opportunities for members to engage in their health and well-being at the level and in the way that is most comfortable for them. For those who prefer more independence, we are here to address any issues that emerge along the way, and for those wanting or needing more support we offer a complete care management program and customer service department to assist them at every point

of service. Our commitment to member self-determination and personal responsibility includes being culturally responsive and offering members opportunities to engage in their health care in ways that are respectful and supportive of their culture and beliefs.

We are here to support providers with the training and tools they need to assess, communicate and deliver services in a culturally responsive manner, and we work to ensure that all members' needs are met—including cultural needs that impact their access to and effective receipt of health care services. Primary care medical providers (PCMPs) who provide care management within their practice are required to assess for member and family/caregiver needs, including communication and cultural preferences, and provide an infrastructure to ensure each need is met. We encourage practices that do not offer on-site care management to conduct similar assessments. We are also working to evolve system level supports to enhance the ability of providers, and the Regional Accountable Entity (RAE), to collaboratively collect this information in a way that respects individual provider capacity. With our support, the provider network uses a variety of modalities to communicate with members and family members/caregivers including email communication, text messaging, telephone communication, use of interpreters and auxiliary aides, and live video chats.

We are committed to incorporating member feedback and insight into our member engagement and communication strategies. We realize that the only effective communication platforms are those that are easily accessible, understandable, and delivered in a manner that resonates with members.

In December 2016, we conducted a survey to solicit feedback regarding preferred means of health plan engagement from members and our broader community. The enhanced understanding of member preferences garnered through this survey helped us align our communication methods with those most likely to be effective, thus supporting sound stewardship of public funding. The survey was purposefully administered in a way that encouraged feedback from members with varying degrees of engagement with Colorado Access (COA). The 528 respondents yielded a wealth of information that directly impacted member communication strategies, including:

- When the use of mail is more effective than email, text, or phone;
- How members prefer to contact COA regarding health and insurance issues;
- Under what circumstances members would be most likely to access health information through a web portal or other digital means;
- What digital options might be most successful in more fully engaging members in their own health care;
- The importance of incorporating incentives into member engagement strategies.

During the past six years as a Regional Care Collaborative Organization (RCCO), and for previous decades as an administrator of public assistance medical programming in Colorado, we have gained invaluable understanding of, and experience in, how to best communicate with members. Encouraging feedback and incorporating member insight into programs and policy heightens members' awareness of COA and the supports we can offer, enhances member engagement with their own health and health plan, and continues to help us tailor strategies to best meet the needs and preferences of our diverse membership.

In addition to the required member materials described below (e.g., member handbook, website), we utilize a variety of tools to provide information to members through the following means:

- **Member Mailings: The Partnership Newsletter** is a quarterly member newsletter which contains information about current educational and advocacy events, seasonal health issues, Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, issues that may concern members, the Member Advisory Council, and how to contact COA, the Ombudsman, and the State. The newsletter also features articles that educate members and families about symptoms and treatment of mental illness and substance use disorders, medications, and integrated physical and behavioral health services. The content of this newsletter will be expanded under the RAE contract to include broader preventive health and physical health information.

- **Health Promotion Initiatives:** Written health promotion materials are created and are available in provider offices and on our website. These include information on the connection between various behavioral health issues and physical health conditions, tips for achieving and maintaining physical and behavioral health wellness, and seasonal material such as the need to contact a primary care provider to get a flu shot. We also contact members through text and phone campaigns to inform them about needed services. These communication tools have been added as a result of member feedback. The member communication preference survey described earlier in this section suggested that members are open to receiving communications from COA in a variety of formats.

Delivering Health Outcomes by Aligning Initiatives

We align regional efforts with statewide initiatives such as Colorado's 10 Winnable Battles. An example is a PCMP based pediatric obesity prevention and treatment initiative we are collaborating on with researchers at the University of Colorado's School of Medicine. In this project, we act as a liaison, connecting interested and willing providers with the university for program participation. Members/families that are recommended by their pediatrician and choose to participate receive education about healthy cooking, exercise, and other healthy lifestyle choices, and are connected with care management support for other physical, behavioral, and social needs as appropriate to support successful program completion and obesity reduction.

- **Assisted Communication**: For members who have limited English proficiency and/or require assistive technologies/services due to visual/hearing/reading impairments, we provide translation and interpreter services.

- **Customer Service**: We maintain a highly trained customer service department ready to support members who call for a variety of reasons, included but not limited to: needing assistance contacting their

PCMP and/or RCCO, customer service issues, and/or care management issues. The toll free customer service telephone number is included in all of our publications.

Member Advisory Council

The Colorado Access Member Advisory Council (MAC) ensures that members, their family members, and caregivers have a voice in the initiatives and programs at COA. Council members meet on a monthly basis for two hours, either in person or remotely through video conference (supported by COA technology), and provide recommendations about upcoming projects, review member materials, and give feedback regarding other agenda items. Members are asked to be representatives of the region, and we recruit members to the MAC in an effort to represent the diverse membership in each community. Members participate in an annual in-person conference in addition to the monthly meetings and quarterly subcommittees to help coordinate and promote regional outreach projects in their area (e.g., resource fairs, Family Field Day).We ensure all meetings are held in spaces that accommodate members with disabilities and work with members to facilitate transportation, child care and other expenses that may be incurred by their participation. MAC members also receive a stipend to recognize the time and effort they commit to this important work.

Members and family members comprise the MAC. Participation is voluntary, and the council is self-governed, receiving minimal direction from COA leadership. The council annually elects a chairperson and other governance roles as needed. Currently, the chairperson represents the MAC on the COA Performance Improvement Advisory Committee (PIAC) as a full member with the same rights and responsibilities as other members. As described in Offeror's Response 23—Quality Improvement Program, the PIAC is the committee that evaluates and directs our quality improvement initiatives. The member representative makes formal reports to the committee, detailing MAC activities, concerns, and recommendations. The chairperson gathers information from the PIAC meeting and reports back to the MAC, ensuring a continuous feedback loop between COA and the membership. This information is also shared in our Partnership newsletter.

In addition to the MAC, we offer Partnership member meetings to members and their families. Meetings are held quarterly, and operate in a town hall style, with participation open to everyone who attends. Guest speakers include noted experts in physical and behavioral health as well as local and national leaders from various health and human service agencies. The director of member engagement & inclusion attends each council meeting to provide technical support and coordinate the exchange of information between the Partnership member meeting and COA.

At the meetings, which average 200 to 250 attendees each quarter, members and families receive useful information about COA and network provider services and have the opportunity to bring up and resolve issues that may be hindering their ability to fully utilize the services offered through COA and providers. For those who do not choose to speak out, comment cards are distributed to promote feedback and communication. During each meeting, all comments are recorded and later distributed to the appropriate COA department for review and action. That COA department is required to

specify steps that have been taken to address the member's issue. This process has been crucial to helping us to understand members' perspectives, act upon member input, and incorporate member voice into our planning, programming, and policy.

In addition to participation on the MAC and at Partnership member meetings, we offer members and families roles in the design, implementation, operation and oversight of our programs through:

- Employment through the peer specialist program and staff member positions;
- Periodic focus groups that solicit member and family feedback on quality improvement issues;
- Involvement in the grievance resolution process;
- Active involvement in the development of individual care programs and services decision-making; and
- Support of grassroots efforts to develop self-help and mutual support systems.

We make active efforts to address any challenges that members, family members and caretakers may face in participating in groups and advisory committees associated with COA or providers. This includes:

- Covering all financial costs of the council, including meeting space, food, supplies, and other expenses;
- Designating administrative support for making meeting arrangements, distribution and storage of printed materials, report preparation, and dissemination of results and data;
- Providing appreciation gift certificates for meeting attendance;
- Providing additional reimbursement to members with special responsibilities within the board for their time MAll member meetings are scheduled in locations that specifically meet ADA handicap-accessible standards. If we have questions about a facility's accessibility, we consult with the Colorado Cross-Disability Coalition to evaluate the location prior to making a determination as to its appropriateness.

In addition to the MAC meetings, Partnership member meetings, trainings and other educational opportunities for members and families described earlier in this Response, we have hosted an annual Partnership resource fair for the past nine years. This fair provides opportunities for members to learn about a variety of community resources, and to meet with our staff members in a relaxed setting to talk about the services available to them. Community organizations such as the American Diabetes Association, Healthy Communities, NAMI and the Wellness Treatment Center have historically hosted display tables, offering information about their services and health and wellness promotional materials.

Cultural Competency through Innovation

We are committed to encouraging meaningful participation of members for whom English is not their primary language by using interpreters and providing materials in Spanish and other languages. One notable example of our efforts to ensure participation comes from experience at our member Partnership meetings. In Denver, we noticed particularly high rates of representation from the Mandarin-speaking population. Our success in attracting these members led to a new challenge: the language barrier presented by a primarily non-English-speaking, but engaged, subpopulation of members. In an innovative accommodation, we now use translation headsets through which non-English speaking members can listen to real-time interpretation of all meeting proceedings. This strategy has successfully addressed their obstacle to information and participation, and partly, as a result of these accommodation efforts, attendance regularly exceeds 200 members.

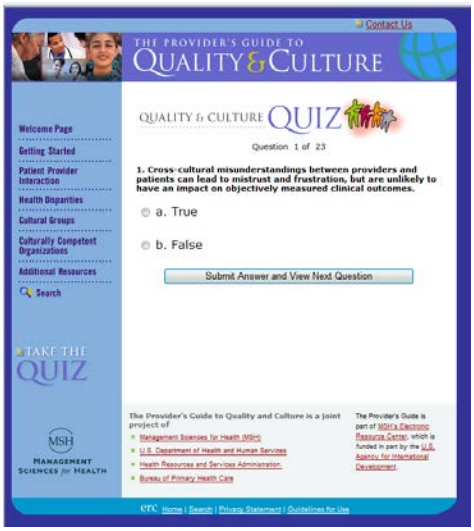
CULTURAL RESPONSIVENESS

We strive to deliver culturally responsive care to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, races, disabilities, and regardless of gender identity or sexual orientation in accordance with 42 C.F.R. §438.206 (c) (2). We emphasize the member, not the process, and do whatever it takes to support members as they engage in their health care—without expecting them to compromise their cultural beliefs or settle for solutions that are less than ideal. This is a standard we require of providers as well, and we support them in adhering to the standard in a variety of ways.

Member perception of our cultural responsiveness is positive. Recent member survey data shows that 80% of respondents feel that they receive culturally competent care from COA and network providers

We have been providing training on cultural competency for nearly 15 years. Our director of member engagement & inclusion, Claudine McDonald, is recognized as a statewide leader in cultural competency and has crafted a comprehensive and flexible staff development program with activities specified in our strategic plan. All COA staff members are required to attend cultural competency training, and we have developed a variety of cultural training opportunities for network providers. Training includes information about ethnocentrism, "things to remember" when working with diverse clients, exploration of the acculturation continuum and cultural competence continuum, along with experiential exercises designed to heighten self-awareness of cultural differences and the existence of bias and stereotypes. We also provide a training that examines health care disparities among ethnic groups, materials for which we extracted from the Institute of Medicine's March 2002 release "Minorities More Likely to Receive Lower-Quality Health Care, Regardless of Income and Insurance Coverage" and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the Office of Minority Health of the Department of Health and Human Services.

To foster and promote our philosophy of the value of cultural sensitivity and responsiveness among providers, we provide a tool entitled, "The Provider's Guide to Quality and Culture." This tool can help providers rate themselves honestly and anonymously.



To ensure our staff members are equipped to meet the needs of all of members, we now require all staff members to pass a mandatory ADA training each year. This training includes information specific to Colorado. Staff members can access additional information and resources on our Intranet site, including training materials about the disability community, such as the "Disability Etiquette Manual" and "What is Disability Discrimination?"

We promote quality cultural responsiveness by requiring all staff members and delegated provider practices to participate in regular cultural competency trainings. In addition to providing regular trainings online and in person, we offer individualized trainings tailored to respond to the unique needs of our internal departments and providers as needed.

In Region 3, where there is a high population of members whose attitudes, values, customs, and beliefs affect access to and benefits from health care services, we employ specific strategies to address the interaction of these variables and engagement in health behaviors. As a result, providers and communities are equipped with skills and tools to promote health for all members. Our experience with refugees in Aurora and surrounding communities, for example, has led to a rich understanding of the political, cultural and economic realities unique to that member population. Tri-County Health Department, COA and the City of Aurora collaborated on a needs assessment of refugees in Region 3. Access to health care was an identified priority, with behavioral health being the highest priority. The assessment led to the development of a strategic plan for refugee services that includes a public relations campaign targeted specifically at young members of refugee communities. The campaign promotes healthy behaviors (e.g., reduced tobacco use) and educates them about how to access health care. In addition, as part of our collaboration with the State Office of Refugee Resettlement, we helped organize a Healthcare Task Force that meets quarterly. This group has made several recommendations to COA and the Department of Health Care Policy and Financing (the Department) that have improved the attribution process for refugees. These activities demonstrate the strength of the relationships we have cultivated, which play a major role in our ability to engage members, providers, and communities in the development of effective programming and policy. Our approach is one of cultural respect—grown from years of relationship building—coupled with our expertise and infrastructure, aimed at supporting highly independent communities in achieving their health care goals. Our ultimate goal, through this approach, is to support sustainable independence for these communities while ensuring improved outcomes for members and providers.

In order to effectively address the variety of cultures in Region 3, we will provide statistics that describe the regional and RAE population in detail, as we have done for the RCCO. These statistics will raise provider awareness of the unique member population's racial, ethnic and socioeconomic conditions and provide suggestions for member engagement (obtained by members from each region through our MAC and

Partnership member meetings) based on risk and protective factors. Data will be gathered during member onboarding and through ongoing interactions with members via care management and customer service.

Members are prompted to provide cultural information when they activate their benefits through a cultural screening questionnaire. This questionnaire asks specific questions regarding the member's cultural identity, preference for communication types (i.e., text message, written communication, recorded telephone messages), and service types (i.e., integrated care, clinic care, and language preferences). The information obtained from these surveys is compiled and provided to leadership in each of our RCCO regions so they may develop engagement strategies to address access to care for all of their members.

Ensuring Cultural Responsivity through Organizational Assessments, Audits and Performance Improvement

To ensure members are receiving value-based care, we require that all employees pass annual cultural competency training. We expect all staff members to be aware of and honor cultural, linguistic, spiritual, and lifestyle differences. On the provider level, quality improvement staff members perform record reviews focused on the need for recognition of the cultural and spiritual factors that may impact members' responses to treatment, and determine the appropriateness of interventions. During the review, we check for cultural and spiritual factors identified in the psychosocial history and incorporated into individualized service plans. Finally, our member satisfaction process includes queries about cultural sensitivity. Specifically, we ask about the experience members have had with our staff members and providers as it relates to cultural competency. The survey results inform our training and evaluation processes for staff members and providers.

Culturally Competent/Responsive Providers

Our comprehensive network of care and broad spectrum of providers enables us to serve the diverse needs of members and their families. Our goal is to continue to contract with all providers in our service area, as well as nearby communities, who have the appropriate qualifications to treat members. Network providers understand that identifying the individual preferences, strengths, and contributions of members improve overall health outcomes. We pride ourselves on working to leverage these strengths in every appointment we have. Our region boasts a wide variety of providers that specialize in serving members with diverse cultural and linguistic needs. In addition, we often link members with network specialists in nearby regions to further honor their preferences for responsive services. Some examples located in Region 3 include:

- **Elmira Refugee Health Center** is a collaborative effort of the Metro Community Provider Network, Aurora Community Mental Health Center, the University of Colorado School of Medicine, and other state and community organizations. It offers physical, behavioral and oral health services to members with a wide variety of refugee experiences from countries such as Bhutan, Burma, Burundi, Congo, Eritrea, Ethiopia, Iraq and Somalia. Many of the staff and providers have themselves been refugees and are therefore very knowledgeable about the barriers and issues that can impact their patients' health status and outcomes.
- **Plains Medical Center,** located in Strasburg, is the federally qualified health center serving the rural, easternmost part of Region 3 in Adams, Arapahoe and Elbert counties. All providers are embedded in the community, have a deep understanding of the area's cultural profile, and work actively to address the geographic and cultural barriers to health care access in their community.

- **Salud Family Health Centers** is a large federally qualified health center that provides bilingual/bicultural care at locations in Brighton and Commerce City (in addition to several clinics in northeastern Colorado) in Adams County. This includes specialized services for women at the Brighton Clinic and integrated primary care co-located with behavioral health care at the Community Reach Center in Commerce City.

Examples of specialized services for specific cultural groups located near Region 3 include:

- **Asian Pacific Development Center**, located on the Denver/Aurora border, provides integrated physical and behavioral health care as well as a wealth of culturally focused activities for members from a variety of different Asian cultures. Asian Pacific providers offer treatment in a number of Asian/Pacific languages.
- **Clinica Tepeyac** is based in Denver but able to serve Region 3 residents who want the choice of a smaller, culturally sensitive practice that provides bilingual services focused primarily on the Latino population.
- **Denver Element** coordinates the programs for gay men offered by Mile High Behavioral Healthcare, which has locations in Denver and Aurora. Services include substance use/mental health counseling; HIV+ prevention, intervention and support; and other activities focused on social determinants of health.

Finally, we recognize that cultural sensitivity is particularly important when care is delivered in members' homes. Therefore, we have developed a robust network of home health care agencies that employ a broad group of ethnically, culturally and linguistically diverse providers who tailor their services to members' needs and preferences.

To ensure members are receiving culturally responsive care, we monitor providers to determine whether services are being provided in a culturally sensitive/responsive manner through provider audits and our annual provider satisfaction survey. If the results identify gaps or inadequacies, they are addressed in a variety of ways. Upon initial identification, our quality improvement staff members review current training materials for needed enhancements or modifications. If training appears adequate, policies are reviewed for needed changes. When an investigation reveals that providers or particular staff members are the cause of culturally insensitive treatment or failed language accommodations, we work swiftly to take corrective action as needed, up to and including contract termination.

To further support member choice, we have adopted *Colorado Access Policy 304 Consumer Choice of Behavioral Health Providers,* a policy that states that we will offer contracts or single case agreements to providers who offer a necessary cultural/linguistic specialty. This is particularly true in the case of members who may prefer out-of-network providers based on cultural, linguistic, lifestyle, or spiritual choices. We actively outreach to these providers to evaluate their qualifications and offer contracts for inclusion in our network. We believe that these strategies help us build the broadest possible network, so that members can choose providers that best suit their individual needs. Our care managers support them in making informed decisions about choosing a PCMP that aligns with their cultural, linguistic, location, and other preferences.

Identifying Culturally Diverse Members

We identify the specific cultural identities of members through a variety of methods. When members or family members contact us directly, our staff members recognize, and are sensitive to, the various indicators of language or personal identity. We understand that all members have their own identities and that we must be sensitive to these as we convey information about health plan benefits or help them access the care they need.

We have multilingual customer service representatives who are able to communicate with members in their primary language. If a staff member is not able to identify the primary language of a member or family member, we use technological innovation, specifically the AT&T language line, to name the language and offer interpretation services in real time.

The Colorado Access *Policy CCS305, Care Coordination*, emphasizes the importance of identifying members with "complex cultural health care needs." Identification is a critical component of the outreach to members to assess their needs and effectively coordinate care with multiple providers. We ensure that these unique characteristics are incorporated into providers' care plans and considered in all interactions as members access services from specialty providers and ancillary services.

We are aware that youth transitioning into adulthood are at a high risk of losing their benefits as a result of a variety of cultural factors. In response to this understanding, our care managers contact Child Health Plan *Plus* (CHP+) members three months before their 19th birthdays (when benefits would expire) and educate them about the importance of having health insurance, how to choose a doctor, and how to access and use their health benefits. In addition, we have partnered with several Cherry Creek School District high schools with high free and reduced lunch eligibility to improve the health/health care literacy of their students by providing a series of presentations throughout the year to their student body. These seminars are focused on the value of preventive and primary care, understanding what health insurance is and providing information about how to apply for Medicaid, CHP+ or Connect for Health Colorado (health insurance marketplace) programs. They are required components of the school's health program for all students.

In addition to factors that affect members of various ages, we know that there are specific regional issues that impact engagement. As members are part of a larger regional culture, we must be aware of broad population characteristics and not just those of the Medicaid sub-population. In many ways, the communities and neighborhoods that make up Region 3 are among the most diverse in Colorado. They encompass urban, suburban, rural and frontier areas, with residents representing a broad mix of ethnicities, cultures and socioeconomic backgrounds. Although our four-county region is generally considered suburban in nature, all include large rural areas that have more in common with other Eastern Plains communities than with the residents of the Denver Metropolitan areas. The rural towns in our region are currently experiencing rapid growth, bringing tensions between the mostly urban and suburban newcomers and longer-term residents who have generally lived in the area for decades and embrace a self-sufficient farm/rural culture.

Region 3 (2016) (Adams, Arapahoe, Douglas and Elbert Counties) Total Population = 1,470,051	
Homes where English is not the Primary Language	311,313 (21.2 %)
Persons Living Below the Poverty Line	133,582 (9.1%)
Persons 65 Years and Over	160,760 (10.9%)
Foreign Born Persons	200,075 (13.6%)
Veterans	90,821 (6.2%)

The overall population of residents in the region differs from statewide demographics in many other ways. For example, although the region has a lower than average number of people living below the poverty line, it is extremely diverse economically. Douglas and Elbert counties have among the highest per capita incomes in the state, but both have pockets of low-income residents. Adams and Arapahoe counties have wide variation in economic circumstances within their boundaries, from well-to-do neighborhoods to areas of extreme poverty. In addition, US Census data from 2016 shows that Region 3 counties overall have much higher proportions of foreign born persons (13.9%) than the statewide average (9.8%), as well as more people who live in homes where a primary language other than English is spoken (21.2% for Region 3 vs. 16.9% statewide). Again, these statistics only tell a small part of the story – the foreign-born residents of Region 3 encompass first generation African, Hispanic/Latino, Arabic and Asian people from a wide variety of backgrounds, from rural Hmong and Somali farmers to Central American and Indian domestic workers and technicians. We know that the individuals in these groups define their health care needs and access services differently. Our in-depth understanding of our region's demographic makeup allows us to respond with culturally competent and locally relevant services and interventions.

In the rural areas, for example cultural sensitivity often means helping network providers collaborate with one another to deliver a robust offering of services at affordable prices and at accessible locations. Geography can be a barrier to access, and culture is a barrier to willingness in these rural areas. In response to this struggle, we have engaged in advocacy at the local and state level, raising awareness of the barriers members experience and seeking collaborative solutions to promote the health of rural residents. Elbert County, which is growing rapidly but still retains its rural character, is new to RAE Region 3 as it was previous part of RCCO Region 7. We intend to continue to support the primary care medical provider and mobile health care services in this county, and will explore the use of telehealth to further enhance access.

The "East Colfax corridor" is another example of a geographic area with sub-cultures that we must understand and serve. This urban thoroughfare and its surrounding neighborhoods are home to a variety of low income and at-risk individuals, including refugees, residents of motels and single room occupancy dwellings, persons with substance use and mental health disorders, and runaway and homeless youth. We work with providers who are well versed in "street culture" and are skilled in the outreach, brief intervention and engagement strategies that are most likely to be successful with members in this area. For example, Mile High Behavioral Health operates a mobile van and works with Rainbow Alley, a drop-in center located on East Colfax, to provide health care for the LGBTQ youth who frequent this area. Because East Colfax spans Denver and Aurora, we have had the advantage of creating an integrated approach to serving residents of this area by coordinating Region 3 and Region 5 activities. On a system level, we have also worked closely with the East Colfax Corridor Connections project in an effort to improve transit and mobility options not only for members, but for the community as a whole. We intend to continue these efforts as the RAE in both regions.

Finally, Region 3 is home to the state's largest concentration of refugees. It also boasts one of the most progressive cities in the state with regards to immigrant and refugee integration. One in five residents of Aurora are foreign-born and 139 languages are spoken in their public school system. Over the past several years, Aurora has increased its commitment to include immigrants and refugees in civic and public life, including the development of the previously described strategic plan. We have been active in educating Colorado's refugee communities about their health care benefits through the RCCO and will continue to fulfill this commitment as the RAE. We currently work closely with refugee centers in each of our RCCO regions to support newcomers to

our communities and help them access the benefits they and their families need. According to the U.S. Department of State Refugee Processing Center, the top 10 languages spoken by incoming refuges in 2017 include Arabic, Somali, Nepali, Sgaw Karen, Kiswahili, Farsi (Western), Spanish, Armenian, Chaldean and Burmese.[1] We are prepared to provide information in each member's native language. The table below summarizing refugees by county in 2016 provides a sense of which communities are experiencing the greatest need for refugee support. As the RAE, we will continue to identify members who are refugees who are members, and support multicultural services provided both at the plan level and through our partner agencies.

Refugees per County (2016)	
Arapahoe	843
Adams	536
Denver	450
Weld	360
Morgan	78
Other	45

Language Assistance Services

Communication and language assistance is a critical component to providing culturally and linguistically competent care. We consistently take whatever steps are necessary to assist members, family members, or designated member representatives (DMRs) with limited English proficiency and people who have a sensory impairment/speech impairment, to receive clinical and non-clinical information in a language or format that they understand. We provide language assistance at all points of contact, in a timely manner, and during all hours of operation. In determining what type of auxiliary aid is needed, we will give primary consideration to the request of the individual involved.

We make members aware of their right to receive services in their preferred language through the member handbook and in annual mailings. We also regularly include notices in the Partnership newsletter that members can request assistance in their preferred language. Finally, members receive offers of language assistance at the Partnership meetings, at provider sites, and when they contact us directly through clinical staff members or customer service.

We maintain TTY/TDD capability, which is available at our larger network provider sites, including network hospital emergency rooms and other provider sites. We use RELAY Colorado for sites that do not have TTY/TDD capabilities. We make interpretive services available in a variety of modalities and in various settings. Language assistance is available 24 hours a day, seven days a week, to members or providers who contact us. Within the provider network we offer language assistance to individuals who have limited English proficiency and/other communication needs.

[1] (Top Ten Languages Spoken by Arrived Refugees. (2016, December 21). Retrieved from http://www.wrapsnet.org/admissions-and-arrivals/).

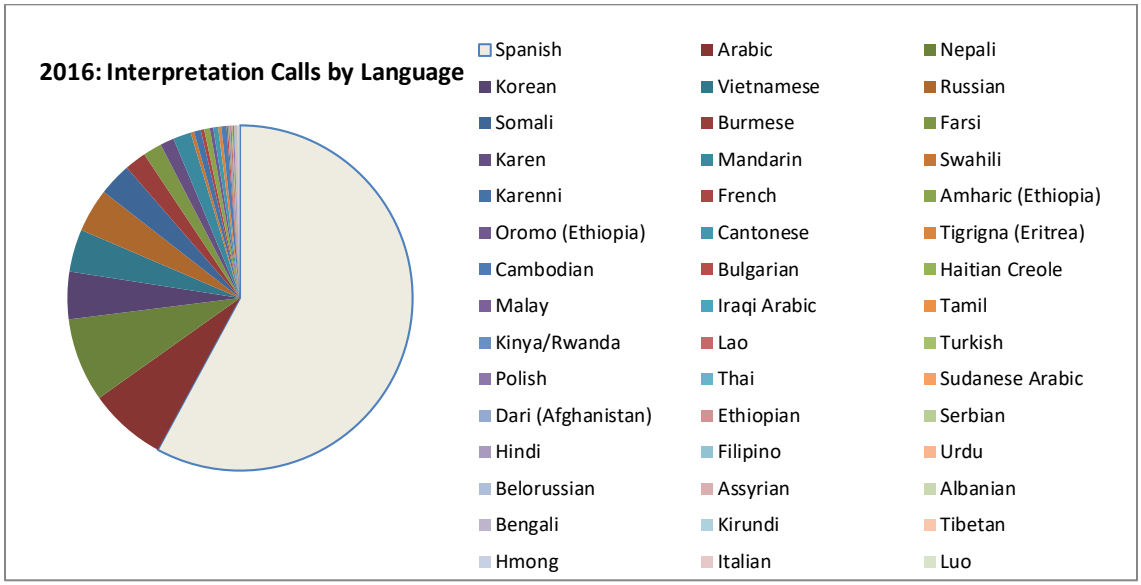
We believe it is rarely appropriate to allow a member's friend or family member to serve as an interpreter during a provider visit or when communicating health information. The only time we would consider this arrangement is if a member specifically requests their family member or friend provide the interpretation. Even in this circumstance, we would carefully review the clinical presentation and consult with the provider, as necessary, prior to agreeing. The agreement would be in writing, and signed by the member, the provider, and the family or friend called to interpret. We also offer a training that focuses on achieving effective communication through an interpreter that is a resource to providers who work in communities where interpretation services are used more frequently.

Our larger network provider sites and other facilities, such as inpatient hospitals, emergency departments, and residential sites, are required by contract to offer language interpretation as needed. When needed, our customer service department serves as the contact point for all interpretation services. Our customer service department staff members are trained to evaluate the need for an on-site interpreter or the AT&T Language Line and to arrange an appointment for interpretation services based on the needs and preferences of the member.

Our cultural diversity strategic plan includes a goal to increase our capability for assessing members' language needs. We have developed a process to capture the language preferred by members, particularly those with limited English proficiency (LEP). We plan to use the Department's Health Needs Survey to help identify any special health care needs members have, as well as any spiritual, cultural or other beliefs that impact their health care. We will use this information to work with each member to develop a unique approach to their services. We are committed to providing oral and written information in at least the top 15 languages spoken by those who are not proficient in English, listed above, and including Braille.

To ensure that members can effectively communicate with both their health plan and health providers, and in accordance with 42 C.F.R. 438.10, we employ bilingual staff members and contract with providers who are proficient in diverse languages. We also contract with qualified local interpreter service providers and agencies. Interpretation services are available in any language and are available at no cost to members. We encourage our staff members to be proficient in multiple languages and incent this important skill with a pay differential. We screen and test staff members for language fluency prior to their being approved for interaction with members in any language other than English. An external, objective contractor completes the testing process as per our *Policy ADM214 – Language Pay Differential*. We currently employ more than 30 Spanish-speaking employees, as well as employees who fluently speak Russian, Amharic, and Tigrinya. Members who are deaf and hard of hearing may access our TDD/TTY system or call Relay Colorado at 711 for assistance. When non-English speaking members call us, our customer service department staff members are trained to accommodate any and all languages. As the large majority of the non-English speaking members speak Spanish, our automated system includes options in Spanish and routes those callers directly to an appropriate staff member.

For members who contact us and need to communicate in another language (by phone, or in person), a customer service representative determines the language and will immediately access an on-demand interpreter. If the representative cannot determine the language need, they will contact Voiance, our phone interpreter vendor, for triage support, and then will connect with the appropriate interpreter. Voiance provides over the phone interpreter services, available to all Colorado Access staff members who interact with members over the phone. In 2016, we supported 3,899 encounters with over the phone interpreter services.



We also actively work to maintain a robust provider network that includes bilingual providers who speak a wide variety of languages to meet member needs, including: Amharic, Arabic, Cambodian, Chinese, Farsi, French, German, Greek, Hebrew, Hindi, Japanese, Persian, Romanian, Russian, Sign Language, Spanish, Tagalog, Tigrinya, and Ukrainian. Providers who need additional interpretive services may also access our bilingual staff members and interpretive services at no charge. Providers may contact our customer service department and we will set up a three-way call with the provider, the member and an internal, or externally contracted interpreter to support the member in making appointments, requesting health information, or otherwise meeting the member's needs. In addition, providers can request on-site interpreter services. Our customer service representatives will coordinate to ensure that a certified interpreter is available in any needed language to be at the clinic for the member's appointment. We have contracts with three vendors for in person interpreter services to support member and provider choice. During 2016, we received and arranged for in person interpreter services for 744 encounters and 24 languages.

Written Materials

We understand the importance of written materials to members and the potential these communications have to help members understand programs and access needed services and/or confuse or complicate the same goal. In order to achieve the most effective and efficient communication to members in a written format, we utilize our Member Advisory Council (MAC) described above. All member materials, programs, and policies, except individualized correspondence directed toward specific members, are vetted by members and their families through our MAC. Once our MAC has approved the materials, we will submit them to the Department for final approval, providing at least ten days before the planned roll out of such materials, unless otherwise agreed upon by the Department.

We will provide the Department with information regarding the intended audience, purpose, delivery method and frequency related to all materials submitted for approval. We understand that the Department may review any materials, and require changes or redrafting of the document based on their assessment of the readability and need to align all correspondence with Department priorities and standards.

We ensure that all member materials are written in an easily accessible manner and available in alternate formats in any language necessary, including Braille or large print, on request from the member. Materials will be written with no higher than a sixth grade English reading and comprehension level, as assessed by the Microsoft Word Readability Statistics or Health Literacy Advisor tools. Additionally, we will include tagline information on all of our written materials with instructions for requesting and accessing information on alternative formats, auxiliary aids and services. We will also include our toll free TTY/TDD telephone number for our customer service department on all written materials. Our member handbook is written in at least the top 15 languages spoken by individuals with limited English proficiency in the region including: Spanish, Vietnamese, Chinese, Korean, Russian, Amharic, Arabic, German, French, Nepali, Tagalog, Japanese, Cushite, Persian (Farsi), Kru (Bassa), Ibo, and Yoruba. Finally, all materials created for broad distribution are reviewed for cultural and linguistic appropriateness by our marketing and communications department with consultation, when necessary, provided by our member engagement and inclusion department. As the RAE, we will ensure that these materials are also tested by our Member Advisory Council.

All of our materials posted at provider sites are printed in English and Spanish in a font no smaller than 12 points and in fonts compliant with ADA guidelines. Providers may request posted material in another language if they find they are serving a large limited English proficiency population that speaks a language other than Spanish. We regularly monitor member data and other available information to determine if other languages are becoming more prevalent in the region. In addition, we review customer service logs and requests for materials in other languages to identify when we need to produce materials in a new language and/or add to the provider network and customer service staff to ensure we are meeting the members' needs. Finally, members are notified of alternate forms of information, such as web-based, and given instructions about how to access them in the member handbook.

One example illustrates how we have gone the extra mile in helping members understand the written information they receive. Through careful listening, we discovered that many members who are refugees did not understand the newsletters they received because they lacked context about the United States health care system. We also learned that many had not used their home addresses on their application forms, but rather the address of the local refugee center. In response, we trained staff at the refugee centers to provide helpful health care information and to give our mailed communications to the members with directions to take the letters to their doctor. We then trained providers to communicate information about how enrollment, attribution and Medicaid benefits work. This strategy was very successful. As a result, we subsequently worked with the Department to print, in the top five languages that members speak, the following message on the envelopes of mailings: "If you do not understand what this letter is for- please take it to your doctor."

MEMBER COMMUNICATION

We work to provide consistent communications with members to promote continuous awareness of their rights and the resources available to them. Further, our long tenure serving the Medicaid population provides a level of name recognition that members trust when they receive materials. We make sure members are aware of their health benefits, any restrictions on their choice of network provider, our requirement to provide access to behavioral health services, our responsibility to coordinate member care, and information about where and how to obtain counseling and referrals for services that we do not provide but which are their right to receive as a

result of moral or religious objections. We do this by providing this information during the member onboarding process, at community health fairs and other local events, during meetings with providers, and as part of our trainings offered online and in person through our Partnership meetings. In addition, we provide members with a notice of privacy practices upon initial enrollment, upon request, and annually at a minimum.

Currently, we provide information about the role and duties of the RCCO and Behavioral Health Organizations (BHOs) in many ways and at various points in time. Initial rights information and an overview of our role and responsibilities as the RCCO and BHO are included in the new member welcome packet. Members seeking health services also receive information about their member rights from their providers at the intake appointment. Annually, all Medicaid recipients who are RCCO and/or BHO members receive a Division of Insurance mailing which reiterates their rights as a member and the HIPAA privacy requirements. When a member files a grievance or appeal, they again receive information about their rights.

Along with these formal communications, we distribute rights information and articles on RCCO and BHO responsibilities in the Partnership newsletter on a quarterly basis. Paper copies of this information is also available at our Partnership meetings. Our director of member engagement & inclusion, and other COA staff members, make verbal note of member rights and discuss the role of our RCCOs and BHOs at these meetings. Additionally, clinical staff members communicate member rights during treatment option discussions, updates, and/or reviews. Communication of rights may also occur in the context of a phone call with a member, or during a treatment update staffing. We make every effort to ensure that members know their rights, whether they receive treatment services or not.

As the RAE, we intend to continue using all of these communication strategies. Upon award of the RAE contract, we will include information about the basic features of RAE managed care functions as a Primary Care Case Management Entity and Prepaid Inpatient Health Plan, as well as information about which populations are subject to mandatory enrollment into the RAE, in our regular member communications.

Member Onboarding

Orienting members to their health benefits and helping them to learn how to actively engage in their health is a vital component in meeting the Accountable Care Collaborative (ACC) program goals. In the current environment, members must be educated about at least two, if not three, different programs among the RCCO, the BHO, and the Single Entry Point (SEP) or community centered board (CCB) systems. As the administrator of many of these programs, we are familiar with the various member communication requirements, as well as how potentially complicated and confusing these communications can be to members. We are enthusiastic about the opportunity to develop more integrated, streamlined and comprehensive materials that provide the necessary information in a way that members want to receive it and work to eliminate much of the confusion about how to get questions answered, where to go for help, and other important issues. We currently provide BHO members with a new member packet that includes a welcome letter and member handbook, described above. As the RAE, we will integrate the current BHO member handbook and materials with the physical health information currently provided by the State and the RCCOs, as well as the SEP (with the Department's permission), to provide an integrated, comprehensive member onboarding process to support the full spectrum of care for which the member is eligible. We will also train providers to assist with the onboarding process.

The member welcome materials will contain the required components such as:

- Information on how to contact Colorado Access with any questions they might have or for any other matter with which they need assistance;
- Member rights and protections;
- The names, language spoken, and contact information of providers;
- Any limits on choice of providers that are in our network;
- How to get services through providers who are not part of our network;
- Information about after-hours and emergency services;
- How to get services through Medicaid that we do not provide;
- Information about how to establish advance directives in case a member is too sick or hurt to think or talk clearly;
- How Colorado Access is structured and how we work;
- How and when to file a grievance (complaint), and how to file for an appeal or State Fair Hearing.

The handbook will also include a notice of privacy practices. Membership activation will include trainings such as *Making Your Benefits Work For You,* which is a brief overview of the components of a Health Neighborhood and role of each provider, in addition to an explanation of each of the benefits a member may be eligible for and how to access those benefits. Members are given the option of attending an orientation either in person, online, or by recorded message. We will work closely with our Member Advisory Council to develop, test and continually improved these important materials.

Silverlink EngageME Platform

Our population health and care management departments strive to design and implement interventions that meet members "where they're at." We recognize the necessity of incorporating member-centric data into our programming to ensure that we are able to efficiently and effectively reach members. In an effort to bring this work to scale, we have designed a new member welcome program that uses targeted technology to improve our call center efficiency, improve member and staff experience, drive outcomes, and reach members at scale. We utilize a state-of-the-art CRM (Customer Relationship Management) platform that allows us to: gain visibility among members by strategically and systematically responding to member needs, increase the efficiency of our programs by using members' preferred channels of communications for outreach and limiting over-communication, and manage costs by leveraging combined messaging and utilizing lower-cost electronic communication channels (e.g. text message). Through the new member welcome program, we will collect member data including: demographics, location, language preference, and communication channel preference. These data will be entered and stored in our CRM and incorporated into future population health and care management programs and interventions.

Website

Our website provides access to descriptions of our service lines, contact information, member rights and handbooks, grievance and appeals procedures and rights, complete provider directories, links to the

Department's website for standardized information, information about trainings, access to care standards, and contact information for the Health First Colorado Nurse Advice Line.

The website provides a rich and easily accessible source of information and education about Colorado Access operations and the provider system. It has a robust array of member-oriented content to help them navigate the complexities of the health care system. The member page offers useful information and tools including:

- Program information
- Community resources
- Health and wellness information
- Care management information
- Member advisory committee information
- Access to care standards
- Health First Colorado Nurse Advice Line
- Plan benefits
- Provider directories and lookup tool
- Pharmacy and medication lists
- Important contact information
- Member rights and responsibilities
- Screening tools
- Access to trainings

The website also offers educational materials and links to other sources of information and support regarding mental illness, substance use disorders, and integrated care. Because many members do not have ready access to web-based tools, all member materials are also available in paper copy or by contacting our customer service or care management departments. In addition, we are exploring the feasibility of installing special computer kiosks in high volume provider waiting areas that would give dedicated access to the COA member portal, health education and health promotion information, health risk assessment entry screens, and member satisfaction survey questionnaires. Our website is currently being redesigned based on feedback gathered in 2016 from members, providers, stakeholders and COA staff members. This newly redesigned website, available prior to the start of the RAE contract, will maintain all the required materials but will offer them in an even easier and more consumer friendly manner.

Our website content is designed to be navigable by low literacy, low income, and racially diverse populations. The current website provides the ability to increase font size for the visually impaired and allows for instant translation of the content into one of 58 languages with the click of a button. All of its contents are provided in a printer friendly format. We will ensure that all electronically distributed information required by 42 C.F.R. § 438.10 is readily accessible and complies with modern accessibility standards (such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines 2.0AA and successor versions). We will place all federally required information prominently on our website and provide it in a format that can be electronically retained and printed and is consistent with the content and language requirements of 42 C.F.R. § 438.10. We will inform members that they can request copies of all federally required information, that they will be provided within five business days, and that the member will not be charged for the copies.

Termination of Provider Agreement

Upon termination for any reason of a network provider's agreement or participation with COA as the RAE, we will promptly notify all members who have chosen that provider of the termination based on the member's chosen communication method. Additionally, we will provide affected members with a list of providers in their region who they might choose to continue services with. Care managers will offer to support individuals in choosing a new provider and proactively outreach high need, high-risk members to ensure that the continuity of their care is not disrupted.

Grievances and Appeals Process

We have a responsive, member-focused grievance and appeals system that complies with the Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8 - Medical Assistance §8.209-Medicaid Managed Care Grievance and Appeal Processes. We also have an entire department dedicated to handling member grievances and appeals.

Our grievance and appeals system encourages members, family members, and their representatives to provide ongoing feedback about their experiences of care in the COA system. Our staff members are ready to take information related to any grievance and/or appeal, and can be reached directly by telephone at 877-276-5184. We believe that early identification of system problems allows us to improve health care effectiveness for a broader population and to resolve the grievance or appeal with an acceptable outcome to the member, family member, or designated representative. It is our intent to resolve grievances and appeals at the lowest level possible, where immediate change can most readily occur. We are passionate about the care members receive and our customer service department is available Monday through Friday from 8 AM to 5pm to assist members in making a grievance or appeal, requesting an exception, checking on the status of a grievance, appeal or exception, and answering any coverage determination questions they might have. All translation and interpretation services described above are available to members in all steps in the grievance and appeal process. Finally, members are encouraged to appoint a person of their choosing to represent them and/or help them through the grievance/appeals process.

Grievances

Members or their designees may file oral or written grievances at any time without fear of retaliation or benefits risk. Our staff members are trained to be responsive to members when they express dissatisfaction with any aspect of their health care experience. We appreciate feedback and assure members that there will be no adverse consequences.

The number of COA grievances remains very low and typically involve issues we can easily address. For example, one grievance involved a family who received a bill from a hospital for a remaining care balance following an in-patient stay. Our COA representative called the hospital, who reviewed the explanation of payment (EOP) and updated their system. The member received an update and accurate bill for a $20 copayment

We provide education and outreach to members, families, and providers to ensure that they are informed of their rights and of the procedures to file a grievance. Members and family members have contributed to our informational materials and they are regularly reviewed and approved by the Member Advisory Council. During their first contact with a service provider, members receive information on their right to file a grievance, as well as the supports available through the department of member engagement and inclusion should they choose to

do so. In addition, we provide information about the process in the member handbook, during regular mailings, at member forums, though customer service calls and through individual meetings with care managers and peer support specialists, who may offer assistance in this process. A workshop on member rights and responsibilities, offered by the department of member engagement and inclusion, is conducted, at least annually, at the Partnership meeting. We have specific policies and procedures for the grievance process. Our grievance team handles the grievance investigation and is responsive to any member needs throughout the investigation. Per Medicaid requirements, we accept formal grievances from members or their designated client representative (DCR) submitted within 20 calendar days of the incident. Once a grievance is filed, a formal investigation begins immediately. Quality of care concerns are addressed in accordance with *Policy QM301: Quality of Care Concerns*.

Members who are enrolled with a network provider can also express a grievance directly to that provider or file the grievance with COA. If a member chooses to file a grievance directly with a provider, all information will be transmitted from that provider to COA to ensure that notifications and resolution of the grievance occurs within the Volume 8 time frames.

Grievance Data Tracking and Reporting

We track grievance information in a secure database, customized for member grievances and appeals. Individual grievance information is entered into the database, which allows ongoing monitoring during the grievance investigation. Individual grievance summaries and aggregate trending data are retrieved easily from the database. Grievance data helps identify potential sources of dissatisfaction with care or service delivery, and improvement opportunities for provider practices. We aggregate member grievances and appeals quarterly, submit them to the Department, and trend the data annually.

Our Quality Performance Advisory Committee will receive and review grievance analysis and reports to assess any significant trends or patterns, with attention to satisfactory resolution, timeliness of resolution, adherence to State and federal rules, and ongoing staff training.

Appeals

Members and/or their designated client representatives (DCRs) may request, either orally or in writing, a review of any action through the appeal process. Possible subjects of appeals include denial or limited authorization of a requested service, or reduction, suspension or termination of a previously authorized service. As the RAE, we will ensure that the grievance and appeals teams are well educated on their role as the sole appeal and grievance program for members in the RAE region for both behavioral and physical health.

Information on how to appeal a decision is provided to members in clear and concise language in the member handbook. Each member receives this information again whenever an action is taken. Care managers and peer support specialists are available to help members throughout the appeal process. We provide written notice to members for any action taken, as defined in Volume 8.209.2 including:

- The action we are taking and the reason(s) for the action.
- The member's or the provider's right to file an appeal and the appeal's due date.
- The member's right to request a State Fair Hearing, and how to exercise that right.
- The circumstances under which expedited resolution is available, and how to request it.

- The member's right to receive continued benefits, pending resolution of the appeal, and how to request continuation.
- The circumstances under which the member may be required to pay the cost of these services.

We will make every reasonable effort to help a member or DCR navigate the appeal process, including completing appeal forms, and providing interpretive services and toll-free numbers that have TTY/TDD capability when necessary.

Appeals Process

The appeals process begins when we provide a written notice of action to members or DCRs as described in *Policy CCS307: Utilization Review Determinations*, and in accordance with Department Medicaid rules. A member or DCR must submit an appeal within 20 calendar days from the date of this notice of action.

We provide a written acknowledgement of the appeal to the member and/or the DCR within two business days of receipt, unless the member or DCR requests an expedited resolution. A member or DCR may request an expedited appeal if they determine that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Under these circumstances, we will provide a written acknowledgement of the appeal sooner than two days, and will not take any punitive action against a member or DCR for expediting an appeal.

Both standard and expedited appeals are resolved and a notice provided to the member or DCR as expeditiously as the member's health condition requires, and not to exceed the following:

A **standard appeal** is resolved and a written notice of the resolution is provided to the member or DCR within 10 business days of receipt.

An **expedited appeal** is resolved and a written notice of the resolution is provided to the member or DCR within three business days of receipt. We make every reasonable effort to provide oral notice to the member and/or DCR within the three business days required for written notice. If an expedited appeal resolution request is denied, we make reasonable efforts to give the member or DCR prompt oral notice of the denial, with written notice provided within two calendar days. The appeal then follows the standard resolution process.

We may extend the timeframe to resolve a standard or expedited appeal for up to 14 calendar days if the member or DCR requests the extension or if we prove a need for additional information and that the delay is in the member's best interest. We provide the member or DCR with prior written notice of the reason for the delay. We also make reasonable efforts to allow the member or DCR to examine the records and documents associated with the appeal, and to present evidence and allegations of fact or law, in person or in writing. Finally, we continue to provide covered services to the member during a pending appeal review under the conditions specified and required by applicable federal and state law, rules and regulations, and line of business contracts.

Appeal Decisions

Appeal decisions are made by a licensed physician with appropriate clinical expertise to treat the member's condition. We employ psychiatrists, family physicians, internists and pediatricians and will determine whom is most appropriate to address each appeal. We maintain a contract with University of Colorado Medicine that provides access to a wide variety of specialists who are available to review and make determinations on an

appeal if the necessary expertise is not available within our clinical staff. The physician who is selected to review the appeal will not have been involved in any previous level of appeal review or decision making if deciding:

- an appeal based on lack of medical necessity;
- a denial of an expedited resolution of an appeal; or
- any appeal that involves a clinical decision.

State Fair Hearing

Members and/or their DCRs may request a State Fair Hearing anytime during the appeal process, but no later than 20 calendar days from the date of the notice of action. We inform members of this right and how to request a State Fair Hearing through the member's notice of action. We also include general information about these appeal resolution avenues in other written member materials.

We provide reasonable assistance to a member or DCR requesting a State Fair Hearing, including completing forms and providing access to interpretive services and toll-free numbers with TTY/TDD capability. In addition, we will continue to provide covered services to the member during a pending State Fair Hearing review under the conditions specified and required by applicable federal and state law, and rules and regulations.

Monitoring Process for Appeals

Clinical appeals are monitored and reported quarterly for emerging trends and timeliness of determinations on review. In 2016, provider clinical appeals decreased even further to a rate of 0.04 per 1,000 members in Denver. The increased availability of physician reviewers, implementation of software that permits rapid transmission and sharing of clinical files, refinement of procedures for review determination, and additional staff training allowed timeliness of resolution to hold steady at 100% during calendar year 2016.

Advance Directives

Ensuring that the advance directive wishes of members are honored is of primary importance to us. We provide information on advance directives to all members and designated client representatives in the member handbook and the information is available on our website, including a link to Mental Health America's specific psychiatric advance directives information. This information is provided in written form at the time of each member's enrollment and annually to be sure that the wishes of the members are known and current. Information on member's rights and advanced directives is also in the provider manual. Our staff members and providers direct members to the Colorado Department of Public Health and Environment if/when there is a complaint concerning noncompliance with any advance directive requirements. The materials and information provided to members and providers is reviewed regularly to ensure it complies with state laws and other regulations.

Our staff members and providers are given ongoing training regarding all policies and procedures on advance directives. We advocate for the members and ensure that they are not discriminated against based on whether or not they have executed an advance directive.

Going forward, we commit to observing any changes in the State law regarding advance directives. In the event of a change, we will reflect any changes to our staff members, providers and members within 90 days of the effective date of the change made.

MARKETING

We are committed to responsible marketing practices. We develop marketing plans and materials with the intention of informing members and potential members of our services, their rights, and the importance we place on their health. Upon award of the RAE contract, we agree to temporarily cease all marketing of our programs until the start-up period is over. Once the start-up period has passed, we will ensure that all marketing materials are approved by the Department and will comply with the discretion of the Department regarding any changes or requests to discontinue any materials or plans we present. Materials will be distributed to the entire region as defined by the contract. None of these materials will seek to influence enrollment in any other program or insurance plan.

We will follow all of the marketing guidelines provided by the Department, and will remain in compliance with federal and state laws, regulations, policies, and procedures. We will also ensure that all marketing plans and materials are accurate and do not confuse or defraud members.

HEALTH NEEDS SURVEY

We are prepared to process a daily data transfer from the Department or its delegate containing responses to the Health Needs Surveys. In addition to delivering the information to the care management team for individual member outreach and care planning, staff from our department of member outreach and inclusion will review member responses to the surveys on a regular basis to identify population trends or concerns that should be addressed on a community or regional level.

INFORMATION ABOUT OTHER BENEFITS, INCLUDING EPSDT

As the current RCCO in three Colorado regions and one of the CHP+ Health Maintenance Organizations (HMO), we are committed to Early Periodic Screening Diagnostic and Treatment (EPSDT) outreach. We are pleased to commit to collaborating closely with family health coordinators and to support their responsibilities to onboard members to Medicaid, through outreach, navigation support of Medicaid benefits, and education on preventive services, with special emphasis on children and families. Upon award of the RAE contract, we will establish Memorandums of Understanding (MOUs) with all Healthy Communities contractors in the region to support alignment of onboarding activities and sharing of member information. Our existing collaborations through the Team4C project – a partnership between COA, Tri County Health Department and Healthy Communities and the Program for Children and Youth with Special Needs (HCP) - has led to a very successful model of collaboration to support coordinated case management for children and youth with special health care needs. This four-year project, described more fully in Offeror's Response 16—Care Management, will provide a strong foundation for the collaborative onboarding and member education efforts required in the RAE contract.

In addition, our CHP+ HMO plan recently partnered with the Department's Member Experience Advisory Council to consult with current CHP+ members about their ease of understanding our explanation of benefits in the member handbooks. This meeting opened dialogue between the health plan and its members to better understand how members wish to be communicated with. Many recommendations from members have been implemented in the re-write of the member handbook to ensure that members are able to easily access the

services to which they are entitled. We intend to continue with these types of exchanges to ensure that we stay in sync with issues that members may encounter when they need to utilize the health care system.

Finally, providers often need help in understanding the billing differences between CHP+ and Medicaid; and we have expertise in both arenas. Denied claims lead to access issues as providers often limit members on their panels after they have Medicaid claims denied. Our role as CHP+ administrator enhances our familiarity and relationships with pediatric practices, statewide. When we provide support to PCMPs, we are often asked to help with CHP+ issues – providers do not distinguish between state programs. This combined expertise directly impacts members, as it helps ensure availability of services across different programs and with more providers.

PROMOTION OF MEMBER HEALTH AND WELLNESS

We are strategically positioned to develop programming, convene partnerships, and promote activities that not only enhance access to health care services, but also encourage healthy behavior and foster long-term improvement to health and wellness. We have the experience, staff members, infrastructure, and connections to effectively infuse population health improvement and member wellness into our daily operations and longer-term strategies—and to do so in a way that is meaningful to the providers we support and members we serve.

Our experience administering RCCO, BHO, CHP+, and SEP programming for the State of Colorado has allowed us to gain a distinct and invaluable understanding of the barriers and opportunities that exist within the region to implement successful health, wellness, and prevention programming for members. This understanding has been gained through years of innovation – which includes trial and error, outreach and engagement, and partnership building. While gaining this experience, we have remained committed to hiring and retaining the staff members necessary to translate learning into viable action. Our medical leadership includes numerous individuals who also serve as faculty for the University of Colorado and the Colorado School of Public Health, and are well versed in the latest research and tactics regarding the promotion of health and wellness for individuals and across communities.

With years of Colorado Medicaid data as a foundation, and an IT infrastructure built specifically to extract and analyze that data, our population health team works closely with our medical leadership, RCCO and BHO management, local communities, and member engagement staff members to create evidenced-based programming that is both effective and impactful for members. One such example is a colorectal cancer screening program in our Region 3 counties that stratifies risk and targets specific individuals, in collaboration with their primary care provider, to mail Fecal Immunochemical Test (FIT) cancer screening kits to at risk individuals, support them in their use of the kits, and provide any follow-up and referral support, necessary, based on results of the FIT test. We have also worked with providers and local businesses in the region to promote community gardens and support grocers in an effort to alleviate “food deserts” in Adams and Arapahoe counties. Another collaborative effort is a partnership with Tri-County Health on a campaign to educate children to avoid sugary drinks.

Finally, we have an enhanced member engagement program that is actively working to articulate a comprehensive set of member behaviors, from wellness to treatment, that quantify the degree of a member’s engagement in their own health. We understand that members are often engaged in their health or health care in ways that do not align with key performance indicators (KPIs) or other company or state initiatives and we

value and want to support individualized engagement that is directionally consistent with the goals of the ACC. As health and wellness behaviors are articulated and operationally defined, we will develop processes, track them over time, and tie them to member incentive or reward programs. We are aligning claims data and population health information to develop incentive programs and unique member outreach campaigns (such as text campaigns) to alert members of opportunities to engage in health behaviors consistent with their individual preferences and health priorities. For example, members who complete a health risk assessment would receive a small incentive or points that could be used for a larger incentive. Members who complete a health risk assessment and complete a designated follow up activity could earn additional points, and members who participate in a community program or take advantage of a local exercise class or nutritional seminar could earn additional points or incentives. These incentives would be aligned to drive outcomes benefitting the member and the region and would be conducted within state and federal requirements.

MEMBER ENGAGEMENT REPORT

We will submit a member engagement report to the Department every six months describing how we engage members and community stakeholders in the ACC. We agree to utilize the format approved by the Department for this report. We currently produce a RCCO stakeholder feedback report that outlines outreach activities for: general membership, unattributed members and special populations. This existing report provides a good model for expansion as we embark upon ACC 2.0 and new and innovative engagement strategies.

Grievances and Appeals

OFFEROR'S RESPONSE 10

Describe how the Offeror will handle grievances and appeals.

We have a responsive, member-focused grievance and appeal system which complies with 42C.F.R. § 438.400. Our customer service department is dedicated to handling member grievances and appeals and provides the expertise and policies necessary to resolve any member concerns quickly and to the satisfaction of the member, family member or designated client representative (DCR).

Our grievance and appeal system encourages members, family members, and their DCRs to provide ongoing feedback about their experiences of care in the Colorado Access (COA) system. Our staff members are ready to take information related to any grievance and/or appeal, and can be reached directly by telephone at 877-276-5184. We believe that early identification of system problems allows us to improve health care effectiveness for a broader population and to resolve the grievance or appeal with an acceptable outcome to the member, family member, or DCR. It is our intent to resolve grievances and appeals at the lowest level possible, where immediate change can most readily occur. We are passionate about the care our members receive and our customer service department is available Monday through Friday from 8 AM to 5 PM to assist members in making a grievance or appeal, requesting an exception, checking on the status of a grievance, appeal or exception, and answering any coverage determination questions they might have. We offer support to members throughout the grievance and appeals process ensuring that they are able to complete the necessary forms, move through all of the procedural steps, and access interpretive services and toll free numbers with teletypewriter/telecommunications devices for the deaf (TTY/TDD) when needed. Finally, members are encouraged to appoint a person of their choosing to represent them and/or help them through the grievance and appeals process.

GRIEVANCES

A grievance is any expression of dissatisfaction about matters not relating to an action (i.e., a denial or reduction of services) made by a member, family member or DCR. Grievances may include quality of care or service problems, aspects of interpersonal relationships with providers or their representatives, and/or a violation of a member's rights. Members or their designees may file oral or written grievances at any time without any fear of retaliation or benefits risk. Our staff members are trained to be responsive to members when they express dissatisfaction with an aspect of their health care experience. We appreciate feedback and assure members that there will be no adverse consequences to the grievances they have.

We provide education and outreach to members, families, and providers to ensure that they know their rights and the procedure to file a grievance. Members and their family members or DCRs have contributed to our informational materials and they are regularly reviewed and approved by our Member Advisory Council (MAC). During their first contact with a service provider, members receive information regarding their right to file a grievance, as well as the support available through our Office of Member and Family Affairs (OMFA) should they choose to do so. In addition, we provide information about the process in the member handbook, during regular mailings, at member forums, and through individual meetings with peer support specialists, who may offer assistance in this process. We also offer a workshop on member rights and responsibilities, offered by our OMFA, and it is available to member and provider communities at least annually.

We have a unified grievance process through which members may express dissatisfaction about any matter related to this contract, and related contracts. Our OMFA handles the grievance investigation and is responsive to any member needs throughout the investigation. Per Medicaid requirements, we accept formal grievances from members or their DCR that are submitted within 20 calendar days of the incident. When a grievance is filed, a formal investigation begins immediately. Quality of care concerns are addressed in accordance with Colorado Access *Policy QM301: Quality of Care Concerns*. All decisions regarding grievances are made within 15 business days of when the member files the grievance. If the member is dissatisfied with the outcome of a grievance, the member may bring the unresolved grievance to the Department of Health Care Policy and Financing (The Department) whose decision regarding the grievance is final.

Members who are enrolled with one of our network providers can also express a grievance directly to that provider or file the grievance with Colorado Access (COA) as their BHO. If a member chooses to file a grievance directly with a provider, all information will be transmitted from that provider to COA to ensure that notifications and resolution of the grievance occurs within the required time frames.

Occasionally a grievance is brought by a member, family member or DCR directly to the Department. In this case, we address all issues as soon as we are made aware of the grievance. When this occurs, we keep the Department informed about progress on resolving the concern(s) in real time and always make the Department aware of the final resolution.

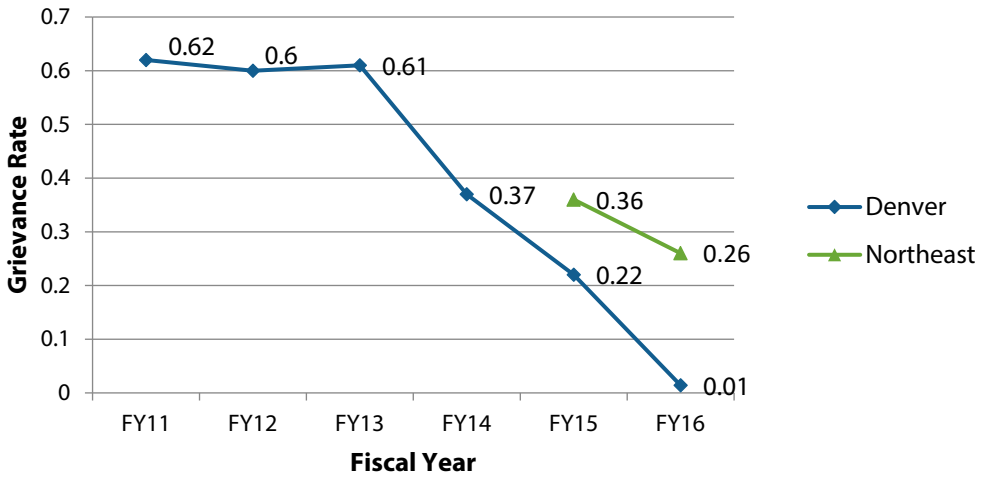
Grievance Data Tracking and Reporting

We track grievance information in a secure database, customized for member grievances and appeals and contract-specific. Individual grievance information is entered into the database, which allows ongoing monitoring during the grievance investigation. Grievance summaries and aggregate trending data are retrieved easily from the database. Our grievance data helps identify potential sources of dissatisfaction with care or service delivery, and informs improvement opportunities for provider practices. We aggregate member grievances and appeals quarterly, submit them to the Department, and review our data for trending problems or improvements annually and/or upon provider request.

Our Medical and Behavioral Health Quality Improvement Committee (MBQIC) receives and reviews grievance analysis and reports to assess any significant trends or patterns, with attention to satisfactory resolution, timeliness of resolution, adherence to state and federal rules, and ongoing staff training. Grievance data also is reported quarterly to the COA Member Advisory Council for its input and guidance in addressing trends.

We historically have a very low rate of grievances. The following graph demonstrates trends of low and decreasing rates of grievances across our two behavioral health contracts.

GRIEVANCE RATE PER 1,000



NOTICE OF ADVERSE BENEFIT DETERMINATION

On occasion, we deny coverage of or payment for a covered behavioral health service. When this occurs, we send the member, family member and/or DCR a notice of the adverse benefit determination that meets the following criteria:

- Is in writing
- Is available in the state-established prevalent non-English languages in the member's region
- Is available in alternate formats for persons with special needs
- Is in an easily understood language and format
- Explains the adverse benefit determination being taken
- Provides reasons for the adverse benefit determination
- Describes information about the member's right to file an appeal (or the provider's right to file an appeal when the provider is acting on behalf of the member as the member's designated representative)
- Explains the member's right to request a State Fair Hearing
- Describes how a member can appeal or file a grievance
- Gives information about the circumstances under which expedited resolution of an appeal is available and how to request it
- Explains the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of continued services

For standard authorization decisions that deny or limit services, we inform the member of the denial within 10 days, unless an extension is requested by the member or provider or an extension is in the member's best

interest, in which cases members are informed within 14 days. In each instance of an extension, members are notified in writing of the reason for the extension and of their right to file a grievance if they disagree with the decision. Service authorization decisions can also be made sooner, within 72 hours of the receipt of request for service, when the standard timeframe could seriously jeopardize the member's life or health or their ability to maintain or regain maximum functioning.

We ensure that members are notified at least 10 days before the date of action if the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services. If we have verified information that indicates probable beneficiary fraud, we provide as few as five days' notice of the adverse determination. Additionally, there are a variety of circumstances under which same day notice of an adverse benefit determination is acceptable to us, including:

- The recipient is deceased
- The member submits a signed statement requesting service termination
- The member submits a signed statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur
- The member has been admitted to an institution in which the member is ineligible for Medicaid services
- The member's address is determined unknown and there is no forwarding address
- The member is accepted for Medicaid services by another jurisdiction/state/territory/commonwealth
- A change in the level of care is prescribed by the member's physician
- The notice involves an adverse determination with regard to preadmission screening requirements
- The transfer or discharge from a facility will occur in an expedited fashion
- When the adverse benefit determination is a denial of payment.

HANDLING APPEALS FOR THE CAPITATED BEHAVIORAL HEALTH BENEFIT

We have a responsive, member-focused system to handle appeals of adverse benefit decisions for beneficiaries of the capitated behavioral health benefit. This appeals process complies with 42C.F.R. § 438.400. Our customer service department is dedicated to handling member appeals and provides the expertise and policies necessary to resolve any member concerns quickly and to the satisfaction of the member, family member or designated client representative (DCR).

Members and/or their DCRs may request, either orally or in writing, a review of any action through the appeal process. Possible subjects of appeals include denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service.

Information on how to appeal a grievance decision is provided to members in clear and concise language in the member handbook. Each member receives this information again whenever an action is taken. Our care managers and peer support specialists are available to help members throughout the appeal process. We provide written notice to members for any action we take, as defined in Volume 8.209.2 including:

- The action we are taking and the reason(s) for the action.
- The member's or the provider's right to file an appeal and the appeal's due date.
- The member's right to request a State Fair Hearing, and how to exercise that right.
- The circumstances under which expedited resolution is available, and how to request it.
- The member's right to receive continued benefits, pending resolution of the appeal, and how to request continuation.
- The circumstances under which the member may be required to pay the cost of these services.

We make every reasonable effort to help a member or DCR navigate the appeal process, including completing appeal forms, and providing interpretive services and toll-free numbers that have TTY/TTD capability when necessary.

CONTINUATION OF BENEFITS AND SERVICES DURING AN APPEAL

We continue member benefits while a capitated behavioral health benefit is in the appeals process under the following circumstances:

- The benefits are accessed within 10 days of mailing the notice of an adverse benefit determination.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The authorization period has not expired.
- The member requests an extension of benefits.

If a member's benefits are continued or reinstated, they are continued until: the member withdraws their appeal, the member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the adverse appeal decision letter was mailed, a State Fair Hearing decision adverse to the member is made, and/or the service authorization limits have been met.

In cases where services are not provided while the appeal was pending, we provide disputed services promptly, within three days (or sooner if the member's health condition requires), from the date either COA or the State Fair Hearing Officer reverses the decision to deny, limit, or delay services. We pay for all disputed services received by members while appeals are pending except in cases where the state covers the cost of such services or COA or a State Fair Hearing Officer reverse a decision to deny authorization of services.

RESOLUTION AND NOTIFICATION OF APPEALS

The appeals process begins when we provide a written notice of action to members and/or DCRs as described in Colorado Access *Policy CCS307: Utilization Review Determinations*, and in accordance with the Department Medicaid rules**.** We provide a written acknowledgement of the appeal to the member and/or the DCR within two

business days of receipt, unless the member or DCR requests an expedited resolution. A member or DCR may request an expedited appeal if they determine that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum functioning. Under these circumstances, we will provide a written acknowledgement of the appeal sooner than two days, and will not take any punitive action against a member or DCR for expediting an appeal.

Both standard and expedited appeals are resolved and a notice provided to the member or DCR as expeditiously as the member's health condition requires, and not to exceed the following:

A ***standard appeal*** is resolved and a written notice of the resolution is provided to the member or DCR within 10 business days of receipt.

An ***expedited appeal*** is resolved and a written notice of the resolution is provided to the member or DCR within three business days of receipt. We make every reasonable effort to provide oral notice to the member and/or DCR within the three business days required for written notice.

If an expedited appeal resolution request is denied, we make reasonable efforts to give the member or DCR prompt oral notice of the denial, with written notice provided within two calendar days. The appeal then follows the standard resolution process.

We may extend the timeframe to resolve a standard or expedited appeal for up to 14 calendar days if the member or DCR requests the extension or if we prove a need for additional information and that the delay is in the member's best interest. We provide the member or DCR with prior written notice of the reason for the delay and make reasonable efforts to allow the member or DCR to examine the records and documents associated with the appeal, and to present evidence and allegations of fact or law, in person or in writing. Finally, we continue to provide covered services to the member during a pending appeal review under the conditions specified and required by applicable federal and state law, rules and regulations, and line of business contracts.

Appeals decisions are made by a licensed physician with appropriate clinical expertise to treat the member's condition and who was not involved in any previous level of appeal review or decision making if deciding:

- an appeal based on lack of medical necessity;
- a denial of an expedited resolution of an appeal; or
- any appeal that involves a clinical decision.

We provide written notice and make every effort to provide oral notice to our members of the decision regarding their expedited appeal and follow up with written notice of the disposition of the appeals process that includes the results and data of the appeals resolution. In the event that an appeal decision is not wholly in the member's favor, we include information describing their right to a State Fair Hearing, how to request a State Fair Hearing, an explanation of their right to continue to receive benefits pending a hearing, and notice that the member may be liable for the cost of any continued benefits if the adverse decision is upheld during the hearing.

Monitoring Process for Appeals

Clinical appeals are monitored and reported quarterly for emerging trends and timeliness of determinations on review. Appeals have remained low and continued to decrease. In 2016 clinical appeals in the Denver BHO

program decreased by 38% from calendar year 2015, and are down 50% since fiscal year (FY) 2013. The increased availability of physician reviewers, implementation of software that permits rapid transmission and sharing of clinical files, refinement of procedures for review determination, and additional staff member training allowed timeliness of resolution to remain at 100% during calendar year 2016. We anticipate similar performance upon successful award for the RAE contract for Region 3.

BHO APPEALS: REGION 5

	FY13	FY14	FY15	FY16
Total number of appeals	16	15	13	8
% of denials appealed	5.3%	3.1%	5.3%	1.0%
Appeal rate (per 1000 members)	0.14	0.08	0.07	0.04
% of UM denials overturned	0.7%	0.2%	1.6%	0.13%

STATE FAIR HEARING AND EXPEDITED STATE FAIR HEARING

Members and/or their DCRs may request a State Fair Hearing once they have exhausted our appeals process, and no later than 120 calendar days from the date of the notice of action, unless we fail to adhere to the timing requirements as laid out by the Department. If we have not met the timelines required, a State Fair Hearing can be requested at any time. An expedited State Fair Hearing can be requested if a member meets our criteria for an expedited appeal or if the appeal was resolved wholly or partially adversely to the member through our process. We inform members of this right and how to request a State Fair Hearing through the member's notice of action. We also include general information about these appeal resolution avenues in other written member materials.

We provide reasonable assistance to a member or DCR requesting a State Fair Hearing, including completing forms and other procedural steps and providing access to interpretive services and toll-free numbers with TTY/TDD capability. In addition, we will continue to provide covered services to the member during a pending State Fair Hearing review under the conditions specified and required by applicable federal and state law, and rules and regulations.

OMBUDSMAN FOR MEDICAID MANAGED CARE

We utilize and refer members to the Ombudsman for Medicaid Managed Care to assist with problem solving, grievance resolution, in-plan and administrative law judge hearing level appeals, and for referrals to community services. When members agree to work with the Ombudsman, we provide the Ombudsman with member protected health information (PHI) (except for psychotherapy notes and/or substance use disorder-related information), except in cases where the member has made the explicit request that COA not share their PHI with the Ombudsman. Upon award of the Regional Accountable Entity (RAE) contract, we will develop an official Ombudsman Policy.

GRIEVANCE AND APPEALS REPORT

Upon award of the RAE contract, we will submit a quarterly grievance and appeals report that includes:

1. A general description of the reason for the grievance or appeal,
2. Date received,
3. The dates of each review and/or review meeting,
4. Resolution at each level of the appeal or grievance (if applicable),
5. Date of resolution at each level (if applicable), and
6. Name of the covered person for whom the appeal or grievance was filed.

Network Development & Access Standards

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.

ESTABLISHING A NETWORK

As the Regional Accountable Entity (RAE), we will continue to expand and develop our already extensive network of primary care medical providers (PCMPs), behavioral health providers, and others. This well established and committed network encompasses more than 300 PCMPs and more than 2,900 behavioral health providers statewide, with concentrations in RAE Regions 2, 3, and 5, allowing members to easily access health care in their home regions as well as neighboring regions in which they may live, work, or travel. Our ability to build and maintain a robust provider network is demonstrated by impressive network growth over the past six years. **Since 2011, our behavioral health provider network alone has increased by 208%.** We continually seek and secure additional providers to meet a growing and diverse membership, and our behavioral health network alone grew by more than 17% in 2016 alone. **As a system-level entity rather than a provider-based organization, we are not impeded by competing business objectives** that could be at odds with network expansion.

As the RAE in Region 3, we will continue to build upon our established network by leveraging strong, positive relationships with existing Medicaid providers and continue to outreach and add new Medicaid providers. Our strong, positive relationships with community partners will also help us identify unmet needs and new opportunities, particularly for providers serving unique neighborhoods and special populations. In addition to active provider and community outreach, our participation in Aurora Health Access in Region 3, ensures that we are well known and accessible to potential providers. Our reputation for providing leadership and support to a wide range of network and non-network providers regarding health care transformation and Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, helps us establish positive provider relationships that often evolve into formal network agreements and contracts.

a. Expanding Provider Choices for Members: Unparalleled Success

We are a system-level entity, rather than a provider-based organization, allowing our network expansion to be focused solely on developing a network of providers that best meets the needs and preferences of our members. As the RAE, we will continue to promote member choice by focusing network expansion on:

- Accessibility through geographic proximity
- Accessibility through timely appointment availability
- Diversity in provider gender, race, and ethnicity
- Diversity in provider languages spoken
- Diversity in provider specialties and service offerings

- Diversity in practice size
- Diversity in PCMP type

Regular analysis and review of network adequacy data (described in further detail in Response 23—Quality Improvement) ensures that we continually monitor and work to expand member choice. As the Region 3 Regional Care Collaborative Organization (RCCO), based on these analyses, we made a rigorous effort to expand our network to allow members to choose providers that are racially, ethnically or culturally similar. We focused both on large practices such as Salud Family Center and Metro Community Provider Network, and in smaller practices made up of one or a small number of providers from African, Asian and Latino/ Hispanic cultures, as well as those experienced in treating people with disabilities and GLBTQ adults and teens. Finally, we worked with large and small providers to extend their business hours to evenings and weekends to improve access and choice. Expanded access was a goal for two Region 3 participants (Doctor's Care and Dr. Suman Morarka) in our Pay for Performance incentive program described in Offeror's Response 17—Provider Support and Practice Transformation.

b. Meeting the Unique Needs of the Region's Members

We will establish and maintain networks based on the number of members (and projected trends in enrollment), the characteristics and health needs of specific populations, the numbers and types of services and providers required, the number of providers accepting new members, geographic location, and accessibility. Population stratification is a key tool we use to ensure that expansion efforts are aligned with actual population needs. Our population stratification model includes members' physical health, behavioral health, and disability data, as well as data regarding social determinants of health (this model is presented in detail in Appendix I). This comprehensive modeling work informs the expansion of the network in a targeted, prioritized way. For example, we recently identified and addressed sub-regions with high numbers of refugees, such as central and north Aurora, and areas that need more Spanish-speaking providers. Additionally, the population health and care coordination teams monitor member needs and provide input to the provider engagement team to address trends and gaps that they observe at the member or subpopulation level. Regular analysis and review of access to care standards, measured on a per member basis, is a further assurance that we continually meet unique member needs in the region.

c. Proven Capacity to Serve Members with Complex and Special Needs

As the RAE, we will ensure sufficient capacity to serve diverse members with complex and special needs by leveraging our well-developed expertise and networks in both physical health and behavioral health. Our role as a Single Entry Point (SEP) also gives us a significant advantage in having both the cross-system understanding and the capacity to serve members with complex combinations of disability, physical, and behavioral health challenges. As long-time members of the Region 3 community, we are well engaged with a broad array of providers with specialized expertise and services, including some providers who are small, independent, and lacking in robust infrastructure. Some examples of large and small providers that have the capacity to deliver specialized services for Region 3 members with complex health and cultural needs include the Asian Pacific Development Center, Clinica Tepeyac, Elmira Refugee Health Center, Mile High Behavioral Healthcare, Plains Medical Center, and Salud Family Center. All of these practices are described in Offeror's Response 9—Member Engagement. Other large providers in the region with significant expertise in treating complex conditions are:

- **Aurora Community Mental Health Center's Intercept Program** – which serves children with developmental disabilities in addition to mental health conditions
- **The Children's Hospital** – serves children and adolescents with physical and developmental disabilities and complex medical conditions in addition to behavioral health issues
- **Metro Community Providers Network** – treats members with complex medical conditions, including HIV+, Spanish and Asian language speaking members, and many other physical and behavioral health conditions
- **Offender Programs at AllHealth Network, Aurora Community Mental Health Center, and Community Reach Center** – all three of our region's community mental health centers have specialized programs for offender which includes treatment for multiple conditions such as mental illnesses, substance use disorders and sex offenses, along with linkages to physical health care.
- **University of Colorado Hospital and University of Colorado Medicine** – deliver a variety of treatment for children, adults and older adults with complex medical conditions, physical disabilities and many other needs.

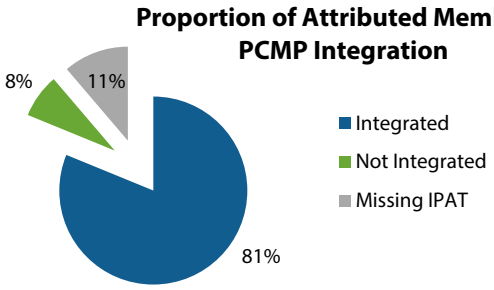
Region 3 also boasts a large number of small practices whose health care staff are experts in one or more specialty areas. These include providers who are of Hispanic/Latino, Asian, Middle Eastern, and African descent; those who live and deliver services in rural/frontier areas; and persons who are themselves GLBTQ and are well versed in the complex health care needs of this sub-population. Other local small providers, particularly those associated with the University and Children's Hospital networks, have a wealth of experience serving adults and children with specific conditions (e.g., kidney failure, asthma, traumatic brain injuries) that complicate their care when combined with other medical issues. We are well positioned to engage and support these providers; conversely, these providers know and trust Colorado Access and are more likely to join and remain in our networks.

Below we describe our network development approach in more detail.

d. Creating an Integrated Physical Health and Behavioral Health Network

Our networks are comprised of primary care providers, behavioral health providers, and other specialties, services, and facilities. Many network members provide both behavioral health and physical health services. Rather than conceptualizing our network as two separate, parallel provider groups—physical health and behavioral health—we will continue to integrate our provider network into a unified system. This approach will create efficiencies for both the RAE and the providers, promote synergies among the system components, and reduce misaligned incentives in order to direct all aspects of the network toward overarching RAE aims.

Many of our most complex and highest risk members have comorbid and chronic behavioral and physical health conditions. Nationally, approximately 20% of Medicaid members account for more than half of Medicaid spending. The average annual total expenditure for a Medicaid member with a behavioral health diagnosis is approximately 3.7 times that of a member without[1]. With our strong experience in whole-person care, we are uniquely prepared to support the transition of two separate behavioral and physical health provider networks into an integrated health care delivery system. We envision our network as the anchor for dynamic health neighborhoods in Region 3, and, ultimately, the foundation for a transformed health system across Colorado. **More than 80% of our PCMPs offer integrated care**, measured by scores on the Integrated Primary Care Assessment Tool (IPAT) of three or higher. This achievement demonstrates our ability to support providers' capacity to deliver whole-person care. As a RAE, we will build upon these successes by expanding and enhancing care integration across our networks.



Supporting Participation of Smaller Practices

Through our experience as a RCCO and BHO in urban, suburban, rural, and frontier areas, we are very adept at understanding and addressing the unique challenges faced by smaller network practices, particularly in the rural and frontier areas of Region 3. We are invested in supporting these smaller practices for the great community value they offer, their appeal to many rural, frontier, and urban members, and the diversity they bring to the provider network. Currently, the majority of network providers are actually small practices, and more than one-third of our members are attributed to these smaller providers, making it especially important that our provider support team offer assistance customized to smaller practices. As a RAE, we will continue our flexible provider support approach and are prepared to engage and maintain smaller provider participation in the Accountable Care Collaborative (ACC) through **education** (e.g. how to align across KPI, MACRA, SIM or other outcome-based initiatives), **training** (e.g. cultural competency training so multiple small providers do not have to arrange that individually), and **system-level support for complex members.** Examples of this include: plan-based care coordination for smaller providers who do not have capacity for intensive case management; interpretation services for scheduling and direct care services; access to on-demand virtual specialty care through our own AccessCare virtual integrated care initiative; and an array of systematic supports for data, analytics and interpretation. Smaller practices typically lack the resources to generate analytics or reports; even when they are able to access aggregate reporting (i.e. through SDAC), they may lack the resources to interpret in the context of their entire patient panel or conduct more detailed analysis to understand underlying drivers. As outlined in Offeror's Response 17—Provider Support Strategy and through our annual Practice Support Plans, we are prepared to deliver enhanced RAE resources to all practices (e.g. small practices without the advantages of centralized billing/ administration/ technology and data infrastructure) that need greater system-level support to participate in and be successful in the ACC.

[1] Medicaid and CHIP Payment and Access Commission (MCPAC) March 2017 Report to Congress on Medicaid and CHIP. Accessed at https://www.macpac.gov/publication/march-2017-report-to-congress-on-medicaid-and-chip/

Rural and Frontier Areas: Keeping Providers and Members at the Center.

Our network includes a very small hospital in a rural county that serves a critical role in providing emergency and outpatient care for the entire county and neighboring counties, including Medicaid members. The recent provider revalidation process required by the Department was particularly challenging for the hospital, given its limited administrative resources and competing clinical demands. While the hospital in question is not a PCMP, the facility is critical to ensuring adequate care for Medicaid members in that region. We stepped in to provide technical assistance and administrative support, and the hospital was able to successfully complete the revalidation submission and thus maintain its Medicaid revenues. This example highlights our commitment and ability to support the network with our system-level expertise, and it further highlights our commitment to Medicaid providers and our members' care. Supporting small providers in rural and frontier regions will be a critical component in Region 3, and we are pleased to bring our robust expertise and resources to this important challenge.

The RAE Network: Central Role of Essential Community Providers in a Diverse Network

We will continue to include and expand the diverse providers in its network and ensure that they meet rigorous credentialing and quality standards and are aligned with the aims of the ACC. We ensure that our network has the capacity to serve all members and includes providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities. The table below summarizes the types of provider groups that we actively recruit into our network:

Provider Type	R2	R3	R5	Statewide
Federally Qualified Health Centers	22	12	27	91
Rural Health Clinics	8	0	0	8
Community Mental Health Centers	2	3	1	17
Substance Use Disorder Clinics	3	9	8	29
School Based Health Centers	0	7	45	52
Indian Health Care Providers	0	0	3	3
Essential Community Providers	11	8	19	38

The RAE Network: Specialty Behavioral Health Providers

We maintain a statewide network of more than 1,100 behavioral health provider sites that includes inpatient, outpatient, and all other covered behavioral health and substance use disorder services, not including the multiple locations of the 17 of the State's community mental health centers. All behavioral health network providers are enrolled as Colorado Medicaid providers. Our approach to maintaining and expanding the behavioral health network and member choice is described in other sections of this Offeror's Response. The behavioral health provider network will meet the access to care standards and behavioral health network time and distance standards required by the contract.

The RAE Network: Geographic Access and New Member Capacity

Our PCMP network and behavioral health network will meet the access to care standards and time and distance standards required by the contract. We are uniquely capable of ensuring that our network will meet the needs of

the RAE members based on an in-depth understanding of Medicaid populations gained through many years of service, coupled with state-of-the art analytics. We use ongoing population stratification model trend analysis (described in detail in Offeror's Response 15—Population Health Management Plan and Strategy and Appendix I) to anticipate member need; we also project future need based on impacts of federal and state policy changes. Our quarterly geomapping process supports periodic analyses of network adequacy. Providers' geographic locations are compared to members' addresses and available transportation options; practices accepting new patients are also geo-mapped.

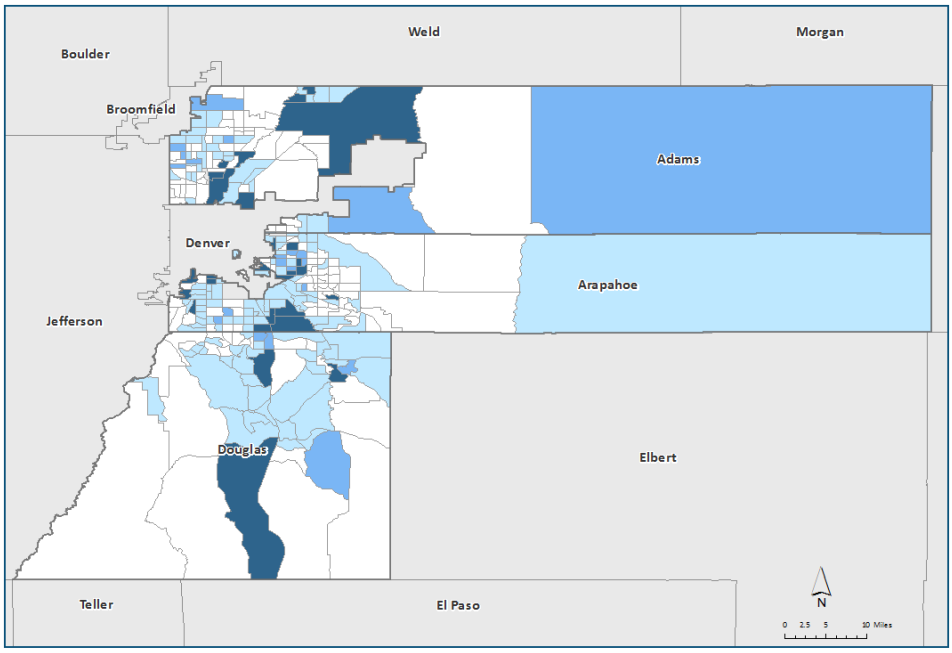
Within our overall behavioral health network, there are currently 189 prescribers and 54 practitioners who are not accepting new patients. This represents 1.2% percent of our provider network. In our PCMP network, about 85% percent of providers are currently accepting new members. This information is reported regularly on our network adequacy reports.

The map below illustrates the network provider locations in the Denver metro area and beyond, as well as the distribution of members. It clearly demonstrates that the provider network covers Region 3 extremely well and is also robust outside of our area. One hundred percent of current RCCO attributed members are within 30 miles of a provider, and they are on average 1.0 miles away. The figures for BHO members are similar: 100% live within 30 miles, and the average distance to a behavioral health provider is 1.5 miles.

Region 3 members are on average, one mile from a RCCO PCMP

Current Membership	Statewide	Region 3 Area
Behavioral Health Organization	Average distance to provider: 1.2 miles	Average distance to provider: 1.5 miles
	99.8% live within 30 miles	100% live within 30 miles
Regional Care Collaborative Organization	Average distance to provider: 1.2 miles	Average distance to PCMP: 1.0 mile
	100% live within 30 miles	100% live within 30 miles

Region 3 Physical Health Provider Network

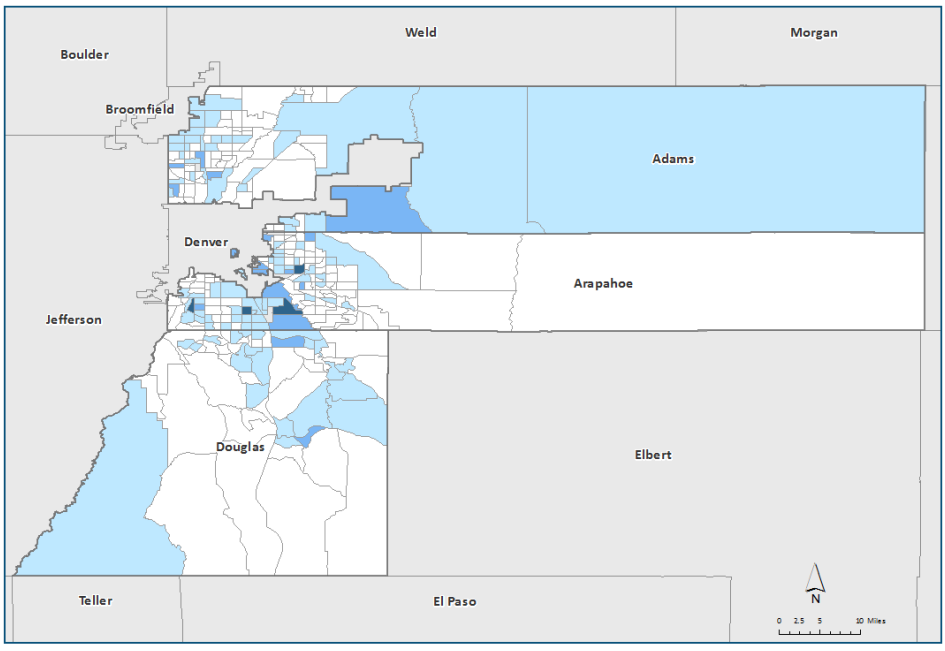


Physical Health Providers by U.S Census Tract in Colorado RCCO Region 3

0 1 - 5 6 - 10 >10

Map created 5/30/2017

Region 3 Behavioral Health Provider Network



Behavioral Health Providers by U.S Census Tract in Colorado RCCO Region 3

0 1 - 5 6 - 10 >10

Map created 5/30/2017

Expanding the Network and Increasing Member Choice

We have long embraced a person-centered approach in our network development, recognizing the importance to members of having a range of meaningful options. Members are more likely to engage and participate in their health care if they have a decision-making role in choosing a provider and feel comfortable with them. To this end, we aim to have a sufficiently large and diverse provider network, as well as processes to make members aware of the options and access points. Tactics we use to expand the network and ensure member choice include:

- Maintaining a large network of a broad variety of provider types
- Offering network participation to all primary care practices sites located within the region that meet the Department's PCMP qualifications
- Encouraging members to take an active role in choosing a PCMP and behavioral health provider and providing them with user-friendly information about available options.
- Regular assessments of network adequacy.
- Prompt action to address gaps or indicators of network inadequacy or quality issues.
- Member-facing activities to increase choice: care coordination support of finding desired providers, posting provider directories online in searchable formats, etc.
- Analysis of member utilization patterns to identify non-participating providers who serve Medicaid members and may be appropriate for recruiting to the network.
- Technology-based solutions to decrease access barriers and leverage existing resources more efficiently. Examples include telehealth solutions such as: services administered through our AccessCare Services subsidiary, treatment and consultation delivered by other network behavioral health providers such as AllHealth Network and Aurora Community Mental Health Center, and an innovative 24/7 service for skilled nursing facilities to consult with a hospital-based physician through telehealth services.
- Leadership role in regional initiatives, such as the Aurora Health Access' to Specialty Care initiative, to address known access challenges for specialty care.

We are well prepared to collaborate with the Department of Health Care Policy and Financing (the Department) to build upon existing techniques to assess and develop network capacity based on quality and credentialing, as well as price. As a RCCO, we have established processes for certifying PCMPs as enhanced PCMPs (ePCMPs) based on their ability to meet the process and quality metrics. Our certification process involves monitoring PCMP status on enhanced offerings such as extended hours and advice line access, tracking this provider-level data, and working with the Department to ensure provider receipt of the enhanced payment. We currently maintain oversight for 127 of Colorado's ePCMPs, almost half the state total. Outcomes from the initial phase of the ePCMP initiative demonstrated a reduced total cost of care for members attributed to ePCMP practices, while other targeted metrics did not differ compared to non-ePCMP practices. Our experience with the ePCMP initiative has yielded a robust understanding of the strengths, weaknesses, and lessons learned, and we are already facilitating collaborations to build upon these in the RAE network development plan.

We will leverage the Region 3 Governance Council and Regional Advisory Council to inform the development of a high-quality network and monitor the accessibility and quality of services available to members. Using a data-driven approach, key performance indicators (KPIs) and other quality metrics will be selected and prioritized for

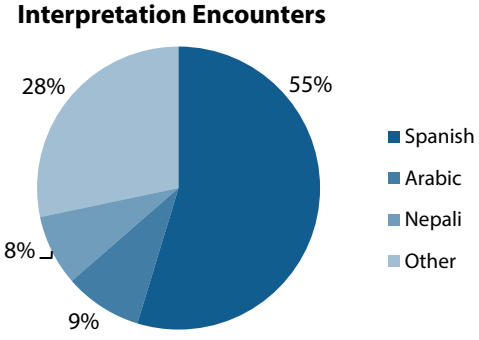
the region, and developing strategies to improve and incentivize access and choice will be done in a collaborative and transparent fashion.

Expertise and Options for a Members with Complex or Special Needs

In addition to ensuring a sufficient number of network providers, including essential community providers, we also use data-driven and qualitative approaches to ensure that the special needs of all our members are met through options available in the network. Members have a diverse range of physical health conditions, behavioral health conditions, abilities/disabilities, comorbidities, and complexities that can create special needs. Additionally, there are myriad individual, social, cultural, and linguistic factors that influence how members perceive and access the health care system. True access is not achieved by having a long list of providers, but rather by the availability of diverse, high-quality clinical services that are also culturally responsive to the unique member and their special needs and a responsive system that facilitates easy navigation for members to get to the right provider. Our data-driven approach to creating the diverse network is based on comprehensive population stratification model (further described in Response 15 – Population Health) that incorporates multiple administrative data sets (behavioral health, physical health, pharmacy, long-term care claims), clinical and care coordination data, and social/public health data. Using this model, we can determine the types and numbers of providers with different specialties required to serve the needs of our diverse membership. We will also actively seek qualitative input directly from members, community agencies, advocates, and other regarding member needs. The sections below highlight selected aspects of the extensive range of specialized services and providers in the Colorado Access Region 3 network.

Special Need: Linguistic and Racial/Cultural Diversity

All of our large providers have staff members with multicultural specialties and expertise. We also recruit network providers with specialized cultural expertise and linguistic competencies. Examples include: Clinica Tepeyac, Denver Indian Health and Family Services, Metro Community Provider Network, Salud Family Health Center, and Asian Pacific Center for Human Development. Although some of these providers are located in Denver, they are nearby, accessible and regularly used by Region 3 members. We routinely survey providers to monitor the availability of clinicians to serve members with special cultural or linguistic needs. We support and facilitate interpretation and translation services if services cannot be delivered in a member's primary language. As the RAE, we will ensure that major clinical sites are TDD accessible, particularly network hospital emergency departments and access sites. Our network providers also have varied language competencies. In Region 3, 307 practitioners speak a language in addition to English. Across the state, we contract with 120 primary care and 41 behavioral health providers sites whose practitioners speak Spanish - the predominant language spoken by our non-English speaking members. Other provider languages spoken include: Amharic, Arabic, Bosnian, Croatian, Farsi, Filipino, French, German, Hindi, Igbo, Korean, Marathi,



Montenegrin, Oromo, Ponjabi, Russian, Serbian/Slavic, Sign Language, Tagalog, Tigrinya, Vietnamese, and Yoruba.

We periodically compare the linguistic competencies of our network against the documented language needs of our members. For example, in 2016 we supported 3,899 encounters with telephonic interpreter services. These services were provided in 45 different languages, with Spanish, Arabic, and Nepali representing the most common.

We directly employ multilingual staff in our customer service and care coordination teams to assist members and facilitate service delivery, including current employees who speak Amharic, Spanish, Russian, and Tigrinya. We take an active role in educating members and families that information and services will be provided in a language or format they are able to understand. We inform providers of the availability of interpretation services and other resources such as cultural competency training.

Expanding Service in a Specific Area of Need:

Indian Health Centers are critical resources for ensuring culturally competent, acceptable care to American Indian families. Many of these families are unlikely to access health care services in any other way/location, including behavioral health services. Our partners at Denver Indian Family Health Services (DIFHS) noted a need to embed psychiatric services for their patient population. Through AccessCare, our telehealth subsidiary, we partnered with DIFHS to provide virtual psychiatry services and expand upon the existing DIFHS team-based care model. Using a combination of virtual direct care psychiatric services and provider-to-provider consultation, the DIFHS primary care clinician is able to maintain treatment and prescription responsibility. In this way, the providers who are most experienced in delivering culturally competent care within this specific population, with whom patients are most comfortable, are able to deliver comprehensive care directly to their patients. This practice is too small to utilize a full-time psychiatrist and would not have had the resources to create this model on a small scale. AccessCare was able to provide a system-level solution at no additional cost to the practice, as well as support individualized implementation of a new virtual component to the work flow. As a RAE, we will disseminate the use of technology to expand access and choice in areas of special need.

Special Need: Persons Living With Disabilities

To enable access for our members with living with disabilities, we have established relationships with the regional Community Center Boards (North Metro Community Services, Developmental Pathways, and Eastern Colorado Services) and the departments of human/social services in our region's four counties. Developmental Disability Consultants, an important provider of services for individuals with developmental disabilities, autism, and traumatic brain injuries, is a long-standing provider in our network, as is Rocky Mountain Human Services' behavioral health program, the Aurora Intercept Program, and JFK Partners. Children's Hospital Colorado, Aurora Community Mental Health Center, and University Health Systems/University of Colorado Medicine have formal relationships with Colorado Access. These organizations are statewide centers of excellence in differential diagnosis and treatment for persons with traumatic brain injuries and autism-specialty care.

Our current BHO network in Region 3 includes more than 31 providers with expertise in meeting the behavioral health needs of persons with intellectual and developmental disabilities.

We ensure that our network includes providers who meet the ADA access standards and communication standards and proactively assists members in finding the best provider to meet their particular needs.

As the Single Entry Point agency for Regions 3 and 5, we are particularly well versed in ensuring that members living with disabilities access appropriate and coordinated health care. Our integrated care coordination process facilitates members' connections with appropriate providers, supports access, and addresses barriers. Our care coordination system ensures seamless continuity for these complex members in a person-centered fashion, designating a single point of contact.

Special Need: Deaf and Hard of Hearing

We partner with the deaf/hard of hearing program at the Mental Health Center of Denver and the Colorado Commission for the Deaf and Hard of Hearing, the organizational leaders of the Colorado Daylight Partnership (CDP). CDP has been working since 2008 to improve access and quality of behavioral health services for deaf and hard of hearing individuals across the state. Through this partnership, we will expand and enhance our provider network for members who are deaf and hard of hearing, including both PCMPs and behavioral health providers.

The maintenance of a robust network of providers of specialized services, as described in the preceding sections, depends on strong relationships and ongoing support. We promote collaboration with the providers above, many of whom are smaller or independent practices, by assigning a single point of contact on our provider support team and providing data, practice support, and other resources as appropriate.

Our written policy for the selection and retention of providers are consistent with 42 C.F.R. Our internal administrative *Policy Selection and Retention of Providers – PNS202* specifies that we will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition, our policies require that our network providers meet ADA regulations. Upon award, we will post policies and procedures for the selection and retention of providers on our public website and will meet all contract requirements regarding documentation and notice of admission/rejection of providers. We ensure that providers meet The Americans with Disabilities Act of 1990 access and communication standards. We inspect clinical sites as required by NCQA guidelines whenever a member complaint is made about accessibility, and member grievances about accessibility are always investigated. Finally, we contract with the Colorado Cross-Disability Coalition to train our staff on disability awareness issues to be aware that members with physical disabilities may experience physical barriers to access.

As a RAE, we will work continuously to expand our provider network through ongoing analyses of network adequacy, identification of gaps, and active interventions to fill those gaps. This may include engaging additional providers and/or working with existing providers to extend their service array in specific areas of need. If our provider network experiences any expected or unexpected changes, we are prepared to follow all contractual obligations to notify the Department if there is the potential that these changes could adversely impact network adequacy.

We have existing policies and procedures that describe our mechanisms for ensuring provider compliance. These policies and procedures are memorialized in the standard written contract that we execute with every provider in our network, including PCMP and behavioral health providers. In addition, we are the only potential RAE contractor with experience contracting with single entities that provide both physical and behavioral health by supporting them in the credentialing and billing processes needed to appropriately bill services to both physical and behavioral Medicaid funding sources without duplicating charges.

We will offer contracts to all federally qualified health centers (FQHCs), regional health centers (RHCs), and Indian health care providers located in and near our regions. As shown in the table above, we have been very successful

in engaging these providers. As a RAE, we will continue these efforts with the goal of including all of these important providers in regional network.

We agree that we will not employ or contract with any providers that are excluded from participation in federal health care programs under either section 1128 or section1128A of the Social Security Act.

Network Adequacy Plan and Report

Upon award, we will submit a network adequacy plan that meets or exceeds Department expectations and contract requirements. Having held multiple contracts we already monitor and report on the full complement of network variables. We are uniquely prepared to monitor and report on integrated network adequacy across both PCMP and behavioral health provider networks and will meet all related contract requirements.

Provider Network Management

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

THE COLORADO ACCESS APPROACH TO MANAGING OUR PROVIDER NETWORK

Our approach to managing our provider network: 1) leverages existing and trusting relationships with community providers, 2) ensures certification, credentialing, provider notification, and access to care standards that meet or exceeds Department of Health Care Policy and Financing (the Department) criteria, and 3) guarantees a robust and diverse network of providers through ongoing positive collaborative relationships and demonstrated regional leadership. **Our current extensive network includes more than 300 primary care medical provider (PCMP) sites, and more than 2,000 primary care practitioners.** There are 900 practitioners that have primary locations within Region 3, but the benefit of the entire network, located across the state, is accessible to all members as they live, work, and travel throughout Colorado.

a. Certifying Providers for Accountable Care Collaborative Network Participation

We have robust and efficient processes and structures in place to assess provider qualifications, execute contracts, onboard and train new providers, and monitor compliance. Our provider engagement team provides tailored support to providers to ensure that each provider is enrolled as a Colorado Medicaid provider, is licensed in the state, renders services under the specified provider types and criteria, and specializes in the specified medical fields. As a system-level entity that has been partnering with both providers and the Department since the beginning of the Accountable Care Collaborative (ACC) program, we not only ensure that providers are qualified but also provide practice supports to help them meet criteria as needed. This includes helping new providers navigate the Department's Medicaid enrollment process, revalidation process, and practice transformation initiatives.

Flexible, Locally Tailored, and High Quality Care Coordination

We are dedicated to maintaining a diverse provider network to meet members' diverse needs and preferences and ensuring that PCMPs deliver the appropriate care coordination interventions directly to members. Our care coordination program, described in detail in Offeror's Response 16—Care Coordination, ensures that all members have access to care coordination when they need it or request it and delivers services as close as possible to the member and the point of care. Care coordination at the PCMP level is the keystone to the overarching care coordination system and is augmented by an array of community-based and centralized care coordination interventions, all informed by a programmatic design that will achieve the RAE outcomes while reducing redundancies and providing a seamless member experience.

As described in Offeror's Response 16—Care Coordination, we have deep experience in supporting PCMPs in the effective delivery of care coordination, as well as robust processes for oversight, data and reporting, and technical assistance. As the Regional Accountable Entity (RAE), we will ensure that network PCMPs provide care

coordination, such as assessments and screening, managing transitions of care, social determinants support, and other services appropriate to the population's needs. We will also continue to provide technical assistance as needed to ensure that PCMPs are able to utilize population-level data, such as risk stratification for their membership, patient registries, and real-time actionable data such as Admission-Discharge-Transfer (ADT) data through the health information exchange (HIE). We tailor our support of PCMP care coordination based on the practices' needs; for smaller practices that are important to meet the members' needs but unable to perform care coordination, we will provide care coordination for those members.

Member-Centered Primary Care

We ensure that network PCMPs adopt member-centered best practices and support providers in meeting ACC criteria including: 24/7 phone coverage with clinician access, regular use of universal screening tools, specialty care referral tracking and informed communication, appointment availability beyond typical workday hours, use of stratification tools and other data to identify and address members' high physical and behavioral health needs, individualized care plans developed with members/family, and use of electronic health records to share data with the Department. As described in Offeror's Response 21—Data Management and Analytics, the use of data to better know, manage, and treat member populations is an area in which our providers seek, and we provide, particularly high levels of support. As the RCCO, we worked collaboratively with providers to develop a regional tailored Provider Performance Portfolio, P3 report, to summarize and present clinical and outcomes data in a way that was easily understood and actionable to providers. These reports were particularly critical for smaller providers who did not have the administrative resources or data expertise to efficiently access and interpret SDAC data without support. We continue to partner with the Department and providers to advance electronic health record adoption and maximization.

In partnership with the Department and CORHIO, we collected in-depth survey data to assess the current state of electronic health record (EHR) and data-sharing within our provider network. As of June 2017, PCMP providers across Regions 2, 3, and 5 are using about 50 different EHR systems. Some version of Epic is the most common EHR system, and accounts for 33% of providers. About 5% of providers are using paper charts and have no EHR system. These metrics and the full set of results will inform regional and Department efforts to make system-level improvements that supplement, rather than duplicate, the current resources of network providers, and support providers in an informed way with information regarding their existing EHR capacities

We will offer network participation for all primary care practice sites in the region that meet the Department's PCMP criteria, considering each site within a health organization, group, or system, as a separate site for the purposes of network definition, management, and description. For smaller or developing practices that do not meet PCMP criteria but want to participate and fill a vital role for members' needs, we may waive some of the ACC criteria and enter into an agreement to fulfill the missing requirements. Our provider engagement team will develop an individualized plan for that practice, setting and attaining goals to work toward full participation as a PCMP.

b. Specialty Behavioral Health Provider Network

We have a statewide network of behavioral health providers that spans inpatient, outpatient, laboratory, and all other covered mental health and substance use disorder services. The specialty behavioral health network includes all 17 community mental health centers (CMHCs) in the state, all psychiatric hospitals in the state, 521 CMHC practitioners, 25 licensed federally qualified health center (FQHC) practitioners, and 920 licensed individual practitioners. There are approximately 167 prescribers in Region 3 and 529 statewide.

Approximately eight Denver area clinics have specific SUD expertise, and many of our providers offer a full continuum of behavioral health services to include substance use treatment. All network providers are enrolled as Colorado Medicaid providers. As the Regional Accountable Entity (RAE), we will continue to maintain and expand this network to meet the aims of the ACC, meet the needs of members, and increase member choice; we will continue to contract with all willing and qualified behavioral health providers. We bring more than 22 years of experience with managing and maintaining an ever-growing and diverse network of behavioral health providers, including contracting, credentialing, clinical oversight, access to care, compliance, training, and provider support. In 2016 alone, our specialty behavioral health network grew by 17%.

TABLE 12-1 COA BEHAVIORAL HEALTH NETWORK PROVIDERS

Type of Provider	Provider Name
Community Mental Health Centers	All 17 CMHCs in Colorado
Network Behavioral Health Providers	920 licensed individual practitioners
Hospitals	Boulder Community Hospital Cedar Springs Behavioral Health System Centennial Peaks Hospital Children's Hospital Colorado Colorado Mental Health Institute at Fort Logan Colorado Mental Health Institute at Pueblo Denver Health Medical Center Exempla Saint Joseph Hospital Highlands Behavioral Health System Exempla Lutheran Medical Center- West Pines Behavioral Health Medical Center of Aurora Peak View Behavioral Health, Colorado Springs Porter Adventist Hospital, Denver All 7 Health One Hospitals St. Anthony Hospital University of Colorado Hospital
Acute Treatment Units (ATUs)	Bridge House ATU (AllHealth), Littleton

Type of Provider	Provider Name
	North Range Behavioral Health ATU
Therapeutic Residential Child Care Facilities (TRCCFs)	Devereux Cleo Wallace Excelsior Griffith Center for Children Jefferson Hills Midway Youth Services Mount St. Vincent Home Savio House Shiloh Home Tennyson Center for Children Denver Children's Home Third Way Center

Credentialing Specialty Behavioral Health Providers

We follow National Council on Quality Assurance (NCQA) guidelines to set credentialing standards, as required by the Department. Our credentialing process, established and maintained by internal policy and publicly available to providers upon request, meets the most recent applicable regulations/standards/instructions as required by NCQA, the Centers for Medicare and Medicaid Services (CMS), Division of Insurance (DOI), the Department, Colorado Access, and any other applicable federal or state regulatory authority. We credential all contracted specialty behavioral health providers and re-credential at least every three years, and will continue to submit credentialing policies and procedures to the Department per Department timelines and in compliance with contractual requirements. Our Quality Improvement Committee (QIC) has the authority and responsibility as outlined in the Quality Management Program Description for overseeing the credentialing program. The QIC delegates responsibility to the Credentials Committee for annual review and approval of the credentialing criteria and the process for review of credentialing and re-credentialing providers, determining network participation status of applicants and re-applicants, and authorizes the senior medical director or designee who is responsible for credentialing to approve providers who meet criteria or exception criteria. QIC renders the final participation decision when a provider appeals an adverse determination following hearing panel review. We maintain a diverse Credentialing Committee, which requires its members to sign an acknowledgement form stating they do not discriminate based on an individual's gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin, and any other such prejudicial policies when making decisions. In addition, we will not discriminate against providers seeking qualification who serve high-risk populations or who specialize in the treatment of costly conditions. Providers have the right to review the information submitted in support of the credentialing application unless law prohibits disclosure. Providers will be notified during the credentialing process if information obtained varies substantially from their submitted information and have the right to correct any erroneous information. They will be informed of the final status of their application. We further assure that all laboratory testing sites with whom we contract have either a Clinical

Laboratory Improvement Amendments Certificate of Waiver or Certificate of Registration along with a registration number.

Responsibilities of the Credentials Committee (maintained by monthly meetings) include:

- Annually review and approve the credentialing and re-credentialing criteria, policy, procedures, and the process used to make credentialing and re-credentialing decisions;
- Review results of ongoing monitoring of sanctions and grievances;
- Review and determine participation status of providers that do not meet the established credentialing criteria.
- Approval of new Credentials Committee members.

The quality and effectiveness of our credentialing processes have been affirmed by successful performance on annual Department audits (conducted by HSAG). In SFY 2013, we received a score of 98%, and in SFY 2010 our score was 100%.

We have robust and effective processes and procedures to promptly notify all providers in writing regarding their credentialing application (or re-application) status and is committed to making the credentialing experience user-friendly and efficient for network practices. Per our *Policy CR301*, providers undergoing initial credentialing are notified in writing within 30 business days of the senior medical director weekly reviews and Credentials Committee decisions. Providers denied participation during initial credentialing are notified in writing of the decision by the senior medical director within 10 business days, and the documentation filed in the provider's credentialing folder. Our internal contracting and provider configuration teams are notified of the denied providers. A list of approved and, if applicable, denied providers are forwarded to provider configuration and includes the provider's full name, degree, specialties, date approved, NPI number, date of birth, primary and secondary practice locations, and other first/last names if applicable. The provider configuration team updates the credentialing status into the Colorado Access claims transaction system, ensuring that only duly credentialed providers maintain network status and eligibility for claims payment.

Ensuring Access to Care—PCMPs and Behavioral Health

At Colorado Access, our mission is to *partner with communities and empower people through* ***access to quality, affordable care***. As such, we are fully dedicated to maintaining and continually improving upon a provider network that meets or exceeds every member's need in terms of quality, accessibility, and care coordination. We have built our provider networks to offer a full range of providers, services, and locations to ensure whole-person, coordinated care across the lifespan. The network size, diversity, and statewide range ensure that members have adequate choices. As a RAE, our long-standing relationships with these broad groups of providers will equip us to effectively serve all of our members' primary care, behavioral health and care coordination needs. It also will enable us to provide the same standard of care to members regardless of eligibility criteria, as we have been working effectively with Medicaid members with all types of eligibility criteria for many years. As a RAE, we will monitor network providers on their compliance with timeliness standards per contract through routine surveillance of after-hours services and trend analyses of member grievances and

complaints. In addition, secret shopper calls, currently used to ensure compliance with access standards across multiple Colorado Access programs, will be an ongoing activity of our provider monitoring program. Through these calls, RAE quality department staff members will directly verify provider response times, appointment availability, access to bilingual staff members and/or translation services, and after-hours coverage.

We have historically, and will continue to ensure that the provider network provides sufficient access to care for members during both standard operations hours (8 AM to 5 PM) and extended evening and weekend hours, as required per contract. This means ensuring access to clinical staff members, not just an answering or referral service. We support this as a critical systematic network feature to provide members access to appropriate levels of care for after-hours urgent care needs and avoidance of inappropriate utilization of ED and other services. The RAE has an important system-level role in supporting the region in meeting key performance indicators and making efficient use of state Medicaid resources. Current Regional Care Collaborative Organization (RCCO) PCMPs are required to complete/update a Practitioner Information Worksheet (PIW) on a monthly basis so that we can stay abreast of any changes to their provider staffing, their ability to accept new Medicaid members and their clinic hours. We report these to the Department monthly. The PIW report serves as the practitioner roster for clinics, helps us to track the adequacy of the provider network, and informs the provider directory. Flexible hours of operation across our Region 3 provider network will help to ensure access to care and convenience for members and families. For example:

- All network PCMPs provide after hours, on-call physician coverage for urgent issues. Most offer same day urgent access appointments. Many network PCMPs offer nurse advice lines, and/or link to the Department's nurse advice line, as well.
- 135 in our network and 77 of our PCMP sites in Region 3 offer early morning, evening and/or weekend appointments.

Provider Directories and Databases. We maintain provider directories and databases for all active contracts: RCCO, Behavioral Health Organization (BHO), Child Health Plan *Plus* (CHP+), and others. Upon award of the RAE contract, we will consolidate these existing directories and verify that all providers listed are approved to deliver services and contracted with the Region 3 RAE. The new directory/database will include all of the information required per contract, will be updated at least monthly, and will be regularly made available to the Department.

In compliance with 42 C.F.R. §438.3(q)(1), the provider network for Region 3 includes an array of accessible treatment for emergency medical conditions. This includes the hospitals listed in Table12 -1.

We contract with Rocky Mountain Crisis Partners for after-hours information, referral, and intervention for members experiencing a behavioral health crisis. All contracted network behavioral health providers are required to provide clinical assistance off-hours. We contract with the statewide behavioral health crisis system for Medicaid-covered services and facilitates linkage to it from Rocky Mountain Crisis Partners and provider-based coverage systems.

We have been a partner to the Department since RCCO inception, and have worked diligently to ensure a PCMP network sufficient to offer each member a choice of two providers within their zip code (or maximum distance for the county classification), and meet standards for provider-to-member contract ratios. As a RAE, we will

continue to meet all contract requirements related access standard and will continue to build on historic expertise towards efforts to improve services for rural and frontier members across the state. We will actively recruit Indian and tribal providers into its networks, as required per contract.

Our network adequacy report, submitted to the Department quarterly, demonstrates our ongoing adherence to access to care standards. In Offeror's Response 11—Network Development we provide Geomaps to demonstrate the location of our PCMP and behavioral sites across the region. Through this RCCO experience, we have also demonstrated the ability to address challenges particular to rural and frontier areas. Since it is not always possible to ensure adequate options to member seeking onsite services in these areas, we have taken steps to seek innovative solutions, leveraging technology, to expand access to care and member choice. A more detailed description of AccessCare, our telehealth subsidiary, and its virtual integrated care programs, is included in Offeror's Response 17—Provider Support Strategy. We have leveraged cross-program oversight to forward technology based solutions that increase member choice, expand the ability of providers to deliver high-quality primary and behavioral health care despite geographic challenges, and support the maintenance of a robust and high quality provider network for all members.

We have a quality improvement team that monitors the accessibility and availability of services on an ongoing basis. Please see Offeror's Response 23—Quality Improvement Program for more detail. Across our provider network, our network has met standards for urgent care visits, outpatient follow up visits, non-urgent, symptomatic care visits (physical and behavioral health), well care visits emergency behavioral health care visits, and initial routine visits approaching 100% of the time.

We take actions needed to ensure that all services provided under Department contracts are provided to members promptly. If necessary, due to capacity or specialized need, out-of-network providers will be utilized on a case-by-case basis. We will employ proactive engagement strategies to recruit out-of-network providers to join the network and accept additional Medicaid members.

Our multi-region experience has yielded robust understanding of member's various and changing circumstances. They often move from one region to another, live and work in different regions, or have another life situation that necessitates seeking care in multiple areas of the state. We work to ensure a seamless member experience through cross-region collaboration within our own program contracts and by working closely with other RCCOs and BHOs. As the RAE, we will build on these processes to ensure continuity of care across regional and provider boundaries. To accomplish this, we address system-level barriers (i.e. ensuring the ability to communicate and share data at the RAE level) as well as provider-level issues (supporting continuity of care plans). As a RCCO, we have developed positive partnering relationships with RCCO colleagues. As the RAE, we will proactively engage in multi-region and statewide initiatives to create seamless coordination processes to ensure optimal member experience and successful health care transformation across the state. This encompasses both system-level and member-level activities, including working with other RAEs to ensure services are not disrupted or delayed as members transition between regions or providers.

We have a historic and successful system in place to monitor patient load and adjust recruitment activities as needed to assure adequate member access to all covered services across physical and behavioral health sectors.

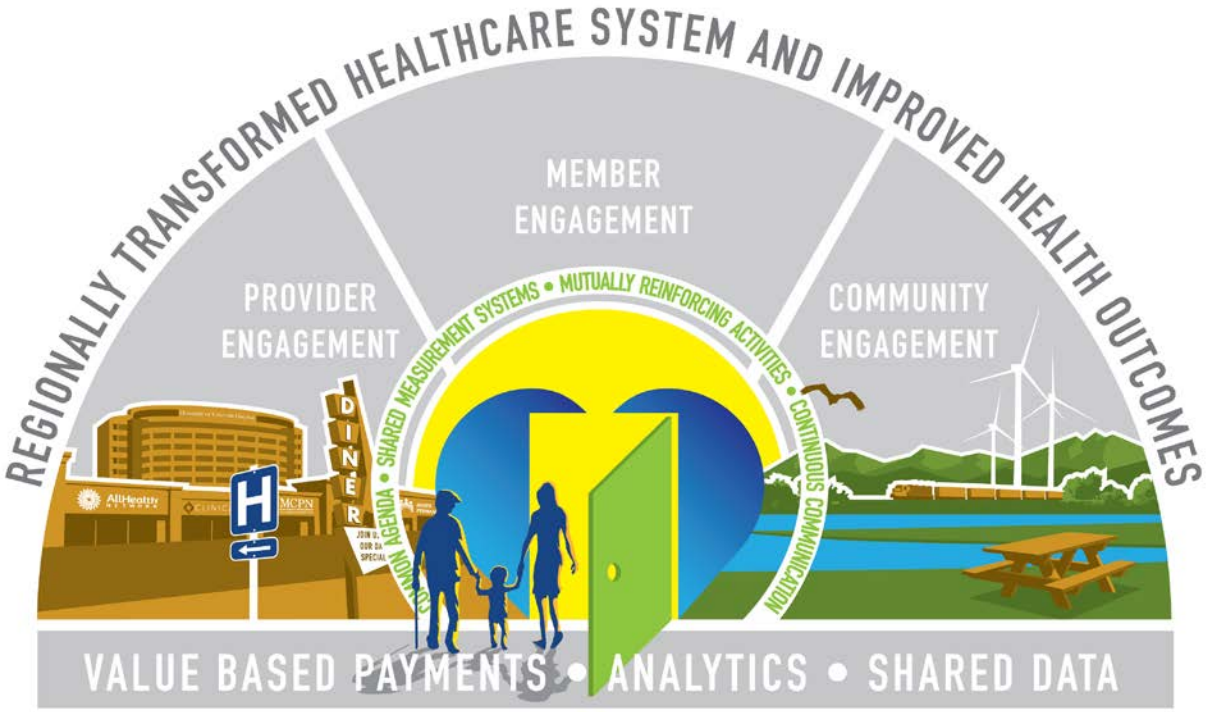
We will notify the Department, in writing, of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery. Our notice shall include information describing how the change will affect service delivery, the availability, or capacity of covered services, and plan to minimize disruption to the members and a plan to correct network deficiency.

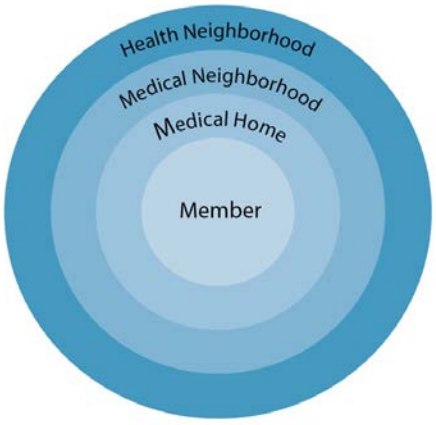
Health Neighborhood

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.

COLORADO ACCESS HEALTH NEIGHBORHOOD MODEL AND STRATEGY





Long ago, we embraced the health neighborhood concept and the importance of integrated, whole-person care. We are unique in the breadth of our experience managing multiple Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, programs: Regional Collaborative Care Organization (RCCO), Behavioral Health Organization (BHO), Single Entry Point (SEP) and Child Health Plan *Plus* (CHP+). While administering each program according to its distinct contractual requirements, we have also sought to create alignment and reduce complexity for members and providers who often interface with multiple programs. We have successfully built, supported, and monitored high-functioning networks and partnerships that include key health care providers and community organizations that must work together effectively to create responsive health neighborhoods and healthy communities for members.

The Colorado Access Definition of Health Neighborhood

Using guidance from respected organizations such as the American College of Physicians and the Agency for Healthcare Research and Quality, we conceptualize the *medical* neighborhood as a primary care medical provider (PCMP) and the constellation of other clinicians providing health care services to the patients it serves. We define a *health* neighborhood as an expansion beyond clinical health care services to include a robust array of non-clinical community resources, public health and social services that promote and support the health of members and families.

The majority of the sick and well care for members is provided by the PCMP. However, for those with complex health care needs, additional services are delivered by specialists, hospitals, long-term services and supports, and community resources such as social services and public health.

The neighborhood is not necessarily a geographic construct but rather a set of relationships revolving around the member and their medical home, based on that member's unique health care needs.

The Colorado Access Neighborhood Vision and Model

The Region 3 Regional Accountable Entity (RAE) vision is a health neighborhood that delivers integrated, coordinated, and person- and family-centered care to all members. At the system level, the neighborhood functions as a coordinated delivery system that engages the full range of providers to deliver optimized care and effectively links members to community resources that address social determinants of health. The American College of Physicians says "The ideal system would be one that integrates multiple clinicians at multiple facilities to function as a single unit responsible for the care of a patient."[1] The measure of success is the quadruple aim: better outcomes, lower costs, and improved member and provider experiences within this system.

As the RAE, we will expand, strengthen and improve the existing health neighborhoods in Region 3. We will lead and support the implementation of eight key functions and areas of activity that will create high-performing neighborhoods. Our model is based on research from experts associated with the federal Agency for Health Care Research and Quality,[2] the American College of Physicians[3], the National Committee for Quality Assurance[4], and other quality improvement authorities.[5] This multi-pronged approach is responsive to all of the RAE contractual requirements and well integrated with other aspects of our RAE framework described in several other sections of this proposal, such as Offeror's Response 17—Provider Support and Practice Transformation and Offeror's Response 16—Care Coordination.

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[1] Spatz C, Bricker P, Gabbay R (2014). The patient-centered medical neighborhood: transformation of specialty care. American Journal of Medical Quality Vol. 29(4) 347.

[2] 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 Health care Research and Quality. June 2011.

[3] Spatz C, Bricker P, Gabbay R (2014). The patient-centered medical neighborhood: transformation of specialty care. American Journal of Medical Quality Vol. 29(4) 344–349

[4] Huang X & Rosenthal MB. "Key Components of the Patient-Centered Medical Home and the Patient-Centered Specialty Practice, adapted from the National Committee for Quality Assurance's recognition programs" from Transforming specialty practice – the patient-centered medical neighborhood. N Engl J Med 2014; 370:1376-1379.

[5] Garg A, Sandel M, Dworkin PH, Kahn RS, Zuckerman B (2012) From medical home to health neighborhood: Transforming the medical home into a community-based health neighborhood. Association of Medical School Pediatric Department Chairs

The eight key functions of the COA health neighborhood model are:

1. **Share clinical information, supported by appropriate Health Information Technology (HIT) systems.** Creating mechanisms for sharing clinical data across the health neighborhood to ensure efficient and effective flow of appropriate member information to facilitate consultations, referrals, and care transitions.
2. **Ensure appropriate and timely consultations and referrals.** Implementing a series of mutually-reinforcing activities that improve the efficiency and effectiveness of specialty resources by ensuring that specialists see the right patient at the right time and in the right setting.
3. **Expand the neighborhood.** Partnering with regional stakeholders to assure that all relevant providers, especially medical specialists, are identified, engaged and participating in the health neighborhood.
4. **Provide ongoing care coordination and ensure successful transitions of care.** Implementing comprehensive care coordination services to improve coordination across the neighborhood, especially during transitions between providers; reducing members' barriers in accessing the system and complying with treatment plans; and honoring a member's preferences and wellness goals.
5. **Guide determination of responsibility in co-management situations.** Improving coordination and collaboration between PCMP and behavioral health providers and specialists, through care compacts, protocols and business processes that clearly define respective roles regarding pre-consultation exchange, formal consultations, co-management, and transfer of care.
6. **Develop individualized care plans for complex members.** Developing individualized care plans for high-risk, complex members that identify their health care needs, honor and incorporate their preferences, and include interventions to connect them with the services and supports they require to achieve whole-person health.
7. **Collect and analyze social determinant of health data consistently across the neighborhood.** Collaborating with neighborhood partners to universally screen for social factors that influence member health. Use data to identify appropriate referrals to community-based resources. Aggregate and analyze data to inform regional population health and care coordination activities.
8. **Build and strengthen community resource linkages.** Developing a centralized resource directory and improving referrals and warm handoffs between clinical providers and community and social service agencies.

The road to a high-functioning neighborhood requires a multi-faceted and phased approach to ensure the successful engagement and utilization of health neighborhood providers. Stepwise growth in the neighborhood will also allow for building on existing opportunities and new innovations, then bringing them to scale over time. Figure 13-1 below maps the key functions in our neighborhood model to specific members of the neighborhood.

Figure 13-1 Applicability of Key Functions to Member of the Neighborhood

		Medical Neighbors						Health Neighbors	
		PCMP	Behavioral Health	Specialists	Hospitals	Pharmacies	LTSS	Public Health	Community
1	**Share clinical information, supported by appropriate HIT systems**	✓	✓	✓	✓	✓	✓	✓	
2	**Ensure appropriate and timely consultations and referrals (including e-consultations)**	✓	✓	✓				✓	
3	**Expand the neighborhood**			✓					
4	**Provide care coordination and ensure successful transitions of care**	✓	✓	✓	✓		✓		
5	**Guide determination of responsibility in co-management situations (care compacts)**	✓	✓	✓					
6	**Develop individualized care plans for complex members**	✓	✓	✓			✓		
7	**Collect and analyze SDOH data consistently across the neighborhood**	✓	✓		✓			✓	✓
8	**Build and strengthen community resource linkages**	✓	✓		✓		✓	✓	✓

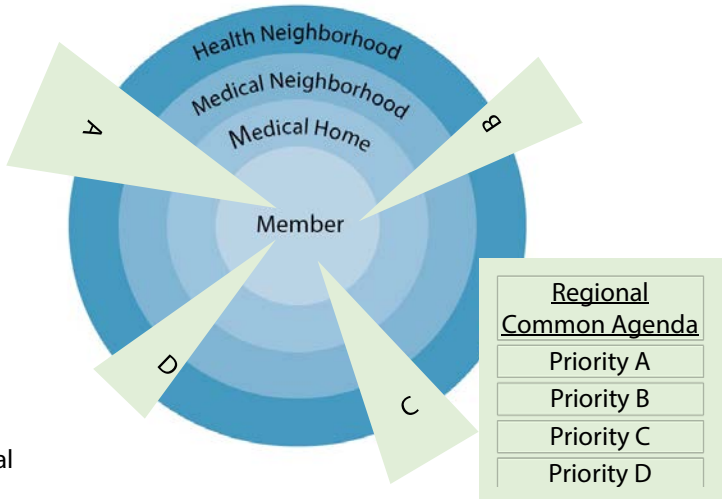
Implementation Approach

Health neighborhoods, like real neighborhoods, are unique, dynamic, and constantly adapting to local needs and opportunities. Within each of the eight key functions of the model, our approach is not one-size-fits-all. Instead, we will build on the local resources, infrastructures, relationships, and processes that we have

developed with our partners to lead the region incrementally toward a more efficient, organized, and effective system.

A central feature to our implementation approach is a robust, provider-led governance structure in Region 3. This includes a Regional Governance Council and a Regional Advisory Council (described in detail in Offeror's Response 8--Governing Body and provides a forum for identifying and addressing health neighborhood strategies, opportunities, and implementation. It will also foster a culture of innovation and change and ensure shared accountability in meeting the RAE program's goals for the Region 3 health neighborhood and community. The RAE will work closely with the Regional Governance Council to implement a set of mutually reinforcing neighborhood activities that:

FIGURE 13-2 REGIONAL COMMON AGENDA PRIORITIES CROSS THE HEALTH NEIGHBORHOOD AND COMMUNITY



- **Contribute to the Regional Common Agenda:** The RAE Transformation Framework (described in detail in Response 7--Regional Accountable Entity) begins with creating shared objectives and corresponding collaborative strategies for Region 3, a regional common agenda. The health neighborhood component, like the other key programmatic components of the RAE (member engagement, practice support/transformation, care coordination, and population health), will align its activities with the regional common agenda so that the majority of efforts are aimed at the same targets, as illustrated in Figure 13-2.
- **Balance broad infrastructure-building efforts with strategic, targeted efforts:** Some of the eight key functions described above are infrastructural in nature, such as information-sharing and IT systems, and are best addressed systematically across all neighborhoods and communities in Region 3. Other key functions are highly driven by local resources and environments and will be addressed within the specific contexts of distinctive health neighborhoods. These opportunities may lend themselves to more localized solutions, pilot projects, and smaller-scale initiatives.
- **Produce incremental improvements in the health neighborhood**: A developmental approach builds on our historical investments and allows for iterative innovation and targeted investments based on priorities and needs. We will use the following progressive phases in health neighborhood development:
  - LEVERAGE local resources, infrastructures and relationships with regional partners.
  - EXPAND and enhance the neighborhood's infrastructure, available providers and other resources.
  - LINK neighborhood members through collaborative efforts and innovative partnerships.
  - OPTIMIZE by regionalizing collaborative efforts, sharing tools and platforms, implementing common care plans, and reducing duplication.

- **Support existing collaborations and creates new ones where needed:** We have a proven track record of supporting effective collaborations as well as facilitating new connections and improved processes in order to strengthen health neighborhoods (Figure 13-2 describes historical and current examples). We will continue to coordinate with regional neighborhood partners to assure that efforts are not duplicative or in conflict with other regional or statewide initiatives.

History of Serving Region 3 Health Neighborhoods

Our health neighborhood activities include leadership in broadly-focused regional healthcare collaboratives such as Aurora Health Access, South Metro Health Alliance, and the Douglas County Collaborative. Current priorities for these regional collaboratives include increased access to specialty and/or primary care, integrated behavioral health and primary care, and strategies for high utilizers. We also participate actively in collaborations focused on smaller geographic areas within the region or on subsets of members with specific medical and/or social needs. Examples include the Family Forward Resource Center/ Far Northeast Health Alliance (Adams and Denver counties), the Anschutz Community Partnership (Adams, Denver and Arapahoe counties), the Arapahoe County Early Childhood Wellness Council, and the Colorado Refugee Network (statewide).

Collaboration with Other RAEs on Behalf of Members

Through our experience in multiple Medicaid programs (as a RCCO, BHO and CHP+ contractor), we have detailed understanding of the membership and attribution processes and member utilization patterns. Members frequently access medical care, social supports and other community resources across a broad geographic range. This is particularly true for members who live in areas such as the Colfax Avenue corridor, which spans three RAE regions in the Denver Metro area; Douglas and Elbert counties, where members may choose to seek care and services in Regions 2, 5 and 7, as well as the East Metro Region; and in northeast Colorado, where members often travel to Fort Collins, Boulder or the Denver Metro Area.

As a RAE, we will continue and expand upon the inter-regional processes we have established as the RCCO and Administrative Services Organization for the BHO in Region 3. We will collaborate with other RAEs to leverage their health neighborhoods to meet members' needs and assist them with health neighborhood access in our regions for the benefit of their members. In all these activities, we will ensure that members' preferences come first, regardless of where they live, the region to which they are attributed, and the locations of their chosen providers. These efforts include:

- **Activities performed on behalf of an individual member or family to help them access a specialty provider or other neighborhood resources in a different geographic region than the one to which they are attributed**. This assistance is generally provided by care coordinators working with care coordinators and providers in the other RAE.
- **System-level activities focused on improving health neighborhood components that cross regional lines.** For example, we have been involved in the Colfax Corridor Connections project, which is working to improve transit and overall mobility for residents who live near East Colfax Avenue in Denver and Aurora (Denver and East Metro Region). We also participate in Mile High Connects, a broader effort to improve the overall Metro Denver regional transit system across the Denver, East Metro and West Metro regions.

SPECIALTY ENGAGEMENT AND UTILIZATION STRATEGY

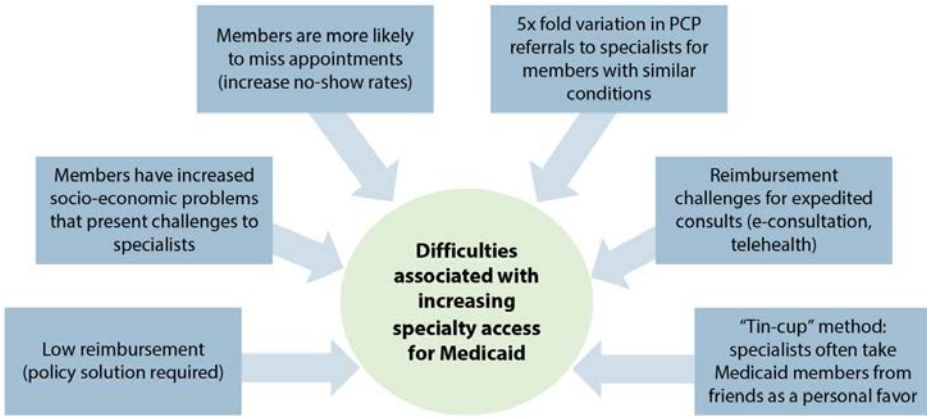
High functioning neighborhoods successfully engage and utilize specialty providers to provide optimal, person-centered care, ensuring that specialists are seeing the right patient at the right time and in the right setting. As the RAE, we will improve specialty care access by:

- Understanding and addressing the challenges in the system to improve the capacity and effectiveness of current network specialists.
- Increasing the number of specialists accepting Medicaid members.

The Challenges of Specialty Access and Barriers to Provider Participation

As illustrated in Figure 13-3 below, there are multiple factors that contribute to specialist participation as Medicaid providers and willingness to accept referrals. Referrals of Medicaid members by PCMPs to specialists are less likely to result in an appointment, compared to referrals for privately insured patients. Lack of specialty care access for Medicaid members can result in increased health care costs through preventable adverse medical events, emergency department visits, and hospital admissions.

FIGURE 13-3 FACTORS INFLUENCING SPECIALIST PARTICIPATION IN MEDICAID



Nationally, cardiology, orthopedics, and neurology are the top three specialties that are in highest demand for the Medicaid population. In Region 3, orthopedic surgery, cardiology, podiatry, neurology and pain medicine are the most utilized specialty visits, based on claims data from the last twelve months.[6] This information is informative for targeting health neighborhood efforts. However, looking only at high-level data on demand and utilization does not fully illuminate the important nuances of local specialty access issues. Our drill-down analysis reveals inefficiencies in utilizing the specialty resources that are already in place. An enlightening example of this is an analysis of orthopedic surgery referrals and consultations. Currently in RCCO Regions 2, 3 and 5 there are 478 orthopedic surgeons in the Medicaid network who have seen a Medicaid member within the last 12 months. This is an impressive number of providers. If the RAE recruits more orthopedists, will it increase access? A deeper analysis of the data tells us not necessarily. The most common triggers for orthopedic surgery referrals were back, knee and hip pain; the data reveal that only a very small percentage of these members go on to have surgery. This

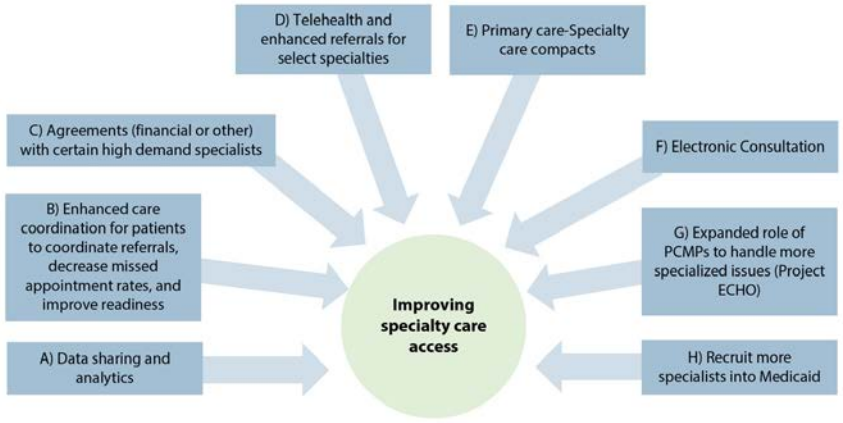
[6] These represent elective, outpatient care. The data did not include patients that were seen by a specialist in the Emergency Department or upon admission to a hospital.

insight leads to different solutions than adding more orthopedic surgeons to the network. For those with back, hip, and knee pain, there are opportunities for using different, and perhaps more appropriate, resources, such as sports medicine, physical medicine and rehabilitation, physical therapy, and medications. This example demonstrates that data exploration may lead to a more informed and sophisticated approach to maximizing existing specialty resources and ensuring that members receive the right care at the right time in the right setting.

Strategies to Address Challenges and Barriers

As above, our two-pronged approach is to improve the capacity and effectiveness of current network of specialists and increasing the number of specialists taking Medicaid. Surveys of specialists suggest that, if the system were made more efficient and effective, specialists would be willing to accept more Medicaid members because they are getting the *right* patients. Therefore, process improvements and system efficiencies will have the effect of increasing the *effective* size of the network. This multi-factorial problem requires a range of solutions, as illustrated in Figure 13-4 below:

FIGURE 13-4 MUTUALLY REINFORCING EFFORTS FOR IMPROVING SPECIALTY CARE ACCESS



With our regional partners, we are conducting numerous current activities in the areas shown in Figure 13-4 and are collectively addressing the challenges associated with their implementation. As the RAE backbone organization, we will use data analytics to focus RAE attention and investment on where we can most effectively improve access and collaborate with provider partners to implement rapid cycle improvement processes to guide how Region 3 is maturing across the spectrum of approaches.

A. Data Sharing and Analytics

Data and analytics are foundational to our multi-pronged strategy to support the efficient and effective use of specialty care. We will identify areas which need investment of resources to improve access, evaluate the effectiveness of interventions, and use data feeds to support the interventions themselves. This includes:

- Characterizing specialty provider utilization patterns.
- Informing decision-making to target specific specialties, providers, or geographic areas for network expansion.
- Guiding provider education and clinical pathway implementation.

- Targeting the right provider organizations to address access and network participation issues.

The following figures are examples of analyses from claims data that provide insights regarding specialist access for specific neighborhood partners and locations.

FIGURE 13-5 SPECIALTY VISIT CLAIMS DATA FROM ATTRIBUTION PERSPECTIVE

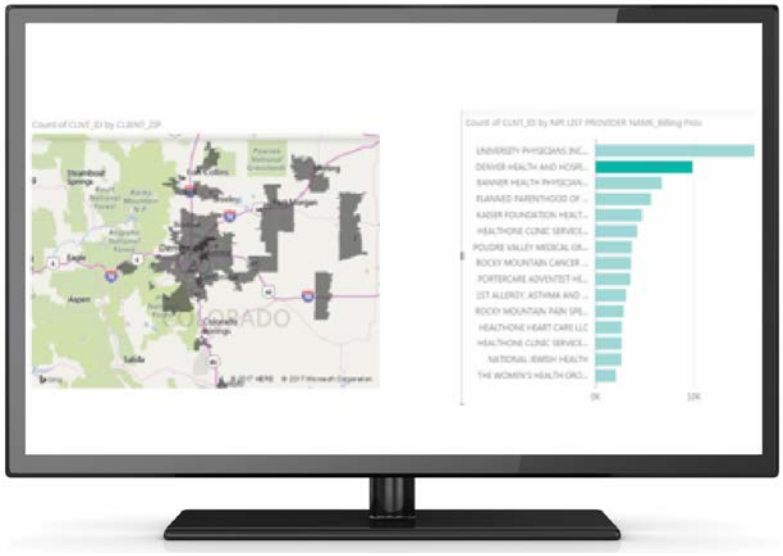
Figure 13-5 demonstrates that 34% of adults seeking specialty care have no primary care attribution and are mostly self-referred. This represents a likely source of inefficiency in that specialty care may be unnecessary for self-referred individuals and because specialists would not have the ability to consult with and hand off care plans back to primary care providers for implementation.

FIGURE 13-6 GEOGRAPHIC DISTRIBUTION OF MEMBERS RECEIVING SPECIALTY VISITS AT TWO LARGE PROVIDER GROUPS

The following are some additional examples of how using data can provide an in-depth understanding of various specialist access issues and drive informed decision-making and mutually reinforcing activities.

- ***Unattributed Members***: As above, we can identify members not attributed to a PCMP but who are nevertheless seeing a specialist. Targeted interventions, such as care coordination, can be implemented to get them associated with a PCMP where their condition can be managed more effectively.

- ***Regional Distribution***: The Region 3 Governance Council (described in Offeror's Response 8—Governing Body) will be responsible for understanding the network data and developing specific strategies and solutions that increase access, more evenly distribute referrals, and effectively utilize current resources. For example, even within a large system with multiple sites, there is often capacity at the specialty clinics scattered around the community. Some systems are set up to find specialty appointments at various sites, whereas others book only for their own locations.



- ***Vertically-Integrated Systems***: The data analyses above demonstrate that many members attributed to a vertically integrated health system seek specialty care outside of that system. This suggests that working within those larger vertically integrated provider systems to prioritize attributed members' access to internal specialists might improve both access and efficiency.

B. Enhanced Care Coordination for Patients to Coordinate Referrals, Decrease Missed Appointments, and Improve Readiness

Care coordination is an important tool in optimizing specialty care resources, including coordinating travel and following up with members who have missed appointments. We use multi-channel modalities to efficiently and effectively deliver these important care coordination interventions in a person-centered, non-intrusive manner (described in more detail in Offeror's Response 16—Care Coordination). One intervention is the delivery of care coordination at the PCMP site. Key functions of PCMP-based care coordination related to specialty care include referral management, linkage to specialists and community resources, preparation for appointments, and coordination of non-emergency medical transportation. Additionally, we directly deliver or organize certain care coordination activities centrally for the entire region, supplementing (not duplicating) the activities provided at the PCMP sites. These are generally activities that are done best at a larger scale, involve digital delivery mechanisms, or require intensive/complex interventions. Our care coordinators go on-site to homeless shelters, community centers, hospitals, and other locales to work directly with members and neighborhood partners. Our centralized telephonic care coordination team serves as a hub and a resource for members, care coordinators, and providers (including specialists) throughout the region, providing on-demand assistance, consultation, information, resources, and linkage with primary care and specialty care when needed.

With University of Colorado Medicine (CU Medicine), one of the highest-volume specialty providers in the state, we are partnering in an innovative program to improve the effective and efficient utilization of specialty care. CU Medicine generates a daily report of Medicaid members' upcoming specialty care appointments, including

the member's PCMP, whether there is a referral, and reason for the visit. Our care coordinators intervene telephonically with members who: do not have PCMP-based care coordination available to them, have an appointment with a specialty that has historically high missed appointment rates; or have an appointment with a surgical specialty. Our care coordinators' interventions include helping the member prepare for the appointment, coordinating transportation if needed, scheduling PCMP follow-up after the specialist visit, and assisting in incorporating the specialist's recommendations into the plan of care. For PCMP-attributed members with a specialist appointment but no referral, care coordinators link with the PCMP to ensure that they are aware of the specialist appointment. We are also developing digital delivery mechanisms (e.g. interactive voice response and text messages) to send appointment reminders. The goals of this collaborative program are: decrease specialty missed appointment rates; increase adherence to the care compacts between PCMP and specialists; improve access and referrals to specialty care.

As the RAE in Region 3, we will continue to conduct rigorous evaluations of these multi-pronged efforts to improve the effective and efficient use of specialty access. We will work with provider partners to continue to mature these activities over time, address the identified barriers to provider participation in the health neighborhood, and support the efficient use of specialty care resources.

C. Agreements (Financial or Other) with High Demand Specialists

As the RAE, we will deploy a range of agreements with providers, including financial arrangements, to support specialist access for Medicaid members. Solutions that we are currently supporting or developing include:

- Replicating the approaches used by Metro Community Provider Network (MCPN), which has identified its highest demand specialties and has created opportunities for co-location: A neurologist conducts on-site monthly seizure and multiple sclerosis clinics, an HIV clinic is staffed by an infectious disease specialist, and a cardiologist consults monthly at an MCPN site. Other federally qualified health center (FQHC) partners have expressed interest in this strategy and have begun conversations with us about developing similar models.
- Partnering with local public health agencies, which coordinate access to specialty care services as part of the Healthy Communities Program (HCP, formerly the Children with Special Health Care Needs program): For example, the Tri-County Health Department coordinates clinics where specialists come on-site to serve HCP members.
- Working with Aurora Health Access, South Metro Health Alliance and Douglas County Collaborative to study and identify the highest priority needs for specialty care and develop collaborative activities to fill these gaps.
- We partnered with CU Medicine in 2016-17 to identify additional funding sources to support the expansion of specialty care access for Medicaid members. We worked with CU Medicine and UCHealth to develop a mechanism to draw down additional federal matching funds for academic medical centers, such as CU Medicine, to increase funding for specialty care. This additional funding was secured in the 2017 legislative session. It is being used by CU Medicine to expand access to specialty care throughout the state by adding 10 pediatric and adult specialists in key areas and by working with the RCCOs (and future RAEs) to leverage this enhanced access through telemedicine and other tools. Our partnership with CU

Medicine led to this productive collaboration and significant expansion of specialty access across multiple regions.

- The Region 3 Governance Council (described in Offeror's Response 8—Governing Body and Conflict of Interest Plan) will have a major role in assessing the region's needs and allocating resources, including incentive payments, to address them. We will work directly with the governance council partners to identify and support specific specialty care access projects and pilot different mechanisms to increase access to and effectiveness of specialty care services in the region.

D. Telehealth and Enhanced Referrals for Select Specialties (Section 5.8.2.4.1.4 and 5.8.2.5)

As the RAE, we will fully utilize AccessCare, the telehealth expertise and virtual care delivery arm of Colorado Access, to expand and support specialty care resources in Region 3. Founded four years ago, this enterprise-wide resource combines telehealth, integrated care, and technology expertise to solve problems, overcome obstacles, and deliver solutions to members, providers, and community partners. AccessCare saves members and providers money by reducing travel and time costs, especially for those living in rural or frontier counties or members who have difficulty accessing services due to transportation, disability, family or other issues.

As is described in Offeror's Response 17—Provider Support/Practice Transformation, AccessCare's virtual integrated care initiative (VICI) has proven success in a promoting integrated behavioral health care and expanding access to psychiatry specialists. VICI is currently piloting an in-home teletherapy program for members with behavioral health needs and barriers to accessing services. For RAE providers, AccessCare will offer custom clinical program design and implementation with end-to-end clinical solutions, coaching, and guided implementation for a wide range of settings including primary care, specialty/behavioral health providers, hospitals (urban and rural), patient in-home, inpatient substance use facilities, and private practices. AccessCare plans to add additional medical specialties to the telehealth offerings in the next year.

Children's Hosiptal Colorado (CHCO), one of our large network providers, is a key partner and critical resource for pediatric specialists statewide. Clinicians at CHCO have provided telehealth visits in 22 different cities and towns in Colorado using a hub-and-spoke model that connects via community practices and hospitals. This approach makes pediatric specialist expertise available in areas that may not have many providers – or where it is inconvenient for a family to travel to the Denver area for care. In 2016, CHCO provided 1,846 telehealth services across 26 different specialty programs.

Supporting collaboration between hospitals and skilled nursing facilities (SNFs) to increase access to specialists through telehealth.

In an innovative pilot program, one of our partner hospitals allows nursing home staff members to consult a hospital based physician (emergency medicine, hospitalist, other specialist) through telehealth services provided by the hospital 24 hours/7 days a week for questions/concerns. This program, which aims to improve quality care for SNF residents and decrease unnecessary ED and hospital visits, can serve as a model for other hospital-based specialists in our region's health neighborhood.

E. Primary Care-Specialty Care Compacts

We are committed to promoting care compacts as a major tool for establishing and improving referral processes, increasing member access to specialty care, and reducing unnecessary use of these resources in Region 3. As the

RAE, we will implement the systematic utilization of the Colorado Medical Society's Primary Care-Specialty Care Compact among providers in the region's health neighborhood. We will:

- Identify a cohort of practices with experience implementing care compacts with the help of CMS and the Comprehensive Primary Care (CPC) initiative, which has experience promoting compacts with several of our network providers. Conduct evaluation to identify strengths and weaknesses, opportunities to improve care compacts. Use this to create a training program that anticipates and troubleshoots challenges and barriers.
- Train Region 3's network of PCMPs through our comprehensive RAE Provider Training Program to all network providers (described in Offeror's Response 17—Provider Support).
- Incorporate requirements to implement care compacts into RAE provider agreements to create expectations, financial incentives, and tracking mechanisms for the health neighborhood key performance indicator.
- Implement phased outreach efforts with specific PCMP-specialty neighbors with high flows of referrals and consultation. Target specialties that are ideal for care compacts, which we expect to identify through our evaluation. Criteria could be practices that: are outside of vertically integrated systems; do not share EHR systems with the specialists to whom they mostly refer; or are treating conditions that often require co-management. Provide data, and incentives and venues to organize these co-management arrangements.
- Identify and support high volume specialty providers to develop templates and workflows to optimize their participation in the neighborhood and full integration into the clinical workflow.

F. Electronic Consultation

As the RAE, we will promote and ensure the use of the Department-adopted electronic consultation software in the following ways:

- Train Region 3's network of PCMPs through our comprehensive RAE Provider Training Program to all network providers (described in Offeror's Response 17 – Provider Support).
  - Incorporate requirements to implement electronic consultation into RAE provider agreements to create expectations, financial incentives, and tracking mechanisms for the health neighborhood key performance indicator.
- Implement phased promotion of electronic consultation targeting specific specialties; focus on specialties best suited for electronic consultation: diagnosis-related and medical management questions that don't require procedures and diagnostic testing, and specialties that are usually a one-time visit. Note that more than one visit may signal a shift from consultation to co-management with the PCMP; examples are shown in Figure 13-7.

FIGURE 13-7 SPECIALTIES THAT HAVE HIGHER PERCENTAGES OF ONE-TIME APPOINTMENTS

Specialty Ratios: Some specialties see over 50% of patients only once—ideally suited for E-consults and virtual care enhancement

- Collaborate with high volume specialty providers to support their current electronic consultation programs. Identify expansion opportunities. Promote and support templates and workflows for electronic consultation and enhanced referrals. For example, neighborhood providers can make online referrals to certain Denver Health specialists via EpicCare (linking to Epic, Denver Health's EHR). In the year since this program has been implemented, 55 providers using this referral mechanism account for about 49% of referrals. Figure 13-8 below illustrates this referral volume. Use this early adopter group to generate lessons learned and improve workflows, then expand to other providers.

Region 3 Example:

CU Medicine has piloted an e-consult software with the Department to expand access to rheumatologists. Dr. Duane Pearson, rheumatologist, reports that approximately 50% of referrals were handled effectively by electronic consultation. CU Medicine is also doing dermatology electronic consultations for the Medicare Shared Savings Program and is interested in expanding to Medicaid if funds and an interested PCMP partner were available.

G. Expanded Role of PCMPs to Handle More Specialized Issues (Project ECHO)

Another key strategy for helping members get the right care at the right time is to improve the capability of PCMPs to manage complex conditions themselves, limiting the amount of specialist consultation that is needed. Project ECHO Colorado (Extension for Community Health Outcomes in Colorado) is a promising vehicle for implementing this strategy. The nationally recognized ECHO model uses a hub-and-spoke knowledge-sharing networks, led by expert teams using multi-point videoconferencing to conduct virtual clinics with community providers. As the RAE, we will continue our work with Project ECHO Colorado to implement specialty care trainings that are identified by our PCMPs as priorities. Examples include child and adolescent psychiatry and rheumatology. We will build upon Project ECHO to enhance the development and dissemination of standardized clinical pathways for PCMPs.

H. Recruit more specialists into Medicaid

By optimizing current resources and implementing the other strategies described in the preceding responses, we will significantly expand the Region 3 capacity to provide specialty care for members. In addition, we will increase the number of new specialists participating in Medicaid and accepting new Medicaid referrals. This recruitment will be supported by:

- Specialists knowing they are getting the right patient, at the right time and in the right setting.
- Care coordination support to reduce missed appointments and improve patient preparedness for the visit.
- Assisting specialists in the application/validation process to become Medicaid providers.
- Providing training and other supports available through our provider engagement team.
- Prioritized recruitment by identifying specialists who are already engaged with PCMPs in the neighborhood.

In addition, we intend to continue to partner with the health alliances in our region to implement the collaborative strategies they have identified to improve access.

Coordination with Behavioral Health Entities

Colorado Crisis Services

We have current contractual arrangements and long-standing, mutually supportive relationships with all Colorado Crisis Services vendors in Region 3. This includes the walk-in centers, mobile crisis teams, crisis stabilization/respite care units, and follow-up peer support and case management services operated by Community Crisis Connection, a partnership of the six community mental health centers that serve the nine counties of the greater Denver/Boulder region. We also work closely with Rocky Mountain Crisis Partners (RMCP), the vendor for the system's statewide crisis line, which provides immediate, 24/7 crisis intervention by phone or

on-line chat. Even before the Colorado Crisis Services system was created, we had a contractual relationship with RMCP to handle member crisis calls off-hours and conduct a warm handoff to our care coordinators for follow up.

As a RAE, we will build on these already-established relationships to continue coordinating care, including follow-up services, for members who have contact with Colorado Crisis Services programs. We also will work to promote the availability of Colorado Crisis Services resources to members and providers by distributing their pocket cards and flyers, putting notices about these services in member and provider newsletters and on our website, and by discussing the availability of these emergency resources directly with providers through our provider support and care coordination contacts.

Managed Service Organizations

Based on our role as the BHO in two regions, we have developed an extensive provider network for Medicaid-covered services for substance use disorders as well as an effective collaboration with Signal, the Managed Service Organization (MSO) serving Region 3, for services not covered by Medicaid. Signal's network of providers is also contracted with COA for Medicaid-covered substance use disorder services. This allows providers to use MSO funds to provide a comprehensive array of services. For example, through our partnership with Denver Health, we are able to ensure that members move seamlessly from social detoxification services (Medicaid-covered) to the Transitional Residential Treatment (TRT) program within Denver CARES (funded through the MSO). Our care coordination staff members include clinicians with advanced training and credentials in substance use disorders and treatment; these care coordinators serve as a resource for other care coordination staff in the region and point of contact for substance use-focused agencies. Additionally, our practice transformation and support team is currently training several PCMPs to increase their skills and resources to identify and coordinate care for persons with substance use disorders in that setting.

Coordination with Hospitals and Long-Term Support Services

Hospitals, Long-Term Support Services (LTSS), and Transitions of Care

Our experience as the SEP agency for Colorado Region 11 (Adams, Arapahoe, Denver, Douglas and Elbert counties) and our recent selection as the pilot site for the Metro Region (Adams, Arapahoe, Denver, and Douglas counties) No Wrong Door (NWD) initiative has well prepared us to understand and respond to the needs of members who require LTSS, and to assure that hospitals are valued, contributing and connected members of the Region 3 health neighborhood. We have substantial knowledge and skills in person-centered counseling at all points of a member's care and, as the RAE, we will extend this training to hospital staff to assure that they too will be able to offer person-centered care coordination for LTSS members throughout their hospital stays.

We have built strong relationships with all area hospitals (regardless of the region in which they are located). We deploy on-site care coordinators at University of Colorado Hospital, Denver Health, Colorado Mental Health Institute at Fort Logan and other locations. This on-site presence with hospital staff facilitates addressing complex member needs and allows us to regularly educate hospital staff on LTSS processes and non-institutional discharge options. In addition, we review daily admit/discharge/transfer (ADT) data to identify members who require care coordination support to effectively manage their transitions. For hospitals and long-term care facilities where we do not have an on-site presence, we conduct training with their discharge planning staff to help them manage needs for complex members.

Using Data to Support Care Transitions

As described more fully in Offeror's Response 15—Population Health/Pioneering External Data Exchange, we pioneered a legally compliant strategy for disseminating real-time, actionable admit/ discharge/ transfer (ADT) data to network providers so they can track emergency room utilization and improve the quality of care transitions into and out of hospitals. When Colorado's statewide information platform, CORHIO, began to aggregate hospital and ADT data across providers and regions, we became the first health plan to contract with CORHIO to disseminate this data. While the CORHIO connection has been a significant asset to providers' ability to utilize ADT data, some hospitals in Region 3 are not linked to this platform. For this reason, we have receive, analyze, and interpret systems- and regional-level ADT data, separate them into provider-specific subsets, and share this information directly with the network hospitals and health care systems; as a RAE, we will continue this data-sharing practice. As described in Offeror's Response 16—Care Coordination, we will review this information daily and use it to inform members' care transition processes, both in delivering responsive care coordination and in working with hospitals and community providers to facilitate transitions.

Hospital Transformation Program

We became involved with the Hospital Transformation Program (HTP) early on in the stakeholder process, as we believe the move to bring hospitals into the Accountable Care Collaborative addresses an important gap in member care and transformation of the health care system. We fully support this initiative and look forward to collaborating with Department and with the hospitals that will implement the program in order to strengthen the effective partnerships between these hospitals and the regional health neighborhood.

To ensure that the hospitals receive the necessary collaboration and support and that other regional stakeholders receive appropriate information and direction on the HTP, we have participated in numerous HTP informational and programmatic development sessions hosted by the Department at hospitals throughout Regions 2, 3 and 5. During these sessions, we sought to clarify the objectives and parameters of the program and to assist in weaving the various stakeholder roles and resource components together to establish a solid foundation on which to build the HTP.

Throughout the initial stakeholder involvement process, we have kept in close contact with the leader of the HTP initiative for the Department. We have participated in numerous stakeholder feedback sessions throughout the region and communicated frequently with the Department as the program developed, both around potential strengths of the proposed model and potential vulnerabilities. Building on our strong relationships with local hospitals, we traveled to a number of facilities to discuss the potential for HTP and what projects might be most effective under the proposed model. Going forward as the RAE, we pledge to continue to work with these hospitals and the Department in order to determine priorities and select projects, interventions and performance goals for program, emphasizing mutually reinforcing activities that are congruent with the region's common agenda and priorities.

Coordination with LTSS Providers

We are the current Single Entry Point agency (SEP) for all the counties in Regions 3 and 5. In addition, we were recently chosen as the lead agency for one of four regional pilot sites (Adams, Arapahoe, Denver and Douglas counties) for the State's No Wrong Door (NWD) model for older adults and individuals with disabilities who need access to long-term services and supports. NWD is designed to improve collaboration, communication and shared technology across relevant service agencies to ensure that people can access long-term services and

supports within a seamless system regardless of their age, disability or payer source. Our current involvement with these two programs places us in a strong position to be able to coordinate long-term services and supports (LTSS) with members' physical and behavioral health needs. Through these programs, we have long-standing and close collaborative relationships with LTSS providers, Community Centered Boards, agency care coordinators, options counselors, and the Denver Regional Council of Governments, which serves as both the Area Agency on Aging and the Aging and Disability Resource Center for Regions 3 and 5.

The centerpiece of our NWD pilot program is a traveling team of person-centered options counselors, care coordinators and others tasked with improving awareness of and access to LTSS, and with fostering collaborations and partnerships that connect LTSS to the region's larger health neighborhood. As a RAE, we will capitalize on this initiative by building strong links across network providers and NWD. This partnership will allow providers to understand the options and easily make referrals when members need access to LTSS.

In addition to the synergies provided through our involvement in NWD, we will work to ensure that home health services are closely linked with our regional health neighborhoods. We recognize that these important neighborhood members can have a critical impact on such key performance indicators as reduced ED visits for ambulatory sensitive conditions, behavioral health readmissions, and total cost of care. With this in mind, staff from our LTSS unit will deliver home health provider, eligibility and benefit information to other neighborhood members. They will also offer practice support to our primary care and behavioral health providers to facilitate timely and appropriate referrals to home health agencies when needed.

Health Data Sharing

We have already begun preparing to support health data sharing among the providers that will be part of our regional health neighborhoods, as described in detail in Offeror's Response 21—Data Management and Analytics. Recently, we completed a contract with the Colorado Regional Health Information Organization (CORHIO) to conduct health information exchange (HIE)/health information technology (HIT) assessments of all PCMPs in our RCCO provider networks in Regions 2, 3 and 5, as well as our BHO providers in Regions 2 and 5. This process measured these providers' electronic health record (EHR) connectivity to the Health Information Organizations, CORHIO and Quality Health Network (QHN), and their utilization of HIE services and modalities. Additionally, the assessment determined practices' capacity to receive and report clinical quality measures, make changes and adjustments to their current EHR reporting functions, their overall technical capabilities, and their ability to move further along the data sharing continuum. We are using the results of these surveys to develop a regional HIE strategic plan, which details our plans to facilitate data sharing across all our PCMP and BH practices, as well as provider specific associations, independent practice associations, other programs such as SIM and CPC+, and other related neighborhood providers.

As we develop and implement this plan, we will take into account the wide variances among practices in their levels of connectivity, HIT/EHR infrastructures, capacity for data collection and analysis, and amount of sophistication in interpreting, understanding and acting on the health data they produce and receive. An example of advanced data sharing is Children's Hospital Colorado's PedsConnect™ platform, a fully integrated pediatric electronic health record (EHR) and practice management system available to pediatric providers in the community. By enabling pediatricians and other healthcare providers throughout the region to efficiently access and share clinical patient data at the point of care, PedsConnect helps ensure that every child receives the most effective and immediate care where and when needed. Utilization of this shared record allows primary care

providers and hospital based providers to share real time information and better deliver coordinated care to each child and family.

We recognize that data sharing across the region and its neighborhood providers is critical to the development of the RAE common agenda; identification of regional goals, objectives, and priorities; development of mutually-reinforcing activities, and tracking and monitoring key performance indicators and outcomes. Thus, as described in more detail in Offeror's Response 17—Provider Support Strategy, Offeror's Response 15—Population Health, and Offeror's Response 21—Data Management and Analytics, we will use a variety of strategies to implement our regional plan. Broadly, these will include providing practice consultation and assistance with HIT, HIE and EHR issues, producing user-friendly analyses and informatics on topics and measures requested by providers and other health neighborhood members, developing strategies for neighborhood members to exchange clinical information, and using our Regional Governance Council, Regional Advisory Council, and Quality Performance Advisory Committee as forums for disseminating data focused on provider and regional performance and quality improvement.

Non-Emergency Medical Transportation

We are committed to establishing relationships and communication channels with the Non-Emergency Medical Transportation (NEMT) vendor in order to ensure that members attend their medical appointments on time. Our care coordinators routinely educate members about the availability of services through Total Transit and make referrals accordingly. Beyond this relationship with the NEMT vendor, we engage in other activities to expand transportation resources for members. We recognize the importance of reliable, affordable transportation and therefore have committed staff time to efforts such as those led through the Colorado Coalition for the Medically Underserved that seek to better understand member experience with NEMT and propose solutions. This group, which also involves many of our partners, met with Department staff in early March and plans to meet again in the summer of 2017.

Additionally, we serve on the advisory board of Mile High Connects in its effort to participate in innovative solutions to transportation issues experienced by members. Mile High Connects is a multi-sector collaborative working to ensure that the Metro Denver regional transit system fosters communities that offer all residents the opportunity for a high quality of life. The partnership formed in 2011 to ensure that FasTracks, the region's $7.8 billion transit expansion, benefits low-income communities and communities of color. One of the group's priorities is accessible transit, including affordable fares and relevant service routes. We have served in an advisory capacity for this effort and have used care coordination data to help inform the group's work.

Finally, our efforts with Treat Not Transport pilot programs in Region 3 are similarly important to addressing transportation needs for Medicaid members. For some members, calling 911 and having police or fire and rescue come to their home gains them a ride to the nearest emergency department. Our partnership with True North and South Metro Fire and Rescue aims to identify frequent utilizers and address their needs in the home or care facilities without transport to a hospital emergency department. In these pilot programs, we have contributed financially to ensure that these priority members are provided the care coordination and community resources they need.

Oral Health

We understand that oral health is critical to members' overall health and quality of life and that tooth decay is the most pervasive chronic disease in children. One of the top reasons for school absences is tooth decay. We are working with the Department's Dental Benefit managed care vendor to ensure that members have regular access to adult and pediatric preventative and specialty oral health care, one of Colorado's 10 Winnable Battles.

We are also collaborating on a pilot project with Delta Dental, who manages the dental benefit for CHP+, and the Colorado Health Institute (CHI) to better understand the utilization of oral surgeries for children ages two to eight years old. Our population had 393 pediatric oral surgeries in 2016, most of them for children in the three to five year old range, for a total cost of over $850,000. Our pilot study is analyzing where the children reside, behavioral or developmental issues that may cause them to require general anesthesia for their safety during a procedure, and whether or not the general anesthesia occurred because of extensive tooth decay. We are also analyzing member histories of utilizing preventative oral health services prior to surgery. The overall goal of the study is to both contain costs for expensive and risky procedures and to target populations at risk for oral surgeries, providing better access to preventative care instead.

Finally, we partner with Kids in Need of Dentistry (KIND), an organization that provides preventive and restorative oral health services in their clinics and at more than 100 area schools, including rural areas such as Logan County. In all of these schools, KIND offers free dental screenings, sealants, and flouride varnish. They educate parents on the importance of good pediatric oral health, and encourage them to bring their children to one of their clinics. When children need more comprehensive care for tooth decay, KIND refers to their specialty oral health providers. In 2016, KIND recorded over 14,000 visits, through clinic visits, school-based screenings and their mobile sealant program Chopper Toppers, in the Denver, Commerce City, and northeast rural regions in Colorado.

Local Public Health Agencies

Local public health agencies (LPHAs) represent a tremendous opportunity for us to collaborate beyond the traditional clinical provider network to affect health outcomes. We have the advantage of working collaboratively with LPHAs locally and with CDPHE at the state level to integrate public health activities into the ACC program. The goals we share with regional public health entities include: shared management of a population with LPHA direct service programs; improving prevention and wellness through public education efforts; and enhancing the data-driven approach to managing populations through social determinants of health and community assessment data. Several elements of our neighborhood approach involve linking the clinical neighborhood to non-clinical resources. LPHAs are in a strategic position to address these elements since they both deliver direct clinical services and act as a catalyst for gathering and analyzing social determinants of health data on the status of local populations and their communities.

We have utilized our institutional knowledge of these key neighborhood partners to develop collaborations that address issues such as smoking cessation and cancer screening rates. We currently work with the LPHAs in our regions on both local department and statewide initiatives. We have an enterprise wide relationship with Healthy Communities (the majority of which are housed with LPHAs) through our current RCCO, BHO, and CHP+ contracts. We are actively involved in reducing duplications across the Healthy Communities program and COA contractual obligations in order to extend these program resources further.

Through the Colorado Opportunity Project, we spent two years working with LPHAs and CDPHE to define how we could appropriately share Women, Infants and Children (WIC) program data to receive monthly utilization information. With technical assistance from our legal experts, data-sharing language was developed at the regional level and completed through the State WIC Office at the CDPHE level. This legally-approved language can now be incorporated into any LPHA WIC paperwork so that any RAE can benefit from this innovation without having to duplicate the effort. Our leadership in this initiative has laid the foundation for sharing WIC program data with RAEs throughout the state.

As a HIPAA covered entity, we can act as a repository for LPHA data which can then be shared with network partners and used to improve the care offered to members. A recent example of this type of partnership began with PCMPs who requested support during a recent LPHA colorectal screening campaign so that they could better provide screening and follow-up services. We partnered with the Colorado Colorectal Screening Program (CCSP) through the University of Colorado to provide additional education, information, and support to our practices. The CCSP partnership allowed us to enhance our program by providing valuable data and statistics on the current state of colorectal cancer in Colorado. We also helped bring a comprehensive training on patient navigation into PCMP offices which included education on colorectal cancer and screening modalities. These trainings now occur twice per year and have allowed us to meet the community-defined needs of our network providers and connect PCMPs to local experts and support systems.

Our experience operating as both the RCCO and the BHO in two regions uniquely positions us to participate in population health initiatives and campaigns that touch all aspects of member health. We have developed the relationships and resources not only to carry the message but also to make the desired impact when such initiatives are implemented by our public health partners. For example, Denver Public Health is currently promoting a regional HPV vaccine campaign which includes radio, television, and print ads encouraging parents to get the HPV vaccine for their children. The campaign was adopted by Tri-County and Jefferson County Health Departments in the spring of 2017. We will deliver the campaign to members in all three RCCO regions through a direct mail campaign to members ages 9-26 who have not had any HPV vaccinations or who have not completed the required doses.

Finally, our expertise in care coordination offers a benefit to local public health agencies. In Region 3, we collaborated with Tri-County Health Department to create a model for care coordination and consultation. The partnership focuses on the population served by the health department's Healthy Communities Program (formerly Kids with Special Health care Needs) and members who are enrolled in this program. The work seeks to increase coordination of existing caseloads across the programs and establish clear roles across care coordination programs. This program has proved so successful that it has been replicated in Region 2 as a collaborative effort of COA and the Northeast Colorado Health Department.

As the RAE, we will continue to serve as a leader in leveraging and supporting LPHAs' activities into ACC 2.0 and beyond. We will work to combine our multiple data sets, analyze member and community information to inform population health management approaches, and provide actionable, user-friendly data to providers helping drive improvements in care delivery. Further, we will offer our expertise in providing quality care coordination to members in support of our LPHAs and will use our position in the medical neighborhood to promote health initiatives, campaigns and behaviors. This work not only currently benefits members and providers but sets forth a framework for RAEs across the state to replicate and benefit from.

Community and Social Determinants of Health

OFFEROR'S RESPONSE 14

Describe how the Offeror plans 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.

Social and economic factors have a critical an undeniable impact upon individual members' lives as well as the population-level health outcomes. According to the World Health Organization, social determinants of health are the circumstances into which people are born, live, work, and age; and the systems put into place to deal with illness. These circumstances are in turn, shaped by a wider set of forces: economics, social policies, and politics[1]." To truly improve health, we must transform the regional health care system to one that in concept acknowledges, and in practice integrates with social determinants of health within a community setting. As the Regional Accountable Entity (RAE), we will continue to partner with the myriad of community organizations that address social determinants of health, including: housing, employment, transportation, food and nutrition, education, racial and ethnic discrimination, childcare, and income. Inequities within these social arenas bring health disparities, especially to those living in poverty.

Informed by *The Colorado Access Health Transformation Framework* (described in Offeror's Response 7—Regional Accountable Entity), we will continuously build our network of partners, identify adjacent possibilities that promote the health of local communities and populations, and address social determinants of health. Through this design, our community engagment activities work in synergy with the activities of our clinical network to address the complex needs of members and the communities in which they reside.

[1] http://www.who.int/social_determinants/en/

DEFINING COMMUNITY AND THE COLORADO ACCESS COMMUNITY ENGAGEMENT STRATEGY

We define community as a fluid network of relationships in which people feel connected through common social ties. Communities are complex, made up of individuals with shared and diverse histories. We understand our community to include members, providers, community partners, the local population not utilizing Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, benefits, statewide agencies with a vested interest in the overall well-being of our population, and all of us at Colorado Access (COA). Our community is comprised of an extensive network of providers and community organizations working through a common agenda of understanding the social, health, and economic issues facing our members and the wider local population. As a RAE, we will be the backbone organization that furthers the common agenda, defining a joint approach to addressing challenges within our community through a common understanding of the issues our community members face and the infrastructure through which we progress.

Our understanding of community shapes our mission to provide whole-person care for each of our members. Recognizing that the community conditions in which people reside impact their overall health, we partner with community organizations that hear members' needs and respect their lived experiences. Instead of simply *tolerating* the diversity of our community, we, and our partners, demonstrate a cultural competency that *embraces* and *accepts* the diversity of the members who create and participate in our community. Collaboratively, these efforts positively impact our ability to provide access to care.

Like our community partners, we acknowledge that we are a part of our community, and that we must also partner with members to improve their health and life outcomes. We live and work in the communities we serve, so our care managers are able to develop close ties with members and the community resources that support their unique needs. Additionally, we routinely invite members to provide feedback on their care experience, through our monthly Member Advisory Council meetings, for example.

Our strategy is to promote and support the health of local communities and populations in Region 3, so that all of its members' wellness, physical health, and behavioral health are optimized.

The multiplicity of communities that make up Region 3 offers abundant opportunities for RAE engagement and intervention. We understand that the work we do on behalf of community development and improving social determinants of health, while extremely important, is adjacent to RAE's central focus on the health care delivery system. It is therefore critical that we make strategic choices about where to expend resources and ensure that they are maximally likely to have an impact that aligns with the RAE's goals. Our community engagement activities will accomplish the following objectives, which will have a multiplier effect in driving outcomes.

Strategic Objectives

- **Contribute to the Regional Common Agenda**: *The Colorado Access Health Transformation Framework* (described in Offeror's Response 7—Regional Accountable Entity) begins with creating shared objectives and corresponding collaborative strategies for Region 3, a regional common agenda. The community engagement component, like the other key programmatic components of the RAE (member engagement, practice support/transformation, care coordination, and population health), will align its activities with the regional common agenda so that the majority of efforts are aimed at the same targets.

- **Contribute to the implementation of COA's Health Neighborhood model**: The Health Neighborhood model, which is comprised of eight key functions (described in Offeror's Response 13—Health Neighborhood), leverages connections to non-clinical, community-based resources as key to a high functioning neighborhood by:
  - **Collecting and analyzing social determinants of health data consistently across the neighborhood -** Collaborating with neighborhood partners to universally screen for social factors that influence member health; use data to identify appropriate referrals to community-based resources; and aggregate and analyze data to inform regional population health and care coordination activities.
  - **Building and strengthening community resource linkages.** Developing a centralized resource directory and improving referrals and warm handoffs between clinical providers and community and social service agencies.

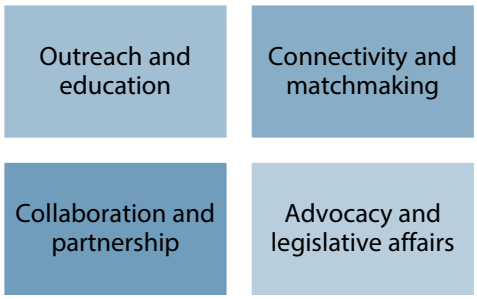
The Region 3 RAE neighborhood vision is a coordinated delivery system that engages the full range of providers to deliver optimized care and seamlessly links members to community resources that address social determinants of health. Our community engagement staff members will be the connective tissue between the medical neighborhood and social service and human service organizations.

- **Seek to reduce health disparities and inequities**: Health care disparities refer to differences in access to or availability of facilities and services. Health status disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups.[2] If a health outcome occurs to a greater or lesser extent between populations, there is disparity. We will continue and expand efforts in Region 3 to address issues of health disparity and use our data analytics capabilities to identify any additional significant issues that merit new programming and investments.
- **Address the needs of members with complex needs receiving services from multiple agencies**: Medicaid members often have more health conditions than the general population and have complex needs that often touch upon multiple systems of care within and outside of traditional health care. We have a proven track record of working with multiple agencies and systems to improve communication and coordination for complex members. As the RAE**,** we will identify how members with complex needs understand their contact points with different agencies, and continue to work across sectors to deliver highly effective communication care coordination at the systems level, on the members' behalf.
- **Use data and evidence**: Data and analytics are foundational to our RAE strategies.
  - We will evaluate health disparities in the region and identify specific communities and populations that need attention and resources. We will partner with local experts and stakeholders to understand and build upon different data sets from inside and outside of health care, including hospital-based community health needs assessments, human services, and public health data sets and research, to gain a comprehensive regional view of the disparity issues.
  - We will promote evidence-based and promising practice interventions. We will evaluate the effectiveness of these programs on health outcomes and use data feeds to support the programs/interventions themselves.

[2] U.S. National Library of Medicine, https://www.nlm.nih.gov/hsrinfo/disparities.html

- **Support existing collaborations and creates new ones where needed**: We have a proven track record of supporting effective collaborations, as well as facilitating new connections and improved processes, in order to promote the health and wellbeing of communities and populations. We trust the work of our community partners and will continue leveraging naturally existing alliances, partnerships, and collaborations as we have done in the past, enhancing current efforts, not dictating or duplicating.

Implementation Approach



Our approach to community engagement work is multi-pronged, allowing us to deliver on the RAE contract requirements:

Our community partner organizations in addressing social determinants of health have varying awareness of and connection to the Accountable Care Collaborative (ACC) program. Some partners may need basic information on Medicaid, the role of the RAE and the goals of the ACC program, while others already work closely with us on initiatives addressing key social determinants. Thus, we have a range of approaches for engaging community partners, adapted for each potential partner or community audience.

Outreach and Education

We will continue to offer community outreach and education to a wide array of community-based organizations to support a broad understanding of the RAE's function within the community. We will deploy digital communication, convene community meetings, participate in member and stakeholder-facing events, hold one-on-one meetings, provide expertise by sitting on boards (e.g. Aurora Health Access, Colorado Prevention Alliance, Colorado Health Evaluation Collaborative, South Metro Health Alliance), and offer formal presentations to community organizations wishing to learn more about the RAE and the services afforded to members. As we broaden the definition of health care to be inclusive of social, economic, and other support systems of members' lives, we must promote outreach and education across human service and social service sectors as a critical component of our community engagement strategy. These connections will increase health literacy at both the community and individual member levels and will impact the tactics we utilize to increase knowledge of, and where appropriate, adoption of specific programming developed through *The Colorado Access Health Transformation Framework*.

Collaboration and Partnership

We have demonstrated our unparalleled ability to form substantive and enduring partnerships with community entities that lead to better outcomes for members. As the RAE, we will extend this partnership and collaborative

effort beyond our existing network of community partners. Examples of collaborations and partnerships take a variety of forms, including data sharing agreements, community-based care coordination placements, research and evaluation projects, marketing/public awareness campaigns, facilitated community forums, and targeted member events. Specific examples of these kinds of partnerships and collaborations are described later in this Response.

Connectivity and Matchmaking

We endorse that the RAE does not always need to be directly involved in a particular project in order for that work to further desired system outcomes. One of the four primary roles of the RAE will be to promote direct connectivity and relationship development among its partners. Limited resources can be used to match partners with similar targets, methods, populations, geographic focus, interests, or funding structures, in order to build upon existing work or create a larger impact.

Advocacy and Legislative Affairs

The RAE is uniquely positioned to serve as a convener of community partners and stakeholders. This important role means that certain advocacy and legislative affairs may be appropriately informed by the RAE. We have a strong track record of working effectively with the advocacy community, as well as the Department of Health Care Policy and Financing (the Department), local governmental agencies, and other entities, to ensure that the voices of members are heard and addressed.

We are an active member of several health alliances. Our advocacy work extends to partner with state and local organizations such as All Kids Covered, the Colorado Refugee Network, and the Rose Andom Center to keep local and state stakeholders informed on the issues that affect members, such as health care access for children, refugee services issues, and domestic and intimate partner violence. These collaborations transcend regional boundaries and work to strengthen communities through multiple avenues. Our long tenure in the community and our relationships with local stakeholders are critical to the success of this important RAE community engagement function.

REGION 3 HEALTH DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH

We acknowledge the specific health disparities impacting members in Region 3. A review of the various Community Health Needs Assessments in the region reveal several potential areas for intervention. Data collected by the Tri-County Health Department for their 2016 Community Health Assessment and by UC Health for their 2016 Community Health Needs Assessment for Adams, Arapahoe, Denver, and Douglas counties revealed that obseity and issues related to behavioral health and substance abuse are problems common to all three of these counties in Region 3. As the RAE, information like this is extremely useful and can help inform our broader education campaigns and region wide initiatives. Other themes that emerged from the data were a need for improved nutrition and nutritional education, increased awareness of commuinty resources, and focus on preventable diseases and injuries. Since these needs were not endorsed by all counties but appeared as strong themes, we might suggest them to our community partners as possible areas of focus. Finally, each individual county identified unique needs of their own, on which we will work to address individually:

- Adams: A need for school based health clinics to improve overall health of students throughout the county, a need for educational campaigns regarding the dangers of binge drinking for both youth between 9th and 12th grades and adults. Additional education, assessment, and support for youth regarding suicidal ideation.
- Arapahoe: A need for additional education on how to interpret insurance plan benfits and enroll. Campaigns to decrease stigma around receiving mental health treatment. Support finding resources to help with medical expenses.
- Douglas: A need to educate youth on the impact of prescription drug abuse, 13% of adolescents between 9th and 12th grade report misuse of precription drugs.
- Elbert: The top two priorities are to address obesity prevention—providing education to increase lifelong physical activity and knowledge of healthy eating; and tobacco cessation—identifying community partnerships that encourage quitting the use of cigarettes.

REGION 3 COMMUNITY RESOURCES AND COLLABORATIONS

Our local presence shapes our mission to provide whole-person care to all members. During 22 years of service in Colorado, we have developed strong partnerships with a regional network of organizations engaged in economic, social, educational, justice, and recreational initiatives promoting the health of local communities and populations. We live and work in the communities we serve, and thus have first-hand knowledge of local resources, as well as close ties to members, their families, and neighborhoods. We partner with community organizations that hear and understand members' needs and respect their lived experiences. Together with our community partners, we demonstrate a cultural competency that embraces the diversity of the members who create and participate in our community.

A complete list of our collaborations in the area of community and social determinants of health includes: human services organizations, housing agencies, first responders/law enforcement, criminal justice programs, transportation-focused organizations, nutrition nonprofits, health alliances, advocacy groups, schools, local public health agencies, and others. We have made investments of time, resources, and funding to many of these community entities.

Examples of Community Partners: Region 3	
• 2040 Partners for Health	• 7 County Child Welfare Resiliency Project
• Association of Community Affiliated Plans	• Adams County Health Alliance
• Adams County Human Services/Adult Protective Services	• AmeriCorps
• All Kids Covered	• Arapahoe County Human Services
• Anschutz Campus Community Partnership	• Aurora Health Access
• Aurora Chamber of Commerce	• Aurora Wellness Problem Solving Court
• Behavioral Health care, Inc.	• Boomers Leading Change in Health
• Brain Injury Alliance of Colorado	• Colorado Behavioral Health care Council
• Colorado Department of Public Health and Environment: Cavity Free at 3, Diabetes Prevention Program Advisory Committee, et al	• Children's Hospital Colorado

Examples of Community Partners: Region 3	
• Center for Improving Value in Health care	• Civic Canopy
• Colorado Telehealth Network	• Colorado Women's Chamber of Commerce
• Colorado Children's Health care Access Program	• Colorado Commission on Criminal and Juvenile Justice: Behavioral Health Taskforce
• Colorado Children's Campaign	• Colorado Children's Immunization Coalition
• Colorado Coalition for Elder Rights and Abuse Prevention	• Colorado Coalition for the Homeless
• Colorado Community Health Network	• Colorado Criminal Justice Reform Coalition
• Colorado Cross-Disability Coalition	• Colorado Education Initiative: Healthy Schools Collective Impact
• Colorado Gerontological Society	• Colorado Health Institute
• Colorado Housing Taskforce	• Colorado Jails Association
• Colorado Prevention Alliance	• Colorado Refugee Services Program
• Community College of Aurora	• Community Corrections
• Connect for Health Colorado	• Connections for Families
• DentaQuest	• Aurora City Council
• Developmental Pathways	• Douglas County Adult Protection Services
• Early Childhood Colorado Partnership	• Eastern Colorado Services
• Empowerment Program	• Excelsior Youth Center
• Food For Thought	• HEARTSMART Kids
• Hunger Free Colorado	• Immigrant and Refugee Public Awareness Health Campaign
• LiveWell Colorado	• MCPN's Bridges to Care
• Kids in Need of Dentistry (KIND)	• Mountain States Employers Council
• Mercy Housing	• Salud Family Health Centers
• Qualistar Healthy Childcare Partnership	• The ARC of Arapahoe and Douglas Counties
• South Metro Health Alliance	• Tri County Health Department
• The Consortium	

We have a proven track record of working with these types of organizations and many resulting success stories that illustrate how a systematic, coordinated approach can improve health outcomes for members and populations. Our community network of partners has been created through longstanding relationships and will not need to be newly created upon RAE contract award.

COMMUNITY ENGAGEMENT: CURRENT AND FUTURE COLLABORATIONS

Below we describe our innovative work that illustrates how we have used our Health Transformation Framework and strategically partnered with community organizations to directly and positively impact members—particularly those with complex medical and non-medical needs.

Housing

We have participated in and supported many efforts related to housing for the Medicaid population. In 2016, we formed a partnership with the Denver Housing Authority that we recently replicated with Mercy Housing and the Volunteers of America in Region 3. This program is designed to increase member engagement and support

on-site at housing developments. The majority of residents are Medicaid-eligible, making the Mercy Housing and Volunteers of America collaboration a synergistic and efficient effort. Our innovative approach places care coordinators directly in contact with populations that are often difficult to reach and creates an opportunity to link and leverage social supports and needed health care services, such as finding a PCMP or preventive care gaps (e.g. immunizations). Members with higher needs are identified and tracked into ongoing care coordination.

This type of partnership adds value through cross-agency, system-level education, because staff members representing two historically separate systems—housing and health care—better understand their intersections and recognize that housing is indeed, health care. Through these cross-agency partnerships, we are able to identify further areas of collaboration and avoid duplicative efforts. We are leveraging the existing housing team infrastructure to coordinate work and reach a greater number of residents; housing staff members have been able to allocate resources toward complementary work that may have previously overlapped with care coordination.

We also participate in statewide initiatives aimed at increasing capacity for permanent supportive housing through agencies such as the Colorado Coalition for the Homeless (CCH), Colorado Medicaid Crosswalk project and Colorado Medicaid Academy trainings. We are partnering with CCH in their plans to build 500 new permanent supportive housing units over the next five years. This initiative will reduce costs incurred in the health care system because people who are in permanent supportive housing are significantly less likely to utilize emergency departments and more likely to rely on a PCMP and behavioral health provider for their health care needs. These examples describe both the local and systematic ways we have demonstrated our commitment to enhancing and informing the collaboration between housing providers and the Medicaid system.

Criminal Justice

We are similarly involved with efforts focused on persons utilizing the criminal justice system. We have partnered with the Colorado Criminal Justice Reform Coalition, the Colorado Behavioral Healthcare Council, the Department, and local and state justice-related systems to understand, define, and provide thoughtful leadership to improving the intersection between justice systems and health care. Through our participation in the Colorado Criminal Justice Reform Coalition, we have supported efforts toward meaningful data exchange and are pursuing this issue with local and state justice system providers, as well. Within systems serving youth and adults involved in the criminal justice system, we continue to identify areas of collaboration, particularly in the areas of onboarding, primary care medical provider (PCMP) and behavioral health engagement, and linkage to social supports and peer services.

In Region 3, we have an effective collaboration with the Aurora Wellness Problem Solving Court. After the city identified that a small number of individuals accounted for a large portion of jail days and associated costs, the Problem Solving Court was created to provide an alternative to incarceration for willing program participants. We proactively became involved in the project and found that many potential program participants also represented high utilizers of health care services resulting in high health care costs. Our contributions to the community program have included serving on the court's advisory board to inform program design, contributing to a resource list for program staff, providing training to program staff members on COA care coordination resources, and creating a seamless handoff process for program participants to be connected with

ongoing care coordination. The program's first graduate was recently celebrated, and our care coordinator was proud to attend and see her client's success acknowledged.

All three of the community mental health centers in our region have special programs for offenders, which provide integrated treatment for behavioral health and sexual offending. We frequently collaborate with these centers to train other agencies that work with individuals involved in the criminal justice systems. Further work with parole offices, county jails, specialty courts, community corrections, and the Department of Corrections is underway.

Food Insecurity and Nutrition

We recognize that many members experience food insecurity: limited or uncertain access to adequate food and/or lack of knowledge related to nutrition. In Colorado, 12.9% of the population experiences food insecurity; in Adams County, the rate is 11%; Arapahoe County has a 15% rate, and in Elbert, the rate is 10%. In a recent news release, Feeding America, a national advocacy organization, points out that even affluent counties may have high rates of food insecurity. It uses Douglas County as an example, reporting that the county has a median household income of over $100,000 annually, but that 15% of its children are food insecure.[3] To address these needs, we support providers who have internal food banks and promote these resources to members through our community engagement and care coordination teams. We also support and participate in local events, such as resource fairs and cooking classes led by Hunger Free Colorado. Below are selected examples of our participation in food insecurity and nutrition programs:

Women, Infants, and Children (WIC) Food and Nutrition Service: We work with the Colorado Opportunity Framework and Healthy Mom, Healthy Baby programs to link women and their families to WIC. We also spearheaded a local data-sharing agreement with WIC (the first one in the state) to receive its enrollment lists, including SNAP and TANF enrollment data. We use this information to target care coordination efforts on members who could benefit from those programs. There are two pilot projects with Northeast Colorado Health Department and Tri County Health Department to outreach members about WIC, resulting in increased WIC participation.

Project Angel Heart: We are participating in a pilot project to promote adherence to a low sodium diet for members with congestive heart failure (CHF). Care coordinators will identify persons being discharged after a hospitalization for CHF exacerbation and promote member education and activation around self-management and low sodium diet adherence. Project Angel Heart will deliver low sodium meals for 30 days after discharge.

Childhood Obesity: Children's Hospital Colorado has a grant from the Colorado Department of Public Health and Environment to develop and test a model for overweight children through community-based, family-focused interventions. We are part of the steering group and provide data support.

[3] Feeding America, "Child Food Insecurity Exists in America's Most Affluent Communities," April 15, 2015. Accessed at http://www.feedingamerica.org/hunger-in-america/news-and-updates/press-room/press-releases/map-the-meal-gap-2015.html?referrer=https://www.google.com/

As the RAE, we will continue to build our partnerships with community organizations, schools, and other entities in a strategic fashion, building on existing resources, creating linkages, and investing in mutually reinforcing activities that advance RAE aims.

Regional Resource Directory

We strongly recognize the value of a centralized resource directory through which both members and providers have access to an array of community services and resources. We are working with a variety of agencies to support the 211 system at Mile High United Way. The 211 Resource Directory has contact information for more than 10,000 community resources in Colorado. This directory identifies organizations that provide resources like childcare, housing, food, criminal justice system supports, job training and placements, crisis services, substance use services, and many others. We have been working with United Way to increase resource information for specialty populations such as youth, refugees, LGBTQ-identifying populations, and members who have complex medical and social needs. We collaborate with the Colorado Prevention Alliance and Rocky Mountain Crisis Partners regarding resource sharing. We also maintain an internal directory to which care coordinators and members have access; it reflects the shared knowledge and first-hand experience of users. There are significant challenges and costs associated with maintaining directories like these, requiring wise use of resources, leveraging existing resources and technology, and close collaboration with partners to minimize duplication and make the best information available to members.

The Colorado Opportunity Framework—Promoting Member Engagement

We are well aligned with the Colorado Opportunity Project (COF), a cross-agency collaborative promoting member engagment and upward mobility toward self-sufficiency for low-income populations. Together with the Department, the Department of Public Health and Environment, and the Department of Human Services, we are working within the Colorado Opportunity Framework to utilize evidence-based practices to improve health and life outcomes for members. Since 2016, we have deployed two Opportunity Project liasons to develop strategic relationships with local organizations that support members' wellbeing and address their social determinants of health.

One example of our COF initiatives is the Earned Income Tax Credit (EITC) campaign. Recognizing that the EITC has the potential to lift hundreds of thousands of families above federal poverty levels, we partnered with The Piton Foundation (Colorado's largest EITC champion) to distribute their EITC printed materials during the 2017 tax season. Because many working families have incomes that fall below the federal tax filing threshold, they are often unaware of their eligibility for this substantial tax credit. Through our partnership, we distributed materials to members informing them about the EITC qualification requirements, other public benefits such as SNAP and TANF, and COA resources.

As the RAE, we will retain our commitment to working with the broader community of organizations that address social determinants of health, and we will build on our earlier successes developing relationships and programs in these areas. Through the lens of our Health Transformation Framework, our community engagement team will strategically engage with the programs and partners best aligned with the RAE aims and best able to make specific impacts. This intentional and evidence-based approach will ensure that limited resources are appropriately invested where they have the most benefit to members. We will prioritize programs and partners already working closely with the clinical delivery system, while also having a broad level of

communication and coordination with the wider range of entities that address social determinants of health throughout the region.

The Region 3 Governance Council and Region 3 Advisory Council (described in Offeror's Response 8—Governing Body) will have important roles in developing the strategy to address social determinants of health, prioritizing needs and opportunities, allocating resources, and planning and evaluating implementation. The partners' deep understanding of the specific social needs of their own populations and neighborhoods will strengthen the program design, increase buy-in, reduce duplication, and align efforts toward the overall RAE aims.

Community Collaborations to Remove Roadblocks, Address Gaps, and Expand Resources

We are highly engaged at multiple levels in the region and state with many collaborative efforts focused on the social determinants of health. Our senior leaders actively participate in health alliances, including Adams County Health Alliance, Aurora Health Access, Douglas County Collaborative, South Metro Health Alliance, and others. We also contribute to the social determinants of health work of the Colorado Prevention Alliance, the Colorado Coalition for the Medically Underserved, Colorado Children's Campaign, Healthy Schools Collective Impact, the Healthy Eating Active & Living (HEAL) Network, and others; that work informs policy decisions and builds coalitions among like-focused agencies. Moreover, our active participation in local interagency oversight groups (IOGs) through the collaborative management program affords us an important venue to engage in cross-system sharing, resource pooling, performance evaluations, outcomes monitoring, and staff training. By virtue of this broad and meaningful engagement, we gain insight into the regional social determinants of health and use it to inform the Region 3 community engagement strategy and implement the right solutions.

In Region 3, we are founding members of Aurora Health Access (AHA), the regional health alliance; in May 2017, AHA convened a social determinants of health taskforce. This taskforce is comprised of leaders from COA, Children's Hospital Colorado, Metro Community Provider Network (MCPN), the Tri-County Health Department, and other local organizations. It aims to promote collaboration among existing organizations, augment their resources, increase awareness, and find solutions to issues such as inadequate access to quality childcare, nutrition access for older adults and those with disabilities, and racial inequalities that create barriers to health care system access. Currently, the taskforce is focused on creating community spaces in which the local refugee and immigrant populations can meet neighbors and learn about resources that will support stronger integration into their community. These ongoing collaborative efforts with community organizations go well beyond the RAE requirements to establish relationships and communication channels; we are already making meaningful strides to efficiently improve access to both medical and social services for members.

Local Public Health Agencies and Hospitals

Local public health agencies represent an important collaboration opportunity for us, as they bring critical data, insights, and resources that inform planning and drive improved health outcomes. As a locally engaged company, we are already well aware of and, in many cases, involved in, LPHA activities; recent examples include smoking cessation and cancer screening campaigns. We also collaborate with LPHAs on regional and statewide initiatives such as Regional Health Connectors and the Colorado Opportunity Project. We have a strong working relationship with the Healthy Communities programs (most are housed within LPHAs) based on experience as a contractor for Medicaid (physical health and behavioral health) and Child Health Plan *Plus* (CHP+). We seek to

reduce duplication across the Healthy Communities programs and Colorado Access contractual obligations, in order to extend resources further and streamline the member experience. In Region 3, we collaborated with the Tri-County Health Department to develop a model of care coordination and consultation that was subsequently replicated in Region 2. The intervention targets the population served by the HCP (formerly Kids with Special Health Care Needs), coordinating care across programs and clarifying the roles and responsibilities of involved persons and agencies.

System-level collaboration with hospitals and LPHAs will also inform our RAE community engagment strategy. Their community health needs assessments provide important information that will add rich perspective to our understanding of the needs and opportunities in Region 3. This includes health data, population characteristics, and social and economic factors. Key needs and gaps are identified through this process, such as access to care or environmental factors affecting a specific disease cohort or neighborhood. Our relationships with the Colorado Prevention Alliance and Colorado Coalition for the Medically Underserved, both actively working in the area of social determinants of health, will help align the RAE efforts with other community organizations.

STATEWIDE HEALTH INFRASTRUCTURE

We have extensive participation and alignment with advisory groups, existing programs, and statewide initiatives designed to strengthen the health care system by virtue of our current role as a contractor for the ACC, BHO, and CHP+ programs. While many of these collaborations are described in further detail throughout this proposal, the following is a brief summary of some of our work in these areas:

Managed Service Organizations

We have a long-standing effective collaboration Signal Behavioral Health, the MSO for Region 3. We regularly work with Signal to align our activities, particularly those related to mental health and substance use disorder (SUD) services and to the integration of these services with primary care. Our relationship with Signal is also important to assure coordination of care. Signal's network of providers is also contracted with us for Medicaid-covered substance use disorder services. This allows a seamless transition from Medicaid-covered services (e.g. social detoxification) to MSO-funded services (e.g. residential treatment programs). As the RAE, we will continue to coordinate care and services with Signal and also invite their participation on the Regional Advisory Council and relevant subcommittees and workgroups. This will ensure that issues related to SUD are appropriately informed by their expertise and appropriately addressed in the region's common agenda and key priorities.

Colorado Crisis System

We recognize the importance of the Colorado Crisis System as a critical resource for behavioral health help, information and referrals. We have contractual relationships with all the component organizations of the system, such as the crisis programs operated by the Community Crisis Connection in the Metro Denver region and Rocky Mountain Crisis Partners (RMCP), the statewide crisis line. The Community Crisis Connection partners are represented on the Region 3 Governance Council to promote alignment with the regional common agenda and priorities. As we have done since the crisis system was established, we will continue to promote all the elements of the crisis system to providers and members by distributing information and by educating providers and members through in-person contacts, care coordination interventions, and educational presentations.

State Innovation Model (SIM)

We have been designated as a SIM Practice Transformation Organization (PTO) for SIM Cohort 2. As a PTO, we are tasked with outreaching and working with PCMPs in our network to enhance the patient-centered medical home and move practices toward higher levels of transformation and integration. Currently, 25 network PCMPs for the RCCO program (across Regions 2, 3, and 5) are participating in SIM Cohort 1 and are supported by Colorado Access, as the RCCO/BHO, in their efforts with their SIM PTOs. We are also directly involved in the SIM initiative; we have representatives serving on several statewide workgroups, including the vice president of integrated care and the director of population health. We will continue to expand this involvement to align the SIM with the RAE practice transformation and support activities, as described in detail in Offeror's Response 17—Provider Support.

Colorado Opportunity Framework

As described above, we have been involved in the Colorado Opportunity Framework (COF) since 2015, when we were awarded contracts to support two community liaisons in RCCO Regions 2, 3, and 5. Their role has been to build working partnerships and implement collaborative interventions that support members' social determinants of health and financial wellbeing. Community partners have included Women, Infants and Children (WIC), Earned Income Tax Credit (EITC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the Nurse Family Partnership (NFP). With these partners, we conducted a community environmental inventory which identified needs and led to selecting evidence-based solutions unique to each region. Interventions include:

- A data use agreement between the state WIC program and COA, allowing COA to match WIC participant information with Medicaid member records to inform outreach efforts to eligible members not currently enrolled in WIC.
- A WIC campaign designed to increase the number of members using WIC during pregnancy, using mailers with information about WIC benefits and eligibility and incentives to visit the local WIC office.

Through this experience with COF, we have developed strong and long-lasting partnerships with state and local public health agencies and other community agencies and organizations involved in addressing social determinants of health. We will build on these relationships to develop additional collaborative activities as the Region 3 RAE.

Comprehensive Primary Care Initiative (CPC+)

We participated in the original CPC initiative from 2012-2015 as a payer on behalf of our Medicare Advantage and CHP+ programs. We participated actively on the multi-payer collaborative, making care coordination payments to network providers who were participating in CPC (approximately half of the 70 CPC practices in Colorado). We helped to design, fund, and launch the Stratus tool for data aggregation at the practice level. We submitted claims data from Medicare and CHP+ members in those CPC practices to the Stratus tool. We are very familiar with the conceptual framework and outcome of the original CPC initiative and the current state of CPC+ and the multi-payer work within SIM. Capitalizing on our past experience with the initiative and the relationships we formed with other payers and the CPC practices, we are committed to supporting this initiative to assure that our mutual goals, strategies, and quality and outcome measures are aligned.

Community Living Advisory Group

As the Single Entry Point (SEP) agency for the East Denver Metro Region and a contractor for the No Wrong Door pilot program, we are intimately involved in state and local efforts to adopt system changes in the long-term services and supports system to enhance community living options. The director of Access Long Term Support Solutions program serves as a representative to the State's Community Living Advisory Group. She will ensure that the efforts and directions of this group are aligned not only with our SEP and NWD programs, but also with the related activities and strategies performed by the RAE.

Pharmacy and Therapeutics Committee and Drug Utilization Review Board

We actively align with state and local boards and committees regarding best practices for prior authorization criteria for medications and prescribing guidelines. Our senior medical director, Dr. Scott Humphreys, is a member of the Department's Pharmacy and Therapeutics (P & T) Committee. He is a board-certified psychiatrist with a focus in forensic psychiatry and addiction medicine. On the P & T Committee, Dr. Humphreys contributes to discussions reviewing medications and medication classes for safety and efficacy. The committee also considers new medications and, if appropriate, their adequate placement on the Medicaid preferred drug list.

Utilization Management Vendor

We have an established relationship and communication channel with the Department's utilization management (UM) vendor and are currently linked to both the Health First Colorado Nurse Advice Line (NAL) and COUP. Our director of care coordination is the single point of contact for the UM vendor. We have experience working directly and collaborating with the NAL in our ED reduction program, which targeted members with avoidable ED visits using digital channels and directed them to the NAL. In addition, we have conducted periodic analyses of NAL data usage by members to better understand their needs and design care coordination interventions accordingly.

CONCLUSION

As the RAE and its communities evolve, we will continually work to adapt and ensure that members have a voice in their care. We are committed to improving the overall wellbeing of members and communities and recognize the critical imperative to understand and address social determinants of health. Through the collaborative efforts described above, we will use person-centered, locally-tailored, inclusive approaches in an intentional, data-driven, and evidence-based way to address social factors and achieve the maximum benefit to members and communities.

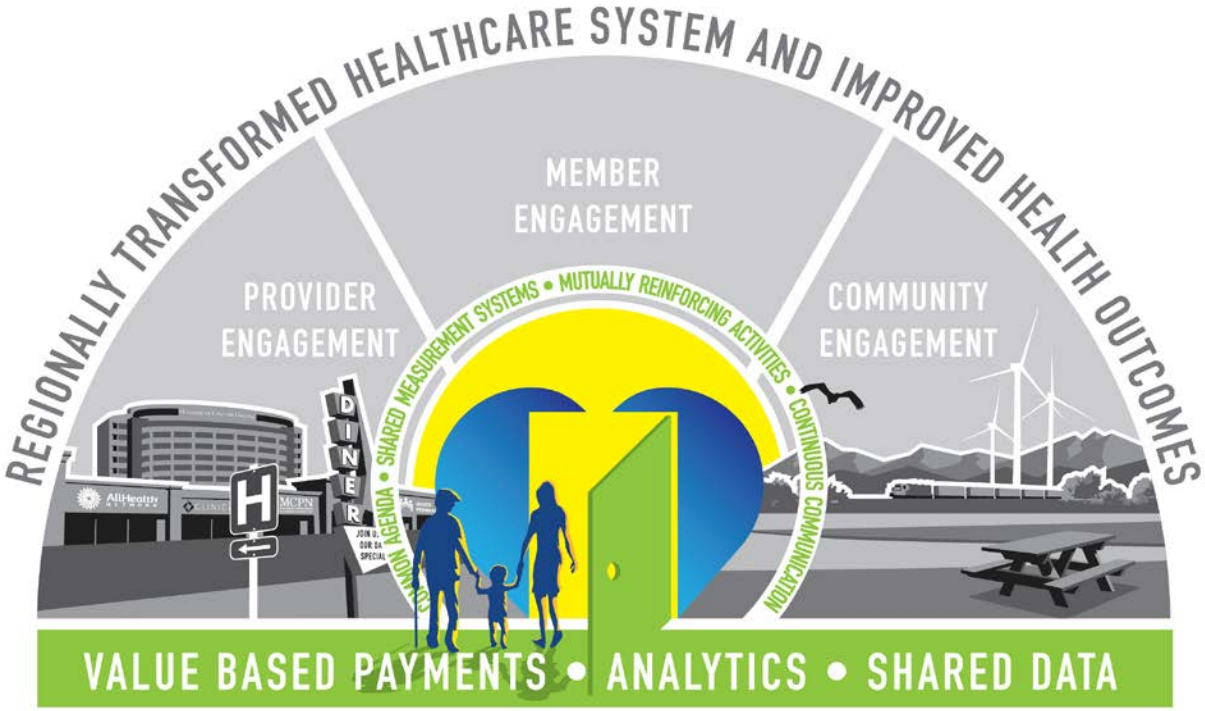
Population Health Management

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.

EFFECTIVELY MANAGING THE HEALTH OF ALL MEMBERS

Managing the health of a population and coordinating care for all members have been central to our philosophy and mission and represent one of our well-established core competencies. We strongly support the Department of Health Care Policy and Financing (the Department) vision of a more efficient system that offers a seamless experience for members and promotes the health and wellness of the entire population. While it is widely known that many parts of the health care system are fragmented and operate in silos, as a Behavioral Health Organization (BHO), Regional Care Collaborative Organization (RCCO), Single Entry Point (SEP), and Child Health Plan *Plus* (CHP+) contractor, we have made substantial progress developing a comprehensive understanding of our member populations. This has been achieved by integrating disparate systems and evolving to an advanced population health management approach that segments the population and relevant subgroups by key health and social indicators rather than by enrollment in BHO, CHP+, RCCO or SEP.



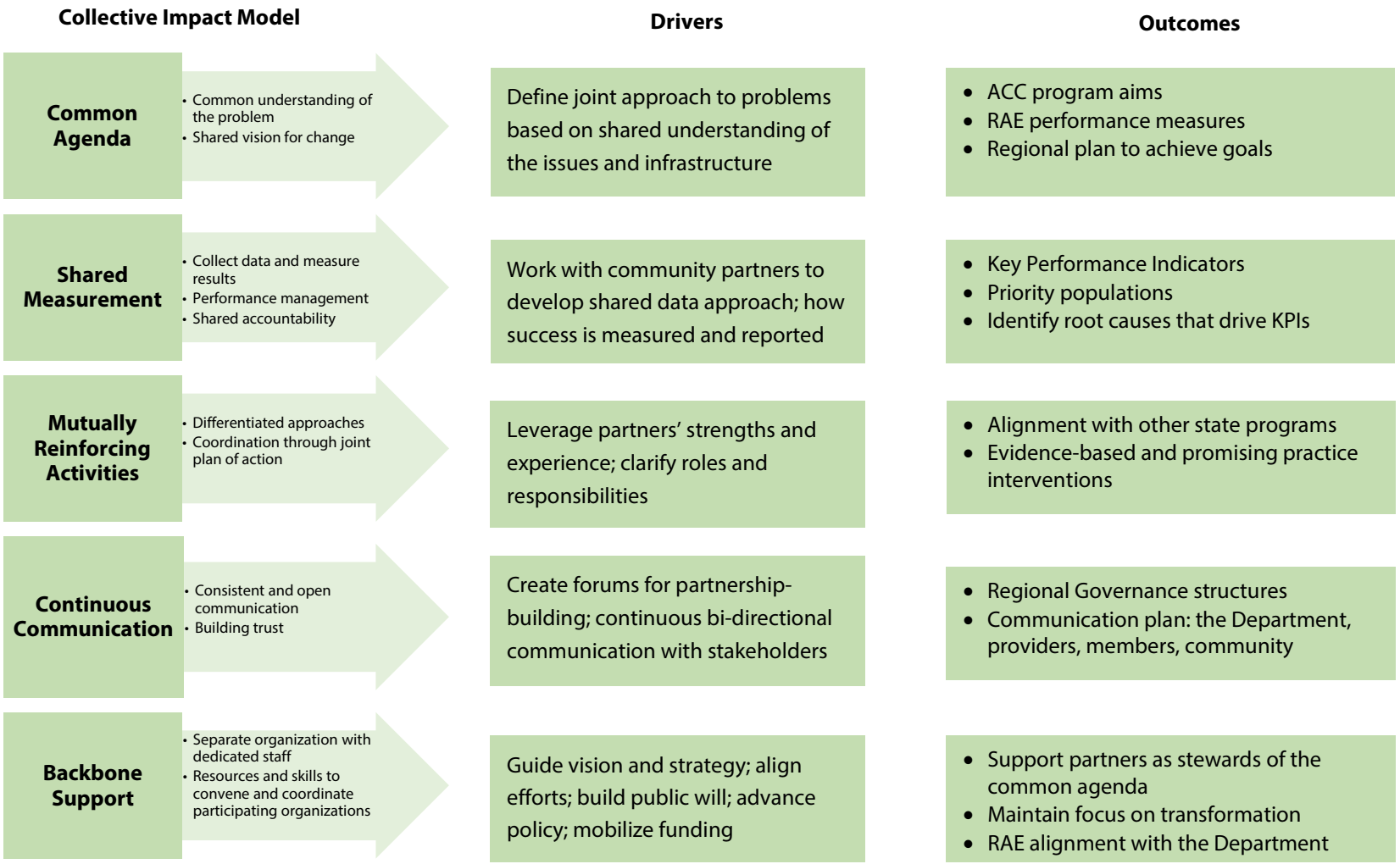
As the Regional Accountable Entity (RAE), we will accelerate this evolution and deliver a fully integrated system of population management that includes both population health interventions and care coordination. In preparation for becoming a RAE, we have worked hard to develop an approach to foster regional collaboration and innovation in a thoughtful, effective manner. The *Colorado Access Health Transformation Framework* - serves to design and align regional initiatives to forward a shared vision for RAE outcomes. This framework is built upon the Collective Impact Mode[1]l and its five conditions for success which, working synergistically, produce alignment and lead to powerful results. Please see Figure 15-1.

The framework is founded upon the key concepts outlined in the Collective Impact Model and locally tailored to the needs of the RAE. They include:

- Identifying a backbone organization (the RAE)
- Creating a common agenda and goal alignment
- Ensuring shared measurement and stratification systems that allow the collective group of stakeholders to adopt a common definition of success
- Establishing continuous communication and organizational supports across network providers, specialists, community entities, and other key stakeholders in the RAE
- Implementing mutually reinforcing activities that include role clarity RAE among stakeholders involved in caring for Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, members.

[1] Kania, J and Kramer M. Collective impact. *Standford Social Innovation Review;* winter, 2011

FIGURE 15-1 COLORADO ACCESS HEALTH TRANSFORMATION FRAMEWORK



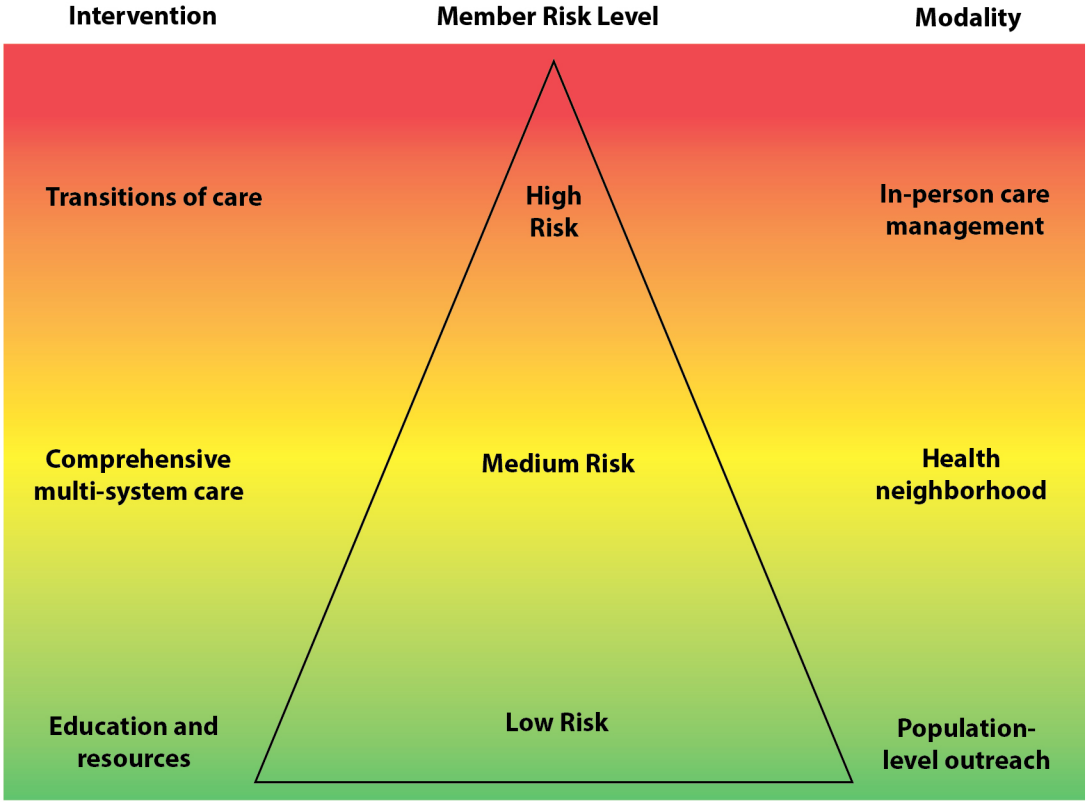
This organizing and transformative framework is the center of our **Colorado Access RAE Model** that uses the *Health Transformation Framework* to align our service offerings upon a foundation of data to create a transformed health care system and improve health outcomes.

Our comprehensive population management strategy is designed to ensure the right level of care is delivered at the right time and in the right setting. The strategy is made up of two core components: a dynamic population stratification model and a comprehensive population health management approach that includes a continuum of population health programming and care coordination activities. The stratification model leverages the analytics generated by the Department and builds upon them by incorporating additional data sources and segmenting the population in different ways based on varying types of risk to develop a holistic view of a population. As a result, our staff members, partner providers, and community agencies are equipped with a comprehensive view of their populations that yields timely and robust information for actionable interventions. The population health management approach is made up of both population health programming and care coordination activities, which are delivered on a continuum, based on the level of risk and targeted outcome to be achieved, thus ensuring the entire population receives the right level of intervention and support. Our strategy builds upon the unique and diverse opportunities and innovations in our communities and provider systems, but is not merely a collection of discrete programs and pilots that may be overlapping, misaligned, or under-scaled. Our regional approach, based on population characterization, will proactively design and evaluate an array of programs and interventions, identify and address gaps, ensure adherence to evidence-based and promising practices, reduce duplication, improve the member experience, and align activities to drive improvements in the health and outcomes of the region's population.

HEALTH PROMOTION/POPULATION HEALTH MANAGEMENT TO IMPROVE HEALTH OUTCOMES

Our health promotion/population health management approach is jointly led by our population health and care management departments, a team that includes licensed clinicians, public health professionals, certified healthcare coders, PhD epidemiologists and regional Colorado Opportunity Project liaisons. Our population health management approach aims to increase overall health (e.g. promoting a healthy weight) and prevent or reduce the burden of disease on defined groups of members who have similar characteristics or experiences (e.g. adults with diabetes and depression). This approach is largely deployed through an epidemiological framework (e.g. analytic studies, evaluation, and linkages of time, place, and person) to identify and examine large subsets of our member population. Specifically, our population health department uses data and analytics to assess and characterize the population's needs in order to plan for delivery of the right intervention to the right population at the right time. Our population health and care management departments work synergistically to design and implement evidence-based interventions that are locally tailored and reach populations across the entire risk spectrum. Interventions include: promoting prevention and wellness (e.g. cancer screening); improving chronic disease outcomes among members with a diagnosis (e.g. children with asthma); controlling unnecessary utilization of high cost services (e.g. ED visits for primary care needs); improving member-level knowledge about their benefits (e.g. providing members education on the benefits of going to the dentist every year). These interventions are continually tracked and evaluated, with meaningful results fed back into the design and deployment of the interventions in order to continually refine and the interventions. This continuum is illustrated in Figure 15-2 on the next page.

FIGURE15-2 COLORADO ACCESS RISK SEGMENTATION AND MEMBER-LEVEL INTERVENTIONS



Population Management Risk Segmentation Model

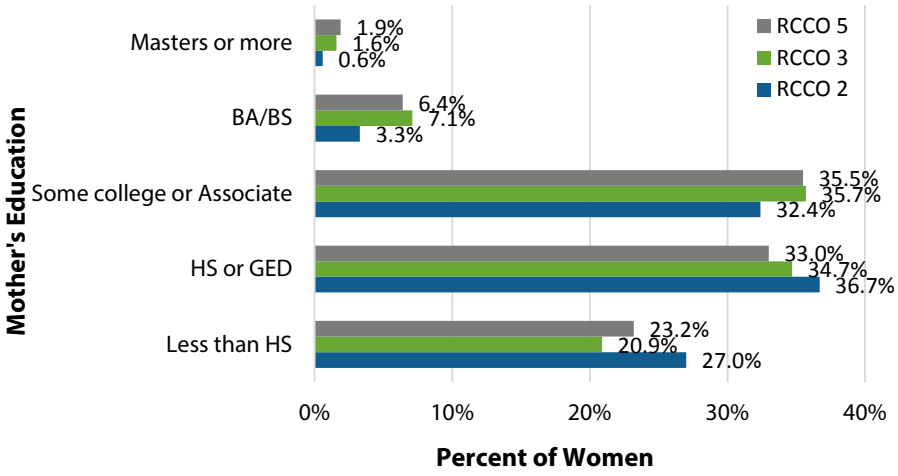
Effective Population Health

We have long recognized that effective population health management requires a detailed understanding of the distribution of health conditions and behaviors and that members' health encompasses not only physical health, but also behavioral, spiritual, and social well-being. This recognition led to our pursuit of multiple Medicaid contracts in order to integrate across behavioral health and physical health domains as well as disability status and other factors. It has also led us to develop a population health management strategy that is based upon member-focused care, guided by an information-driven approach and evidence-based interventions and implemented with innovative medical management that proactively incorporates the social determinants of health as part of routine care. We use a clinical registry-based approach to tracking and managing the health of members, using historical trend data and mining this data to characterize the distribution of health conditions and behaviors within and among our population subgroups. Our advanced data architecture has been designed to interface with the Department across BHO, RCCO, SEP, CHP+, and other programs; we merge all data on member populations together in order to characterize the distribution of physical health conditions and outcomes when intersected with a behavioral health diagnosis (e.g. diabetes and substance use disorder). Additionally, we are able to enhance cross-program administrative and utilization datasets with externally sourced data, successfully building upon the Department's data systems without duplication. We have become a leader in identifying new ways to incorporate population-level and member-level social determinant of health data that is specific to the region and the Medicaid population. Unlike national health plans that seek to bring in

expensive third party social determinant of health data that may not be specific to the Medicaid population, we work within our own communities to map in appropriate data and make it usable, actionable and relevant to the management of the health of the populations. Colorado actively uses population-level data from the *Pregnancy Risk Assessment Monitoring System* (*PRAMS*)[2], *the Behavioral Risk Factor Surveillance System* (*BRFSS*)[3], *Colorado Health Information Dataset* (*CoHID*)[4] and surveys completed by the Colorado Health Institute. We work with partners to stratify those data by our own regional populations and use zip-code level correlations to join this data with claims and other administrative health care datasets we already have.

Additionally, we are the only Colorado health plan currently using member-level vital statistics data from the Colorado Department of Public Health and Environment (CDPHE) as part of the population health management strategy. We have successfully merged these data with claims data to deploy analytic models around prenatal care and birth outcomes, using this information to drive the development of appropriate interventions for the population. Integrating external data sets allows us to more characterize and stratify the population using a fuller array of elements, including social determinants of health, and makes the assessment and management of the population more sophisticated and targeted. For example, by accessing and merging birth certificate data, social determinants information, and administrative data, we found that women with less than a high school education received fewer prenatal visits, which was associated with greater frequency of preterm birth and low birth rates. Further, as reflected in Figure 15-3, by stratifying across three RCCO regions, we learned that women with less than a high school education represent a substantial proportion of each regional population, but are most prevalent in northeast Colorado ($\chi 2 = 105$, df = 8, $p < 0.001$). This detailed analysis then informs our intervention planning, such as using the most intensive outreach and care coordination services for women with less than a high school education.

FIGURE 15-3 MATERNAL EDUCATION BY REGION



[2] Centers for Disease Control and Prevention (CDC). 2016. *Pregnancy Risk Assessment Monitoring System*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
[3] Centers for Disease Control and Prevention (CDC). 2016. *Behavioral Risk Factor Surveillance System Survey Questionnaire*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
[4] http://www.chd.dphe.state.co.us/cohid/

Our integrated strategy also encompasses the philosophy that no one single entity can effectively meet all the needs of a population. Rather, population health management requires collaboration and partnership across systems to ensure that the appropriate intervention is delivered at the right time and place to the right member. Over the past two decades, we have established and led a collaborative infrastructure in Region 3, including health care, social, and community entities. Our strategy recognizes that a member's health is influenced not only by access to appropriate health care services, but also by social determinants of health such as income, culture, race, age, family, housing, education, community environment, and employment. The Colorado Access Opportunity Intervention outlined in Appendix I adopts the Colorado Opportunity Framework and the Life Course Model to implement community-level systems coordination across community programs that serve members. The intervention implements an iterative community-level resource inventory to identify evidence-based interventions, promising practices and entitlement programs that align with the framework indicators, address the social determinants of health, and support members in achieving economic self-sufficiency. We then act as the facilitator to align these interventions and programs with the health care delivery system in order to strengthen the entire system serving members.

We are a leader in leveraging and building upon the raw data and metrics produced by the Department—including analytics provided by the SDAC (now Health First Colorado Data Analytics Portal), raw claims, enrollment and attribution data, roster files, community-based program utilization data, health information exchange (HIE) data, etc. We were the first health plan in Colorado to receive the CORHIO HIE data feeds and have been recognized as a pioneer for other health plans to follow suit. We were also a leader in establishing an agreement with Women, Infants and Children (WIC) to receive monthly utilization data. This agreement, while implemented at the regional level, was completed through the State WIC Office at the Colorado Department of Public Health and Environment; as a result, it can be adopted by other RCCO regions interested in using this data for population management.

We have the technical experience and programmatic capabilities to combine multiple datasets with behavioral health claims and demographic data in order to conduct sophisticated analytics that give a comprehensive understanding of our member population and the distribution of health outcomes and behaviors. We have learned that no single data source or stratification model is sufficient to describe or inform interventions for all subsets of our member population, and we are continuously seeking new opportunities to share and leverage multiple sources of member data to advance our approach.

Colorado Access: Pioneering External Data Exchange for Comprehensive Population Management

Hospital and Admissions-Discharge-Transfer (ADT) Data: While critical to population and operations management, claims data have inherent limitations; perhaps most notably lag time. To better support providers with real-time indices of utilization, we established individual data sharing agreements with Banner Systems hospitals in Regions 2 and 3. These agreements broke new ground in identifying legally compliant ways to provide the health plan and primary care providers real-time, actionable hospital and ADT data in order to drive timely interventions and support successful transitions back to the community. For providers to meaningfully use this type of information, it must be accessed at a systems-level and distributed in provider-specific subsets. As the RCCO and BHO in Region 3, we provided systems-level leadership in this hospital and ADT data access system. Colorado has since implemented a statewide platform, CORHIO, to aggregate this type of information

across providers and regions. As the state-level effort built upon our pioneering efforts, we fully supported its potential and became the first health plan to contract with CORHIO. While CORHIO's data feeds now include a variety of efficiently produced metrics, initial data sets were a deluge of new and diverse challenges that yielded a wealth of experience and understanding of existing data and analytics opportunities for us to build upon and share with providers and partner RAEs. In addition, the experience of establishing direct data-sharing processes with individual hospitals and systems and the capacity to receive, interpret and analyze raw hospital and ADT data is still a significant asset, as some hospitals do not connect to the CORHIO platform. For example, we directly access hospital and ADT data from Denver Health – an entity that serves a large number of Medicaid members from across the state. Our approach – leveraging the state's data systems and developing regional, customized interfaces—has significantly advanced the ability of the RAE partners in Region 3 to manage member panels and drive outcomes such as improved key performance indicators (KPIs). This critical regional leadership and innovative function could not be fulfilled by either the state or by individual provider systems. While the efforts to establish this data system are substantial (i.e. legal, compliance, and technical), we have been able to build upon long-term relationships with the State and the regional providers to develop trust and commitment to the shared outcomes for the region and members.

We are highly experienced in implementing risk stratification models and will build upon, rather than duplicate, risk stratification data produced by the Department. We are experienced in using the clinical risk group (CRG) model defined by 3M/Treo Solutions and the anticipated Verisk DCG (diagnostic cost group) deployed by Truven Health Analytics. Our leadership as the RCCO allowed us to identify ways to enhance the risk stratification deployed by the Department in order to further refine our segmentation of the population and create a holistic lens of the member. For example, our Avoidable Emergency Department (ED) Intervention is a population health management intervention that leverages the CRG model (and, in the future, the DCG model) to risk stratify the population and deliver a targeted intervention to members who may use the ED for unnecessary reasons. The program enhances this risk stratification by also including our Cost of Care Risk variable and Service Risk variable. Through learned experience and an iterative program evaluation process using a nationally recognized analytics vendor, NextHealth Technologies, we identified that some of the members enrolled in the Avoidable ED Intervention, while categorized as appropriate per the 3CRG stratification, had utilization patterns that indicated a misalignment of intervention and member-identified needs. Some members enrolled in the intervention had a high utilization pattern, indicating a need for more intensive care coordination versus a population health approach. Other members enrolled in the intervention were already highly engaged in appropriate primary care provider (PCP) care, indicating their enrollment in an intervention focused on primary care medical provider (PCMP) engagement to be misaligned. As a result, we enhanced the stratification of the population to also include our Cost of Care and Service Risk variables, noted below in Table 15-4, both of which integrate physical and behavioral health data, to obtain a more holistic lens of the target population and ensure the right intervention was delivered to the right members.

TABLE 15-4 COST OF CARE AND SERVICE RISK

Cost of Care Risk	Service Risk
A discrete variable that reflects risk of total cost of care based on previous utilization behavior across pharmacy, physical health and behavioral health claims. This also	A continuous variable that reflects risk of high cost health care services without engagement in primary or outpatient care.

Cost of Care Risk	Service Risk
reflects anticipated cost of care of managing this member through care coordination and population-based intervention. Members are classified as one of the following: • High • Medium Sub-Acute • Medium Stabilized • Low • Unknown/Lowest	Service risk identifies the number of outpatient visits and compares these to the high and medium risk categories. Comparing outpatient to medium and high risk members creates a measure of engagement relative to high cost service utilization, which then informs care management on assessment of priority members for outreach.

We are committed to continuing to partner with the Department and stakeholders to develop an Accountable Care Collaborative stratification framework that will be used to support program evaluation and to facilitate the transition of members from one RAE to another RAE.

At Colorado Access, we have broken new ground in successfully obtaining and leveraging external sources of social determinant data to better understand and serve members. Health care providers need social data for their populations – aggregated, reported, and displayed in user-friendly formats in order to understand and apply information. However, it is not realistic or efficient for most providers to conduct this work or for the state to customize and adapt their data for specific provider or subpopulation needs. As the RAE, we will continue to serve a critical role as a leader in leveraging and combining multiple datasets, analyzing this information to inform population health management approaches, and providing actionable, user-friendly data to providers to help drive improvements in care delivery. This work not only currently benefits our members and providers but also sets forth a framework for RAEs across the state to replicate and benefit from.

Intervention Based on Stratification

We have a comprehensive, data-driven approach to population health management. Interventions are designed with a programmatic infrastructure where multiple sub-interventions may be included in one major intervention in order to support members with wraparound services at all life stages and levels of health. Population health interventions are high frequency (targeting a large number of people) and low touch (a focused/brief interaction that may be one time or ongoing but limited in nature). These interventions often leverage community partners and focus on outreach efforts to engage a population in seeking a health care service or engaging in a health-related behavior. Care coordination is a complementary component of our integrated population health management approach, with member interaction frequency and duration/intensity that is tailored to individual member needs. This complementary component typically is higher touch (i.e. longer/more intensive interactions that may be ongoing or repeated at consistent intervals) for higher-risk members. The two departments work in a synergistic and dovetailed fashion to deliver a continuum of interventions that are driven by our risk stratification model.

POPULATION HEALTH MANAGEMENT

As the RCCO in the first phase of the ACC, we have gained extensive experience in applying and utilizing a risk stratification model to drive interventions and the stratified management of our populations across a risk

spectrum. We have also gained extensive capacity around supporting providers and community partners in understanding, and utilizing, risk stratification models – including how to incorporate these models in a way that complements what a practice may already be using. We use a variety of clinical and administrative data (e.g. raw claims, SDAC/BIDM, eligibility and enrollment, etc.) to understand members' health needs and risk factors, and, based on this extensive experience, are well adept in identifying opportunities to enhance our work rather than duplicate what the Department has already done. We will continue to design our population health management plan according to the agreed upon statewide stratification model developed by the Department and will work in collaboration with other RAEs to ensure there is a seamless transition of the management and support of a member who moves between the RAEs.

We are adept at applying a risk stratification model that is actionable and allows for easy identification of individuals or populations who change stratification levels, particularly into higher risk categories. Through experience, we have identified that it is critical to have timely updates of a stratification model and therefore refresh our models every 30 days in alignment with new monthly data files received from the Department. We will continue to refresh the statewide stratification framework developed by the Department and its partners in alignment with the receipt of new data files.

We are also skilled at identifying emerging risk within its populations through the implementation of stratification models. Through our sophisticated analytics capacities, we create dashboards that allow us to identify members who have changed stratification levels since the last refresh 30 days prior. Change in category over time (e.g. from low to moderate risk) is actually more indicative of the need for intervention than the original risk category in many instances. Our internal models are able to detect slight changes in risk level in order to intervene as early as possible. We will continue to deploy this type of tracking with the statewide analytics framework and will support our network providers in also incorporating this into their systems.

On the next page is an example of the adult population health management crosswalk for Region 3 that reflects a comprehensive approach of interventions across each level of risk. All members are engaged in at least two interventions each year, regardless of risk level and age. Most members are engaged in more than two interventions. Please refer to Appendix I for additional information as well as the pediatric population health management plan:

Stratification Level	ASPIRE Program	Colorado Access Adult Wellness Program	Colorado Access Opportunity Program	HEAL Program	Chronic Disease Prevention & Management Program	ED Follow Up Program	Special Populations Program	Healthy Mom Healthy Baby	Colorado Access Adult Wellness Program	Tobacco Prevention and Cessation Program	Avoidable ED Program	Colorado Access Integrated Care Management Program	Opioid Surveillance Program	COUP	Transitions of Care Program
Low Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
High Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	
Low Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	
High Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓

We use evidence-based practices as the foundation for our population health management plan and then tailor our work to reflect promising local initiatives and entitlement programs (e.g. SNAP, TANF, etc.) when appropriate. The frequency of interventions can vary from brief (member is enrolled in intervention less than 30 days) to long-term (member enrollment in intervention spans multiple months). Interventions are launched in monthly waves, meaning the target population is newly identified each month based on updated risk stratification data and other analytics. Interventions are delivered in multiple modalities, including interactive voice response (IVR), text messages, email, telephonic care management, and in-person care management delivered in the community and/or clinic setting and telehealth. PCMPs, community agencies, and other network providers are actively engaged in the delivery of interventions and may act as the primary delivery system implementing the intervention with the RAE acting as the facilitator and back up support system for the clinic. Members within all risk levels and across all interventions are actively engaged to connect with a care coordinator.

We also incorporate the Colorado Opportunity Project's endorsed interventions in our population health management plan through the Colorado Access Opportunity Intervention. We participated in the Department's proof of concept of the Colorado Opportunity Framework (entitled the Colorado Opportunity Project). Through our Colorado Opportunity Project liaisons, who are part of our population health department, we successfully demonstrated our expertise in understanding the communities we serve while acting as a liaison to the Department on the framework and Department's goals with the project. We have been recognized as a leader with this work, having modeled the level of excellence and innovation desired by the Department across all regions. In early 2017, the lieutenant governor of Colorado visited northeast Colorado and specifically wanted to hear about the work Colorado Access was doing on the Colorado Opportunity Project.

We plan to continue supporting the implementation of the framework through our Opportunity Intervention, which is delivered across all risk levels of the population. The intervention adopts the Colorado Opportunity Framework to implement community-level systems coordination across interventions that serve Medicaid members. As part of the intervention, we conduct an iterative community-level resource inventory to identify evidence-based interventions, promising practices and entitlement programs that align with the framework indicators, address the social determinants of health, and support members in achieving economic self-sufficiency. Each program identified through the Opportunity Intervention has its own set of process and outcome metrics that are measured at a local level, often in partnership with a community partner. For example, as part of our pilot project work, we successfully established a new partnership in northeast Colorado to implement Colorado Youth Matter's Wyman's Teen Outreach Program, an evidence-based program identified within the Colorado Opportunity Framework that focuses on at-risk youth and intended pregnancy. The program emphasizes community service, and program outcomes measure the increase of self-reported resiliency among the youth. We partnered with a local community nonprofit organization, Rural Communities Resource Source Center and Colorado Youth Matter and provided the seed funding to implement the program, which is self-sustaining after the first year. Additionally, we partnered with the Piton Foundation to increase utilization of the Earned Income Tax Credit (EITC), which is also recognized under the framework, and is a tax credit for populations who file their taxes and are below a certain income level. Unfortunately, individuals most in need of this tax credit don't receive it due to being below the income threshold that requires filing taxes. Through a direct mail campaign, we provided myth-busting education and information to members about filing their taxes to receive the EITC and identified the closest site to get free help filing taxes. For a description of all other Colorado Access Population Health Management Plan interventions, please refer to Appendix I.

Colorado Access: Proactively Moving Through all Life Stages of the Colorado Opportunity Framework

While the proof of concept phase of the Colorado Opportunity Framework focused on the Family Formation life stage, we have already completed a crosswalk of internal interventions that align with the Colorado Opportunity Framework. We believe in the success that this framework can bring to members and their communities. For example, we understand how critical the "Decline and End of Life" life stage is for some of our most vulnerable members and the need to address the indicators included in this stage of life, such as falls and use of hospice and other end-of-life services. As part of our ongoing care coordination work, we provide referrals to A Matter of Balance, a local promising initiative delivered by our community-based partners, like Tri-County Health Department. Our intensive care coordination also supports these members and their family supports in planning for, and accessing, hospice care early on in the decline phase and is further described in Offeror's Response 16—Care Coordination.

Population Health Management: Planning and Implementation

We will engage members and network providers in developing and revising the population health management plan. We will share the final plan with network providers and PCMPs and assist them in delivering care coordination, wellness activities, and other population health management interventions based on the population health management plan. We already engage both members and PCMPs in delivering population health management interventions and are skilled at providing support that is locally tailored and reflective of the community's needs. For example, our Adult Wellness Intervention adopts the United States Preventive Services Task Force (USPSTF) A and B preventive screening guidelines and aligns these with evidence-based interventions that are proven to increase screening rates. This includes colorectal cancer screening combined with reducing barriers to timely screening and increasing PCMP engagement. We utilize our colorectal cancer clinical registry to identify target populations out of screening compliance per USPSTF guidelines and mail fecal immunochemical test (FIT) kits. Members who participate in the program receive follow-up care coordination support to ensure they understand their results and are following up with their PCMP for next steps. The PCMP is also actively engaged and receives a copy of the member's test results. In the first year of the intervention, we had a member response rate of almost 20%, which is comparable to national commercial plans' experience with privately insured and Medicare populations. Additionally, those who returned a FIT kit were more likely to then engage with the health care system and an outpatient provider as compared to members in need of screening who did not participate in the intervention (OR = 0.67, $p<0.001$).

A program refinement opportunity was identified by evaluating the undeliverable mail rate; it was noted that a group of members were unable to participate due to having a homeless day shelter listed as their primary residence. These facilities do not accept bulk mail due to space issues. To address this barrier, we worked with the local facilities and the Stout Street Clinic to design a solution that reflected community needs, and hand-delivered member communications and FIT kits directly to their PCMP clinics to improve participation by this group of members. As a result, more than 1,500 additional members will be served in 2017. Another program improvement was based on feedback from PCMPs, who requested additional support before and during the campaign so that they could better provide screening and follow-up services. We have partnered with the Colorado Colorectal Screening Program (CCSP) through the University of Colorado to provide additional education, information, and support to our PCMP practices. By partnering with CCSP, we have been able to enhance our program by providing valuable data and statistics on the current state of colorectal cancer in Colorado and facilitated bringing a comprehensive training on patient navigation into PCMP offices that included education on colorectal cancer and screening modalities. These trainings now occur twice per year and

have allowed us to meet the community-defined needs of our clinic partners and connect our own PCMPs to local experts and support systems that improve the delivery of care to members. For an overview of our other Population Health Management Plan interventions, please refer to Appendix I.

Care Coordination

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.

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.

Introduction

Our comprehensive population health management approach encompasses both population-based interventions and care coordination in a seamless, integrated system. It is driven by a robust understanding of members' experiences and a sophisticated, dynamic stratification of the population's needs. The intent of the programmatic design is to meet the behavioral/physical health risk and complexity needs member populations. Population management and care coordination are aligned programs that are designed to operate on a comprehensive continuum. They arise directly from the population modeling work. This ensures that the care coordination efforts are aligned seamlessly with the overall population health management plan, respond dynamically over time as needs and opportunities evolve, and **deliver the right intervention at the right time and place to all members – across the full continuum of care.** Our approach leverages the deep experience that our community and provider partners have serving members and incorporates the proven local solutions that have been developed. At the same time, there is intentional system design and oversight to ensure that the needs of all members are being met, that duplication is avoided, and that services are effective. The care coordination system, as part of the overall population health management approach, is continuously evaluated for effectiveness, impacts on health, costs, and member experience, and opportunities for improvement.

System Design

Our care coordination system is **member-centered**, **evidence-based**, and **locally tailored**. The **member-centered philosophy** drives service delivery in key ways: all members have access to care coordination when they need it or request it; services are provided as close as possible to the member and the point of care; interventions are culturally competent, strengths-based, and trauma-informed; the member's needs and preferences are prioritized rather than the health care system's needs; interventions are flexibly tailored to a member's unique situation rather than following a rigid protocol. Our care coordination system uses proven, **evidence-based practices** wherever possible and promotes and evaluates promising practices throughout. The focus on evidence-based practices ensures we apply defined interventions to specific populations for which they have been shown to be effective. This targeted approach focuses resources more efficiently where the members are most likely to benefit. The commitment to using and evaluating promising practices is an extension of the

evidence-based approach. Where there are clear needs and a lack of evidence-based options, with our partners, we are proven innovators in developing new care coordination models, accompanied by rigorous evaluation. The commitment to using evidence-based and promising practices in a data-driven fashion ensures that resources are put to the most effective use; specifically that they are member-centered and reduce member exposure to interventions that are not relevant. Another major strength of our population management and care coordination system is its **locally-tailored** design. Unlike national health plans that have a predefined set of programs that are organized centrally, we emphasize and leverage local, on-site resources for care coordination. We provide an extensive array of proven care coordination programs (Appendix I) and have designed and delivered more than 15 population-based interventions for members that include prevention, wellness promotion, disease management, addressing social determinants of health, and ensuring appropriate utilization of health services.

For example, in Region 3, we collaborated with Tri-County Health Department to create a model for care coordination and consultation that targets members enrolled in the health department's Healthy Communities Program (formerly Kids with Special Health Care Needs). Collaborative goals include increasing coordination of existing caseloads and establish clear roles across care coordination programs. This program has proved so successful that it has been replicated in Region 2 as a collaborative effort of Colorado Access (COA) and the Northeast Colorado Health Department.

We support our care coordination teams with a high level of **clinical expertise and medical leadership**. This multi-disciplinary team includes a diverse array of clinical disciplines and experiences, including psychology, nursing, social work, addiction counseling, etc. under the leadership of physicians in several specialties: pediatrics, family medicine, psychiatry, emergency medicine, and others. The physicians conduct routine case reviews and provide direction to care coordinators for complex and high-risk members. Our medical directors also provide regional leadership, outreaching and convening providers and systems when necessary to align care plans, clarify responsibilities, and mobilize resources. Our medical directors work and practice in the Region 3 community and are respected as premier clinicians and leaders, able to effectively collaborate with colleagues and systems based on both their expertise and a shared commitment to the members in our community.

Regionally Tailored Implementation

As the Regional Accountable Entity, we will serve as the region's leader in designing the overarching care coordination system, establishing standards, providing tools and training, managing data and reporting, and evaluating the effectiveness of care coordination activities. This locally tailored system will leverage care coordination activities delivered by a range of entities in Region 3 including primary care medical homes, other providers and community partners, and COA-based teams. This multi-pronged approach allows the needs of all members to be met in a locally tailored way, builds on existing services and resources, and creates flexibility for both members and providers. Below we describe the roles of the primary care medical providers (PCMPs), other providers and community partners, and COA-based teams in the regional care coordination system.

We have been a statewide leader in **advancing the vital role of primary care medical homes in care coordination** and sees them as the keystone of care coordination delivery. Care coordination at the PCMP site supports member engagement at the point of care and leverages local expertise and linkages to the surrounding health community and medical neighborhood. As the Regional Care Collaborative Organization (RCCO) contractor in Region 3, we are supporting 98 practices to deliver care coordination, of which 73 have

achieved enhanced PCMP (ePCMP) status, and 12 are participating in the State Innovation Model (SIM) initiative. We have a robust practice transformation and support team that provides technical assistance, training, oversight, coordination, and other resources to PCMPs. Before assuming care coordination responsibilities, PCMPs go through a rigorous application process that includes an on-site assessment and staff interviews. The onboarding process includes training on care coordination tools and procedures, establishing effective connections to other systems and resources, and creating data exchanges to facilitate care coordination. Key functions of PCMP-based care coordination include screenings and assessments, care plans, referral management, linkage to specialists and community resources, preparation for appointments, medication support, registry management, and quality improvement activities. Our investment of financial resources and practice transformation assistance has prepared our network providers for the next phases of transformation and payment reform. As the Regional Accountable Entity (RAE) in Region 3, we will continue to advance the implementation and evolution of PCMP-based care coordination and its seamless integration into the region-wide system of care.

In addition to primary care medical homes, **local providers and community-based entities are critical components** of our care coordination system. We partner with community mental health centers, hospitals, community-centered boards, health workers from local neighborhoods and cultural groups, health alliances, correctional systems, and others in the delivery of care coordination and related services. Because of our local presence and the depth of regional partners' knowledge and resources, we are uniquely positioned to leverage, coordinate, and evaluate an array of local, on-the-ground activities; so they function smoothly as a well-coordinated system of mutually reinforcing activities that are efficient, effective and non-duplicative. One of our most successful community care coordination initiatives arises from the relationships that we have with local hospital partners to serve more members at the point of service. Colorado Access care coordinators are placed in emergency department (ED) settings to outreach and assess members who do not require immediate emergency care. The embedded care coordinators provide a range of interventions: alternatives to ED or inpatient services, connection to a primary care provider, referrals to social service agencies, and connections to ongoing care coordination if needed. These hospital partnerships have been very beneficial to members who are seeking services but have access issues with the health care system and/or social barriers that cannot be fully addressed in an ED visit. Our care coordinators have also been embedded at inpatient psychiatric facilities to support discharge planning and transitions of care back to the community. They facilitate the transition process by supporting referrals and appointments, ensuring proper medication reconciliation between care settings, assessing the member's social supports and resources (such as transportation), and ensuring that any additional needed service or care is properly initiated. We will continue to develop and expand these hospital care coordination initiatives, evaluate their effectiveness, and expand them to additional facilities and settings.

We directly deliver or organize certain care coordination activities centrally for the entire region, supplementing (not duplicating) the activities provided in the PCMP and other community settings, as described above. These are generally those activities that are done best at a larger scale, involve digital delivery mechanisms, require intensive/complex interventions, etc. Our care coordinators are mobile in the community and go on-site to homeless shelters, community centers, hospitals, and other locations. Additionally, our centralized telephonic care coordination team serves as a hub and a resource for members, care coordinators, and providers throughout the region; providing on-demand assistance, consultation, information, resources, and linkage.

Person and Family-Centered Approach

Our care coordination system is designed to meet members' needs and preferences in a **person-centered, culturally competent fashion**. Rather than using a single care coordination protocol or applying a rigid set of disease management programs, we approach each member as a unique individual, to be understood and assisted in ways meaningful to them. Using a semi-structured assessment tool that assesses physical health, behavioral health, and social/cultural/spiritual needs, care coordinators are able to quickly identify members' priorities, build on strengths, and develop individualized plans to meet both short-term and longer-term goals. Care coordinators also leverage clinical, utilization, and care coordination information across systems to inform their understanding of the member and decrease the burden of repeated history taking.

The individualized plan addresses gaps and needs that the member is experiencing and prioritizes activities according to their preferences. The focus areas may arise from a variety of factors: medical issues, barriers to accessing health care services, behavioral health diagnoses, social stressors, financial crises, navigating other systems, spiritual needs, end-of-life planning, etc. The care coordination activity aims to meet the member's immediate priorities and short-term needs first. This may include rapid access to health care services for a newly diagnosed medical problem or dealing with the loss of housing or benefits. As appropriate, members are then engaged in addressing longer-term needs such as better self-management of complex conditions. Throughout the process, the care coordination aims to increase member activation and engagement in their health and wellness. Privacy is also a key component in member engagement. We follow all applicable regulations and standards and proactively communicate with members about information sharing, emphasizing the member's choice in whom to include in communications about the care plan.

In order to be effective, care coordination must be **culturally responsive** to the member's needs. We have designed all care coordination activities to be culturally responsive, reflect member needs and preferences, and increase member choice. We implement a robust cultural competency training program for all COA staff members that emphasizes members' lived experiences and perspectives. This training is also delivered to network providers. In the array of community-based care coordination, we partner with local faith-based, culturally based, and lay/peer resources to deliver care coordination to members. Evidence demonstrates that certain aspects of health promotion interventions are more effective when provided through these approaches rather than by providers or health plans.

We ensure that care coordination is **readily accessible** to all members. This accessibility is achieved through several mechanisms, including having care coordination available at the primary care medical homes and other key touch points such as emergency departments and social services agencies. Additionally, we provide on-demand telephonic care coordination to all members through a toll-free number from 8:00 AM to 6:00 PM. This service connects members and network providers to care coordinators in real time and provides a range of interventions, information, services, resources, and supports immediately. Follow-up care coordination and linkages to additional services are seamlessly arranged, when appropriate. This on-demand care coordination service is staffed by bilingual English-Spanish personnel and utilizes state-of-the-art translation technology so that all members can be served immediately in their preferred language. We have a well-established partnership with Rocky Mountain Crisis Partners; our care coordination staff has been trained to identify and support members who may be experiencing a behavioral health crisis and seamlessly access the Colorado Crisis and Support Line or other services in the Colorado Crisis System.

Our care coordination program is supported by robust expertise and resources for **persons with substance use disorders.** Based on our role as the Behavioral Health Organization (BHO) in two regions, we have developed an extensive provider network for Medicaid-covered services for substance use disorders as well as an effective collaboration with Signal, the Managed Service Organization (MSO) serving Region 3, for services not covered by Medicaid. Signal's network of providers is also contracted with Colorado Access for Medicaid-covered substance use disorder services. This will allow providers to use MSO funds to provide a comprehensive array of services. Our care coordination staff includes clinicians with advanced training and credentials in substance use disorders and treatment; these care coordinators serve as a resource for other care coordination staff in the region and point of contact for substance use-focused agencies. Additionally, our practice transformation and support team is currently training several PCMPs to increase their skills and resources to identify and coordinate care for persons with substance use disorders in that setting.

We have a well-established and effective care coordination model for members with **intellectual and developmental disabilities**. Having served as the Medicaid contractor for both physical health and behavioral health programs, our care coordination teams are well equipped to assist members and families to access a full array of clinical and community services and social supports. Using a supportive, collaborative approach, we use a member-centered comprehensive health needs assessment to identify needs/preferences, current barriers, and resources. Individualized care coordination services are driven by that assessment and may include: coordination of care among PCMP provider, behavioral health provider(s), and other medical specialists; identification and recommendations for services covered under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); referrals to a community centered board (CCB) or Single Entry Point (SEP) to access waiver services; and coordination with the educational system for individualized educational plans (IEP) and behavior plans. Our care coordinators participate as appropriate in interdisciplinary team meetings (e.g. VOICES meetings, Creative Solutions Meetings) and help members and families access community resources and supports, such as HCP (previously Health Care Program for Children With Special Needs), Healthy Communities, advocacy agencies, respite care, specialized programs at the Children's Hospital and Aurora Community Mental Health Center, and other resources.

In order to ensure that care coordination is provided seamlessly to members who are transitioning between health care settings, and populations who are served by multiple settings, we have a **designated care coordination point of contact** for the following systems in Region 3: substance use-focused agencies, intellectual and development disabilities, criminal justice agencies, child welfare (departments of human services), long-term services and supports (LTSS), skilled nursing facilities (SNFs), state mental health institutes, the Colorado Crisis System, and others. These staff members have extensive knowledge, training, and experience in the respective areas and are further supported by ongoing training and the robust resources of the clinical team described above. These staff members are responsible for supporting the Department's activities for their respective areas and participate in trainings, work groups, etc. as required.

We will continuously evaluate success in the implementation of a person-centered approach by using multiple channels to derive input from members. Our member advisory councils are designed to solicit ongoing feedback about the member experience, including the accessibility, responsiveness, and effectiveness of care coordination services. Additionally, we conducts periodic member surveys to assess how we are meeting members' care coordination needs.

The population health and care coordination departments design and implement interventions to meet members where they are. We recognize the necessity of incorporating member-centric data into our programming to ensure that we are able to efficiently and effectively reach members. In an effort to bring this work to scale, we designed a new member welcome program that uses targeted technology to improve our call center outreaches, improve member experience, drive outcomes, and reach larger numbers of members. We utilize a state-of-the-art customer relationship management platform that allows us to: gain visibility among members by strategically and systematically responding to member needs; increase the efficiency of our programs by using members' preferred channels of communications for outreach and limiting over-communication; manage costs by leveraging combined messaging and utilizing lower-cost electronic communication channels (e.g. text messages). Through the new member welcome program, we collect member data including demographics, location, language preference, and communication channel preference. These data are entered and stored in our customer relationship management platform and incorporated into future population health and care coordination programs and interventions.

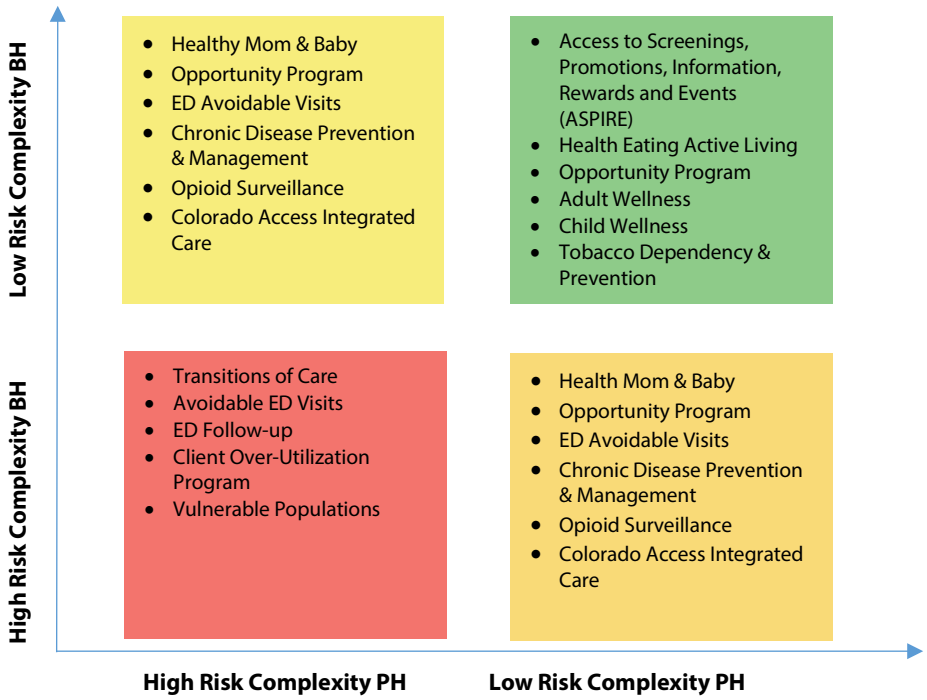
Care Coordination and Population Health Management – A full Continuum of Care

We use a sophisticated, dynamic population stratification model to ensure that the right population management and care coordination activities are strategically applied across the entire population (see Offeror's Response 15—Population Health Plan Management and Strategy and Appendix I). This model considers utilization risk, service risk, and clinical risk factors and generates three broad risk categories that are used as the framework for care coordination activities. The Colorado Access Risk Model has supported the identification of the following programs to meet member needs in Region 3. Our continuum of care coordination activities includes the following:

Wellness Programs	Ongoing Care Programs	Utilization Programs
• Healthy Mom Healthy Baby • Access to Screenings, Promotions, Information, Rewards and Events (ASPIRE) • Healthy Eating Active Living (HEAL) • Opportunity Program • Opioid Surveillance Program • Adult Wellness • Child Wellness • Tobacco Dependency & Prevention	• Vulnerable Populations • Chronic Disease Prevention and Management • Colorado Access Integrated Care Management	• Avoidable ED Visits • ED Follow-up • Transitions of Care • Client Overutilization Program

In meeting members' needs across the continuum of care, having the right array of programs such as those listed above is only the first step. **Matching the individual members and sub-populations to the right intervention type at the right time and place is what really drives the effectiveness of the care coordination system**, including the right intensity, duration, and frequency of interventions. We assess member needs through both the population stratification work and individualized assessment tools and apply evidence-based or promising practices and rigorous program evaluation. This proactive design process yields a robust array of services that is highly coordinated and continuously evaluated for effectiveness, duplication, and gaps.

The diagram below illustrates how some of our care coordination activities are matched to specific segments of the population based on complexity and risk.



We use **multi-channel modalities** to efficiently and effectively deliver population management interventions and care coordination in a person-centered, non-intrusive manner. Digital interventions are well suited for prevention/wellness activities across broad populations, but may also support targeted interventions for medium and high-risk categories.

Care Coordination Channel	Examples of Methodology & Frequency
Person-to-Person Interactions with Members	• Visits provided in the home, provider offices, other settings • Motivational interviewing and goal setting • Patient activation, self-directed care, peer specialist support • Episodic, focused care coordination (e.g. crisis, new event) • Transitions of care • Members with high-risk/complex needs
Telephonic Care Coordination	• Utilize member-specific registries to identify and manage a defined population (diabetes, asthma, non-attributed etc.) • Member engagement and onboarding • Health needs assessments and screening • Referral and linkage to primary care, medical specialists, home health providers • Utilize resource databases to access right type of service (e.g. 311, Aunt Bertha, Colorado Access internal resource directory)

Care Coordination Channel	Examples of Methodology & Frequency
	• Condition-specific education and follow-up (e.g. COPD), self-management support, medication adherence support

Digital Programming	• IVR (interactive voice response) campaigns: all IVR campaigns have the option for members to be routed to a live care coordinator.
	  • Preventive care screening reminders
	  • Wellness visit reminders
	  • ASPIRE: PCMP identification, communication preferences, wellness visit
	  • Pre/post-natal visit reminders
	• Text campaigns: many members prefer being contacted by SMS text. We have programming to deliver several targeted programs.
	  • Preventive care screening reminders
	  • Well-child check/Healthy Mom Healthy Baby program
	  • New member welcome program: PCMP identification, communication preferences, wellness visit
	  • Birthday reminder program: PCP identification, communication preferences, annual wellness visit
	  • Prenatal programming

Medical Neighborhood Care Coordination	• Care coordination services delivered by selected network providers to their attributed members
	• Care coordinator placements
	  • Community settings such as correctional systems, homeless shelters, community centers/agencies, and refugee centers.
	  • Hospital settings (ED and inpatient)
	  • PCMP settings
	• Intra-agency coordination

Other	• Direct mailings to members

We utilize a state-of-the-art **care coordination platform** and tracking system to support the above activities across the full continuum of care. Altruista's GuidingCare™ platform serves as the clinical documentation and communication system for all care coordination activities, as well as utilization management and customer relations management. This platform is designed to easily give a 360-degree view of the member's care coordination activities, other interventions, and clinical, social, and demographic data. The core architecture of the platform is based on the ease of viewing, accessing, and documenting items in any of the modules with the ability to view the whole member profile. GuidingCare™ is designed to support the entire provider network, as well, including non-traditional/non-medical services, and is recognized as a leading software solution in the LTSS area. GuidingCare™ provides both a team care plan as well as the member's service plan that can seamlessly drive authorizations within the utilization management module. Service interventions can be driven by an assessment within the system or manually entered by the care coordinator. Additional information on Altruista's GuidingCare™ platform is described in Offeror's Response 17—Provider Support Strategy.

COA: Aligning and Integrating, Efficient Cross-System Care Coordinators

Our care coordination system facilitates seamless care for members when there are multiple health care providers and other agencies involved and assures proactive communication, elimination of duplicative efforts, and continuity of care. **In Region 3**, we have developed integrated care coordination among LTSS, HCBS, and other programs focused on physical and behavioral health, as we manage Single Entry Point and RCCO contracts for Adams, Arapahoe, Douglas, and Elbert counties. As a result, we have been able to decrease complexity for members and providers and improve the quality and outcomes of care. Particularly for members involved in multiple systems, the primary care coordinator serves as a critical communication manager, keeping the member/family at the center of all activities and decisions, and involving providers, community services, and other agencies as appropriate. Because many community agencies who serve members also have varying elements of case/care coordination embedded in their systems, the primary care manager actively clarifies roles and responsibilities of each person/agency involved to eliminate duplication and prevent misaligned care plans. Additionally, we assign a primary contact person for agencies, such as county departments of human services, to address communication issues, establish workflows, and resolve problems.

In 2016, in partnership with the Department, we launched a novel pilot program to reduce care coordination duplication between the LTSS and HCBS waiver programs and the RCCO Medicare-Medicaid Program (MMP) program. We identified more than 1,400 members in Region 3 that were enrolled in both the LTSS waiver program and the RCCO MMP program. Both programs serve similar populations, have overlapping aims, and require similar activities, such as periodic functional and health needs assessments. Prior to the pilot program, there was at least one instance of a member having two care coordinators doing home visits on the same day. With support from the Department, we developed a model to integrate the work of both programs into a single team, cross training the staff, and assigning a single care coordinator to each member. While still a pilot program, the process outcomes of reducing duplication for members and increasing efficiency for the system have already been achieved. Members report less confusion and stress in working with just one care coordinator, and they feel more comfortable knowing that someone is supporting them to manage all of their needs.

Another key Colorado Access initiative to reduce duplication and provide a seamless, holistic member experience is our No Wrong Door (NWD) pilot program. Awarded in 2017, this Department-funded pilot aims to reduce complexity for community members seeking long-term services or supports for Regions 3 and 5. Most of these services are currently segregated into agencies ("doors") based on funding streams or eligibility criteria, making it very challenging for people unfamiliar with these complex systems to navigate. We have assembled a team of community partners committed to the NWD vision and developed a unique, low-cost bridging and linking system that brings person-centered options counseling directly to members, combined with a toll-free access line and increased public awareness.

Cross-system alignment and coordination are also enhanced by cross-training personnel who work with members at various touch points. We have successfully led or contributed to multiple training events for staff from regional agencies and delivery systems. These successful programs have aimed to increase attendees' knowledge of various systems, clarify benefits and resources, disseminate information regarding accessing services, and foster collaborative relationships. As the RAE, we will continue to lead these cross-training activities, based on needs and opportunities identified through the ongoing care coordination evaluation process.

Leveraging Evidence-Based Programming to Limit Inappropriate Overutilization

Our care coordination system includes a robust range of evidence-based programming to **reduce inappropriate overutilization of health care services.** We use a robust and sophisticated data and analytics approach to identify appropriate focus areas for these efforts, deploy evidence-based interventions to specific populations, providers, or individual members, and systematically evaluate the effectiveness and prioritization of these efforts. The impetus for addressing inappropriate overutilization includes not only cost containment for high utilizers (which represents a relatively small proportion of the population), but clinical appropriateness, member experience and quality of care, and enhancing efficiency and effectiveness for all members across the continuum.

We work across multiple systems to foster partnerships and programming aimed at identifying members who are utilizing health care services inappropriately and supporting their transition to the effective use of resources. Our care coordination activities play a central role in addressing the systems issues that contribute to inappropriate utilization of services (e.g. working with PCMPs to provide evening appointments) and also by providing individualized, person-centered care coordination interventions directly to members. Below we describe several key programs that we have implemented to address inappropriate overutilization.

We have a well-established **Transitions of Care (TOC)** model that has demonstrated effectiveness during the past five years. Adapted from the evidence-based Coleman model, this intervention is systematically applied to members who are being discharged from inpatient and emergency department settings and have characteristics that predict high risk for adverse outcomes, including hospital readmission within 30 days. This model delivers a standard set of evidence-based interventions that are modified based on member needs and preferences, including: post-discharge care coordination services (minimum 30 days, longer if needed), support back to home setting/social/environmental needs, discharge care plan education and support, illness education and self-management, medication education and assistance, coordination and support for outpatient follow-up visits and medical case review from the medical director. This program has demonstrated its effectiveness by decreasing 30-day readmission rates, increasing seven-day outpatient follow-up appointment rates, and improving medication adherence.

We are committed to reducing **unnecessary utilization of emergency department (ED)** services. Unnecessary ED visits occur for all segments of the risk stratification model, not just persons with chronic/complex/severe conditions, and for a multitude of reasons. There is no one size fits all solution. Designing an effective solution to reduce unnecessary ED visits requires a robust understanding of the drivers and opportunities for populations within the low, medium, and high-risk groups and application of evidence-based interventions to these identified sub-populations. Based on population stratification and the availability of evidence-based approaches, the medium acuity group represents the greatest focus for intervention. However, we have implemented a range of interventions to address unnecessary ED utilization for all members across the continuum, including:

Low Acuity	Clinical conditions: Colds, sore throats, etc. Frequency: One or more visits Reasons: • Don't know the best options for obtaining care • Unable to access medical provider in a timely fashion

	• Believe symptoms are too severe to be treated by primary care Solutions: • Care coordinator placed within the ED setting • Predictive modeling to outreach members to educate on PCMP services and help them engage with a provider • Fix barriers at the PCMP and systems levels that drive members to ED
Medium Acuity	Clinical conditions: • Ambulatory-care sensitive conditions such as asthma and COPD • Risk for moving into high acuity category Frequency: Multiple visits in a year Reasons: • Not sufficiently engaged in PCMP; need specialty access • Lack of illness education and self-management skills • Social barriers to addressing health needs Solutions: • Robust analytics program to identify this group via interactive visual analytic platforms • Registry systems to identify care gaps prospectively • Address social determinants such as lack of social supports • Transitions of Care interventions • Referral to well-established community-based multidisciplinary team programs, such as PCMP with highly integrated behavioral health access • Medical director case review and surveillance
High Acuity	Clinical conditions: Chronic diseases such as COPD, acute emergencies unrelated to chronic diseases Frequency: Can be up to multiple times per month Reasons: • Severe illnesses, multiple co-morbidities • Complex regimens, difficulty managing multiple appointments and providers • Not engaged in PCMP Solutions: • Identify those not engaged in PCMP and facilitate active engagement • Embed care coordinators in hospital settings to provide discharge services • Engage home-based health services • Our PCMP partners have two nationally recognized programs that address the needs of this population: 1. The Bridges to Care program (led by MCPN) and 2. Intensive Outpatient Clinic (IOC-led by Denver Health). Both programs provide comprehensive multidisciplinary care coordination services to high acuity members who are high utilizers of acute hospital services (ED and inpatient). All of these efforts have shown significant reductions in avoidable future ED and inpatient use, while improving outpatient utilization.

Preventing **unnecessary ED use for people living in skilled nursing facilities** (SNFs) has been a focal point for us for some time. Our unique perspective from managing the LTSS, RCCO and BHO contracts has helped create partnerships with large hospital systems to address this systems issue. We have played a pivotal role in

facilitating the exchange of information to teams across health care systems, identifying one point of contact for SEP specialists to conduct initial functional evaluation for hospitalized members and creating effective liaisons with SNF and hospital champions. In another innovative solution to reduce unnecessary ED visits, we support and promote ongoing hospital-SNF collaborations that allow nursing home staff members to consult with a hospital-based physician through telehealth services provided by the hospital 24 hours/7 days a week for questions/concerns.

We are in the process of developing a SNF quality of care dashboard that would allow us to look at ED use, hospital admissions, and outpatient utilization at the facility level. Through our visual and interactive data analytics platform, SNF report cards will be used as a tool to outreach SNFs to learn about ongoing quality processes, data sharing, and barriers to care that may lead to unnecessary ED visits. Conversely, we will use this tool to learn from SNFs that have high performance rates and network events where information sharing can occur, leading to process and outcomes improvement.

We support members and families who are in need of end of life care options or planning. Our care coordinators are trained to assess members for this need and appropriately link members to PCMPs or additional service providers, such as palliative care providers, hospice, or home health. Member engagement in palliative care and hospice services are member-centered, clinically appropriate, and effective at reducing inappropriate, unnecessary, unwanted, and potentially harmful ED visits for persons in end of life care. Additionally, care coordinators mobilize community and social supports appropriate to a member's needs to address nutritional, spiritual, and functional realms. The care coordination team facilitates this process and ensures that the proper documentation is included in the care plan and shared when appropriate. We also provide technical assistance with our practice transformation team to train PCMPs on evidence based guidelines on end of life care. Practice facilitators help implement these guidelines into the standard workflow and clinical documentation systems, train practice staff on additional services members and families may require and how to conduct end of life planning conversations with members and families at any time along the continuum of care.

We are fully prepared to support the Department's **Client Overutilization Program (COUP)** and will deliver appropriate and effective care coordination services for members identified as meeting criteria for this program. COUP is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. Based on the member's utilization profile and individualized assessment, we will develop individualized care plans that also align with COUP outcomes, addressing needs such as linkage and engagement with PCMP, ED alternatives for urgent situations, medication adherence support, social needs, linkage and engagement with mental health and/or substance use services.

We will perform additional analysis of members identified by the Department for the COUP program, including assessing for: PCMP attribution, PCMP visits, ED visits, ED risk factors, previous quarter high-risk medication count, and diagnoses. We will systematically track the outcomes of members in the COUP using a registry to measure the effectiveness of the interventions for this population and identify opportunities for refining its approach.

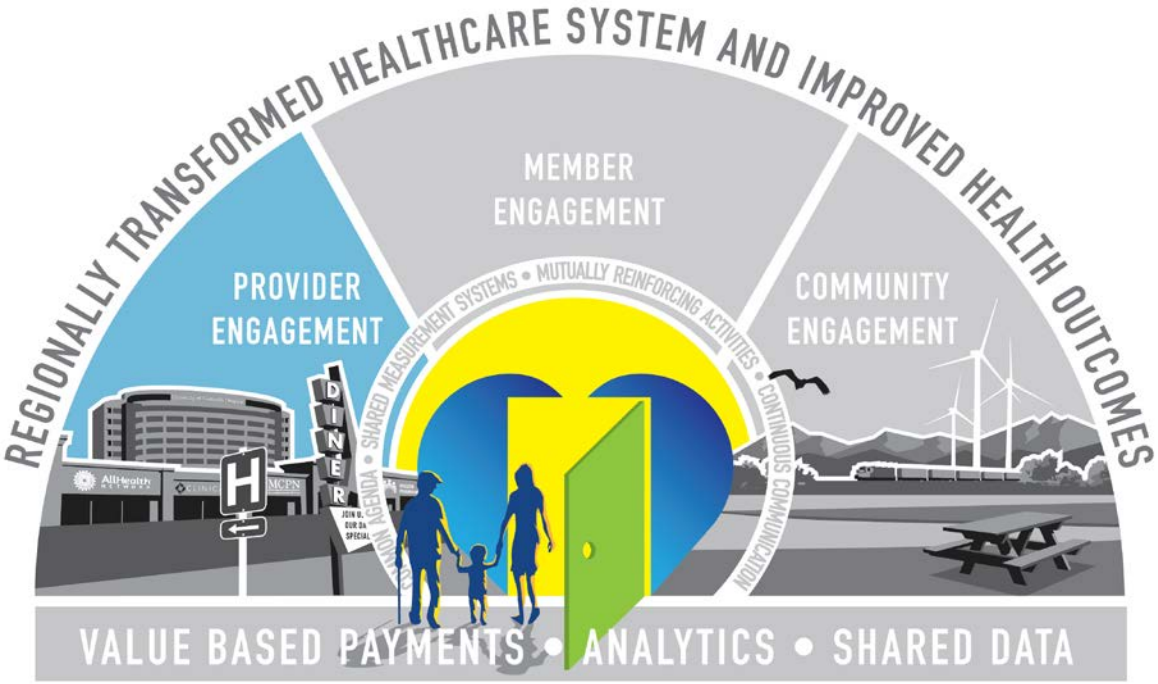
Provider Support and Practice Transformation

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.

EMPOWERING PROVIDERS IN A TRANSFORMING HEALTH CARE SYSTEM

The core of the Accountable Care Collaborative (ACC) is engaged and effective providers. Providers will need to play major roles in improving outcomes, controlling costs, enhancing quality, and ensuring a good experience for members. To achieve the overarching Regional Accountable Entity (RAE) aims, regional providers' efforts will need to be aligned with each other through the common agenda and aligned with other state and federal initiatives. Colorado has already made substantial progress in moving providers along the transformation continuum. Its investments in the Regional Care Collaborative Organizations (RCCOs), the State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+), and other initiatives have resulted in many primary care practices being well prepared for the next steps. Recent assessment from the Colorado SIM initiative estimates that approximately 60-70% of Colorado primary care practices are engaged in meaningful practice transformation and have many of the ten Bodenheimer building blocks already in place. Our vision as the RAE is to support practices in the next phases of this transition, giving them tools that are easy to use and supporting their development of next-phase skills: using cost data in a meaningful way to drive clinical and practice decisions and improve value; applying risk stratification models more effectively to inform resource allocation; and incorporating social determinants of health to improve quality and cost performance.

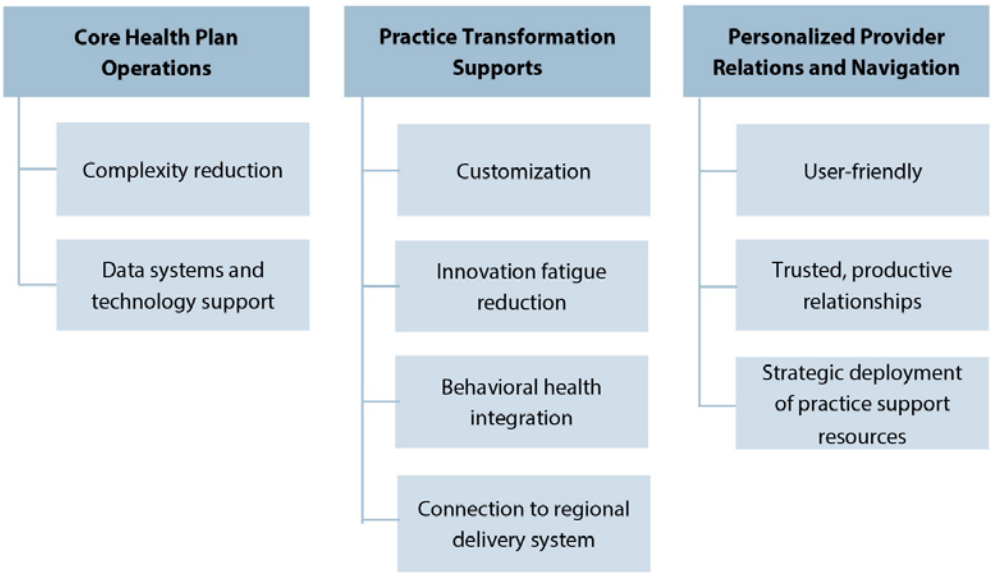


We embrace providers and provider groups as valuable community assets, building on their distinctive strengths and local expertise. We have a proven track record of strong provider engagement, nurturing long-standing productive relationships and building on a foundation of trust, accountability, and transparency. As the RAE, we will evolve our provider support model even further by enhancing three core areas: reducing complexity in core health plan operations; providing effective, individualized practice transformation supports; and delivering personalized provider engagement and assistance with system navigation based on the needs of each individual provider.

COA: A LOCAL PARTNER PROVIDING TAILORED SUPPORT FOR NETWORK PROVIDERS

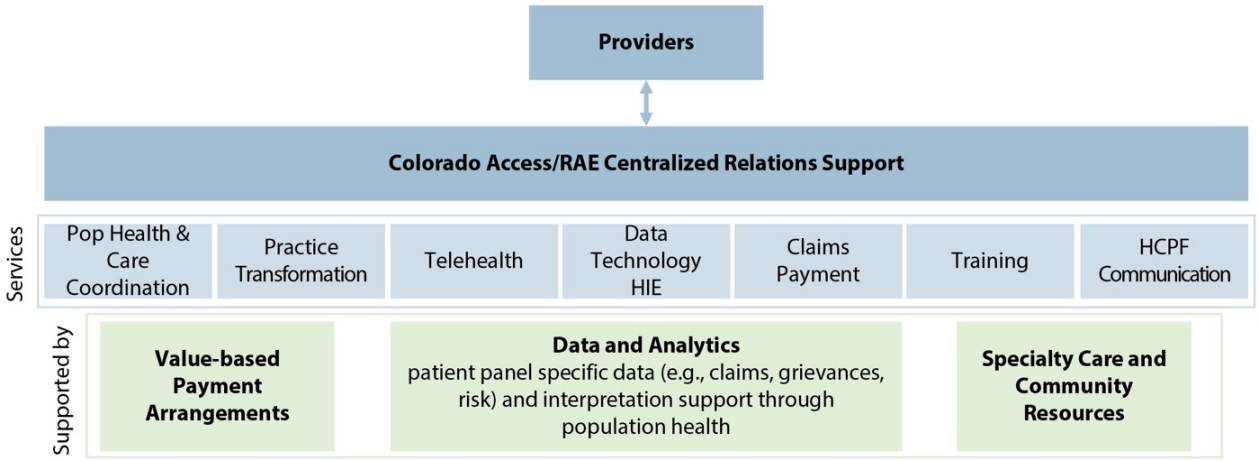
In keeping with our vision of strong health neighborhoods and communities in Region 3, we empower, support, and work with individual providers and provider groups, enabling them to deliver high quality, patient-centered care using their distinctive strengths and local expertise. Just as the Colorado Access (COA) RAE will serve as one point of contact for whole-person care for Region 3 members, our provider engagement team will be a single point of contact for whole-practice provider support within the RAE network. We have a proven track record of strong provider engagement, nurturing mutually productive relationships based on long-standing trust in COA as a source for Medicaid service and program information, regional medical and non-medical resource-matching, and clinical support that employs our expertise in evidence-based interventions and implementation science. As a RAE, we will evolve our provider support model even further by enhancing three core functions: reducing complexity in core health plan operations; providing effective, individualized practice transformation supports; and delivering personalized provider engagement and assistance with system navigation based on the needs of each individual provider. Figure 17-1 below illustrates these elements of our model, their overarching guiding principles, and how this important function relates to our overall vision for the RAE.

FIGURE 17-1 PROVIDER SUPPORT MODEL DESIGN ELEMENTS AND GUIDING PRINCIPLES



Our provider support and transformation efforts are particularly effective because of our cross-program approach. Throughout our history, we have pursued the full complement of health care programs (RCCO, Behavioral Health Organization (BHO), Single Entry Point (SEP), Access Medical Enrollment Services, and Child Health Plan *Plus* (CHP+)) needed to support whole-person care across the lifespan for our most vulnerable Colorado neighbors. Accordingly, our provider support strategy has evolved to efficiently support providers across these programs, with the same regional provider engagement staff team assigned to the long-term care, primary/pediatric, and behavioral health care practices in each health neighborhood and community. Having one RAE contact who can support providers navigating Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, physical and behavioral health issues, as well as CHP+, long-term care and other community resource access issues, is particularly helpful to federally qualified health centers (FQHCs) and other providers who are contracted as both primary care medical homes (PCMPs) and behavioral health providers.

FIGURE 17-2 COLORADO ACCESS PROVIDER ENGAGEMENT STRUCTURE



As shown in Figure 17-2 above, our provider engagement program is built on a RAE-based, centralized contact point through which providers can match their practices' needs to an individualized set of resources (e.g., specialty care access support, integrated care support, non-medical community resource access support). Providers can access these resources within an overall framework of RAE-supported education, training, technology consultation, data and interpretation support, and experience with value-based payment structures, as well as our capacity as an approved SIM Practice Transformation Organization. This centralized structure will also help providers navigate health plan operations such as customer support, claims, credentialing, and grievances and appeals as needed. Finally, it enables our provider engagement team to develop an in-depth understanding of:

- Specific populations of members in each practice;
- The programs and resources associated with each provider;
- How best to coordinate these distributed resources across provider panels/members;

- The most common clinical, population-related and organizational issues identified by providers in the region;
- How best to facilitate coordination and collaboration among providers on common issues;
- How best to link providers and members with community resources and clinical tools;
- What service gaps exist within the community/health neighborhood; and
- How the RAE should prioritize to address identified gaps and opportunities.

LEADERS IN SUPPORTING INTEGRATED AND TEAM-BASED CARE

We are committed to supporting network providers as they transform into fully evolved patient-centered medical homes. We collaborate with providers on a multitude of projects and activities focused on integrated care, advancing business practices and use of health technology, and other areas described in more detail in below. We have been a statewide and national leader in integrating behavioral and physical health care. During the past few years, as both the RCCO for Regions 2, 3, and 5, and the BHO for Regions 2 and 5, we have created flexible opportunities to expand access to and develop sustainable models of integrated care for members.

In order to successfully manage the population of practices, and serve a population of members, we track our providers' integration progress. Using the Integrated Practice Assessment Tool (IPAT) we evaluated the level of integration of 187 PCMP practice sites in 2016. We found that the majority of our practice sites do offer integrated care (as measured by an IPAT score of 3+) and **that these integrated practices serve 81% of RCCO membership.**

Integrated	Sites: N	Sites: % of Total
No	47	25.1%
Yes	140	74.9%
Total	187	100.0%

Virtual Integrated Care Initiative: Provider Support Incorporating Technology, Lay Health Workers, Improved Business Practices

Our integrated care approach also features the dissemination of telehealth technology to drive expansion of integrated behavioral health care. Our virtual integrated care initiative (VICI), administered through AccessCare Services (ACS), our telehealth subsidiary, is an innovative example of provider support that combines integrated care, lay health workers, advanced technologies, and improved business processes. VICI is a team-based care model that leverages BHO resources and care coordination to deploy telehealth services to support primary care practices with virtual same-day access to psychiatric providers, at no additional cost to practices. VICI has been implemented in adult, pediatric, and specialty populations in a variety of practice settings. This program also delivers training and support for administrative/financial staff on billing and reimbursement processes, so that practices can generate revenues for these integrated care services that will contribute to sustainability. A

perinatal-specific program currently uses a licensed behavioral health specialist to engage on site with members and will expand to include a promotora to support the behavioral health component.

The VICI program has been successfully executed in Region 3 at Sheridan Health Services, Rocky Mountain Youth Clinic Thornton and Horizon Pediatrics. Additionally, we have implemented in several sites in Regions 2 and 5, and provided extensive training to the Mental Health Center of Denver to adopt telehealth technology to increase its integrated care services delivered in primary care partner practices. Documented outcomes include increased member access to specialty behavioral health services in primary care settings and improved capacity of primary care physicians to manage the behavioral health needs of their patients.

ACS will deploy telehealth technology strategies to optimize utilization of limited resources through both direct patient care and provider support services and expand the reach of the VICI service to our entire PCMP provider network over the next two years. This integrated, collaborative care framework will support providers in their efforts to deliver integrated behavioral health through a health care technology model that includes telebehavioral health triage, assessment, consultation, brief intervention, care navigation, medication management, and treatment.

While having shared behavioral health providers who can support a system of PCMPs optimizes resources (particularly for smaller practices), VICI's integrated model emphasizes provider-to-provider consultation to enhance workforce capacity: PCMPs gain behavioral health expertise by case consultation and thus improve their own ability to manage whole person care in primary care settings.

Care Coordination Supports Integrated Care

Our unique, multi-disciplinary care coordination team has expertise with physical health, behavioral health, and long-term care services. Our care coordinators support members in accessing integrated care as appropriate for their individual needs. We maintain a provider database that includes provider attributes and services, including each PCMP's status in offering integrated behavioral health care. Our care coordinators assist members with complex and co-occurring needs to find the optimum primary care medical home; often one with highly integrated care that delivers seamless, high quality care in one convenient location. Care coordinators further support these practices and their members in seamless, well-coordinated transitions to higher intensity behavioral health services when needed, such as crisis services or rehabilitative/recovery services. Our model of supporting and promoting care coordination at PCMP practices helps them develop unique care models and provides resources to employ patient navigators, lay health workers, promotores, and other types of patient supports that can best meet the needs of their patients. This model encourages providers to build teams from diverse backgrounds who can best connect with and support the needs of the patients and their families in their communities.

INDIVIDUALLY TAILORED PROVIDER SUPPORTS

As the RAE, we will deliver optimal support to network providers to ensure high quality, coordinated care using the types of support described in the requirement above. These activities will be customized to each provider based on assessments of provider and regional needs, identification of regional and providers' priorities, member feedback and desires, and performance measures. We have a 360-degree view of network providers

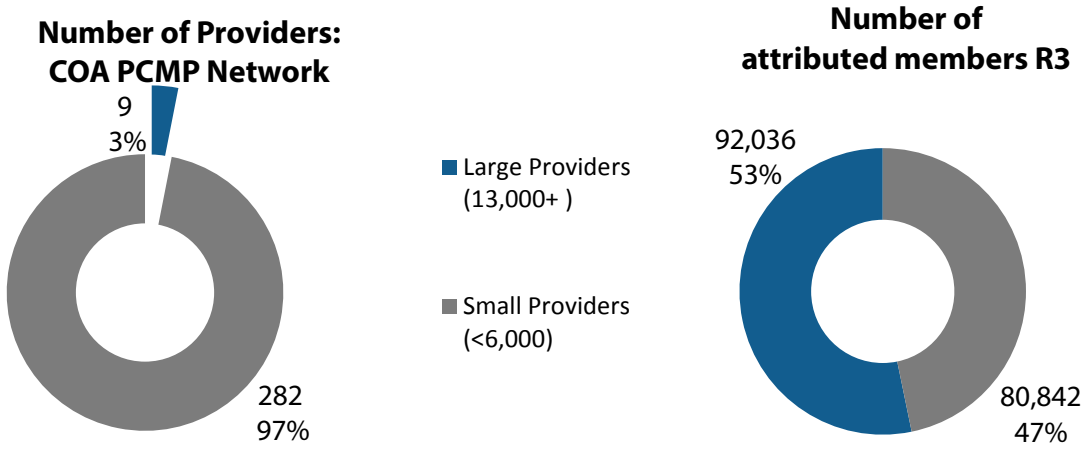
from multiple components: credentialing, claims data, utilization management, appeals and grievances, integrated care status, participation in SIM or CPC, EHR and data sharing capabilities, and performance metrics, etc. This allows customized supports to be developed and targeted at both the clinicians and the practices. All provider communications will adhere to the Department of Health Care Policy and Financing's (the Department's) brand standards.

PRACTICE SUPPORT STRATEGY AND PLAN

We have an established provider engagement strategy and practice support plan, and practice transformation is another key component of this framework for support. Our practice transformation team is closely linked to the provider support staff and is skilled in systems change, clinical and business processes, screening tools, registries, workflow redesign, quality improvement, and other important practice support skills. We are an approved Practice Transformation Organization (PTO) for the State Innovation Model (SIM) initiative. Our proven expertise will assist practices with the ten practice transformation blocks described in the SIM Framework for Integration of Whole-Person Care and also identify and address the myriad of workflow and procedural opportunities through which practices can achieve administrative and clinical efficiencies and value-based goals. The figure below shows the menu of services and supports that we offer.

Practice Transformation Menu						
Care coordination supports	Quality improvement processes & workflow redesign	Data and analytics	Integrated care supports	Tele-health	Value-based payment models	Member orientation and navigation services

Flexibility is foundational to our provider engagement strategy and practice support plan, allowing us to tailor interventions to the individual needs of all provider partners, large and small. Some network providers are large systems with their own practice transformation teams and relationships with community-based resources. These partners typically need less basic infrastructure support, but will need RAE-level support to implement large-scale prevention and screening efforts and participate in region-wide initiatives. Additionally, many large practices are preparing for payment reform and have often taken initial preparatory steps, but will need RAE support to develop the procedural, coding, and/or billing changes and participate in incentive-based payments in an alternative payment model. On the other hand, the majority of network providers are small practices with very different support needs. As the figure below illustrates, more than one-third of current members are attributed to these smaller providers, making it especially important that the provider support team deliver assistance customized to smaller practices. Of 300 network PCMPs, nine have between 13,000 and 99,000 attributed members – and 291 have less than 6,000 attributed members which represents a fairly distinct size dichotomy.



Support for Smaller Practices

Having a network with practices of varying sizes promotes member choice and contributes to improving the member experience. As a RAE, we will continue to actively support smaller practices' linkage to community resources for members by offering training programs on topics such as cultural competency and by providing data and IT support. Our flexible approach means that we will be available as needed for network providers who are already independently implementing transformation, but can give them the space they need to excel in their own way. As outlined in our provider engagement strategy and practice support plan (updated annually), we will allocate greater RAE resources to those practices (typically smaller practices without the advantages of centralized billing/administration/technology and data infrastructure) that need greater system-level interventions. These supportive activities, together with the supplemental assistance we expect to deliver to larger practices, will allow us to maximize the improvement of whole-person care across the region by moving strongly toward system-wide practice transformation.

Some specific examples of activities supporting smaller practices are:

- Children's Hospital Colorado, a large network provider with both primary care and extensive specialty services, provides a service known as One Call to help community providers quickly get a needed consultation for a difficult diagnosis or to help in the management of shared patients. Children's Hospital Colorado also supports many pediatric practices by providing after-hours telephonic triage for those that cannot provide the service in-house. A system for telehealth triage is also being developed to support smaller community practices and to assist families in determining whether or not they should travel to a hospital.
- As the Region 3 RCCO, we chose some small practices as recipients of pay-for-performance incentives to support practice transformation that integrates behavioral health and primary care. A report on the success of one of these providers, Dr. Suman Moraka, is included later in this section.
- ACS VICI is well suited to smaller practices that want to deliver integrated behavioral health and psychiatric services. Having embedded, on-site behavioral health clinicians is not affordable for smaller

practices or cost-effective for the system as a whole. Using technology as a workforce multiplier, relatively scarce and expensive clinical resources can be made available at scale to a population of smaller practices in a sustainable way.

- Care coordination is beyond the scope of some smaller practices based on a variety of factors—expertise, financial constraints, scale, etc. We are fully prepared to deliver comprehensive care coordination to support smaller practices that are critical to the network and population's special needs but unable to provide it themselves.

Simplified Access to General Information and Administrative Support

Streamlined Communication

To ensure coordination with the Department without duplicating state-level efforts, we have designated a single RAE regional contract manager to streamline communication. This contract manager directs the provider engagement team in disseminating relevant information to network providers. Similarly, contract managers will gather, aggregate, and analyze provider-level feedback as an input to the Department, such as suggestions for system-level solutions to common provider challenges. In addition to regular contacts with the provider engagement team, we provide a customer support telephone line designated exclusively for network providers. This service provides on-demand information and problem resolution for providers. We collaborated with the Department to implement this streamlined communication process well before the ACC 2.0 program was developed in response to provider requests for a more integrated approach to information exchange.

Our provider engagement team ensures that providers are aware of the role of Medicaid, the ACC, and the RAE, as well as other programs such as eligibility, CHP+ and long-term services and supports (LTSS). Through this team (depicted in the previous figure), providers receive individualized information/training across a variety of topics, such as ACC policies, billing and coding, and integrated care. All new network providers receive a personalized contact from a provider engagement representative immediately after contract execution. In this initial contact, we provide resources and begin the needs assessment process. Providers are made aware of standardized training offerings (online and monthly webinars) and can also schedule one-to-one consultations on multiple topics based on their immediate priorities. Our designated provider engagement representatives also serve as a single access point to link providers to other COA staff members and resources when needed. For example, the provider engagement team will coordinate with our business intelligence and/or IT departments when a network provider needs help with its health information system.

Regular provider communication vehicles include a monthly provider newsletter, our website (currently being redesigned based on provider and member feedback), call center contacts, and direct in-person visits from our provider engagement team. We also conduct quarterly provider meetings to address program changes, share best practices, connect providers to one another, and promote shared accountability for the region's outcomes. In addition, we offer webinars that deliver general education/information about our provider tool kit and members' rights and responsibilities, as well as training on specific topics such as ACS. When the RAE program is launched, we will modify this online educational content to align with the ACC 2.0. In addition to a regular, ongoing communication mechanism, we also have robust processes to deliver rapid, focused, or time-sensitive information to providers. For example, we have successfully kept providers informed about the SIM program's timeline updates and the CPC and CPC+ programs' application requirements. Over the past year, we developed

a comprehensive provider communication strategy in preparation for the Department's MMIS transition to the new interChange system and placed additional resources to support it. Our provider call center has responded to more than 2,000 provider contacts in the last nine months, dealing with revalidation and the interChange conversion. Under the RAE contract, we will add other tools to further customize provider communications based on the provider needs, emphasizing efficiency and eliminating redundancy. The Colorado Access provider toolkit (http://www.coaccess.com/for-providers) also offers a self-service capacity for practices to check eligibility and claim status, enter Colorado Client Assessment Records (CCARs), check on prior authorization requirements, access practice guidelines, request training, and locate other tools and forms.

Finally, the Region 3 Governance Council and Regional Advisory Council (further described in Offeror's Response 8—Governing Body and Conflict of Interest Plan) are key components to support system-level information sharing and create efficient regional communication plans and mechanisms.

Since January 2017, we have been actively forming a Regional Governance Council for Region 3. Regular group meetings have included the major providers in the region, coming together around the ACC Phase II aims and the RAE vision to identify opportunities for collaboration. The information communicated through this venue has greatly facilitated a shared understanding of the RAE program, use of common language, awareness of opportunities and barriers, and new communication channels among the members. As the RAE, we will continue to develop the Regional Governance Council and Regional Advisory Council as major venues for provider network communications, problem solving, collaboration and development, and implementation of the region's common agenda.

Comprehensive Program Information

Our provider engagement team offers online and monthly webinars/training programs for network providers that efficiently provide information on Medicaid eligibility, Medicaid covered benefits, State plan services (including EPSDT), HCBS waiver services, the capitated behavioral health benefit (currently provided through the BHO), and claims and billing procedures. The webinars also cover such topics as compliance, appeals, members' rights and responsibilities, and provider responsibilities. Once the RAE is in place, we will modify this online training to assure that all important informational topics are included, accurate and up to date. This training will be supplemented by articles in the Navigator, our provider newsletter, and in periodic provider updates when Medicaid program changes occur or when issues arise that need to be addressed promptly.

We were recently selected as a regional pilot site for the No Wrong Door initiative through the State's Long Term Services and Supports (LTSS) program. Through this initiative, we will deploy a traveling team of experts specializing in Medicaid eligibility, covered benefits, HCBS waiver services and behavioral health services to collaborate with agencies and practices across Regions 3 and 5. This new initiative will allow us to supplement the work of our provider engagement team, offering a wealth of additional resources to providers and community partners.

We serve a key function as a centralized source of information regarding Medicaid, Department programs, technology platforms and vendors, and statewide initiatives that interface with Medicaid, and serve overlapping populations. These include: Business Intelligence Data Management (BIDM), Colorado Medicaid's fiscal agent, enrollment broker, pharmacy benefit management system, utilization management, oral health contractor, non-emergent medical transportation administrators, Healthy Communities, case management agencies, community centered boards, and the Health First Colorado Nurse Advice Line. We will continue to proactively keep

providers informed and, as the Region 3 RAE, efficiently utilize and coordinate state and regional resources using webinars, the Colorado Access website, individual provider communications, the provider newsletter, and other communication methods developed in response to the Department's and providers' needs.

Liaison between the Department, Specialists, and other Providers

Our statewide experience as a CHP+ contractor, RCCO contractor (three current regions), BHO contractor (two current regions), SEP, and Medical Assistance (MA) site enables us to be a particularly effective liaison to the Department; it gives us a unique perspective and potential to understand the RAE's broad impacts across all types of providers and regions. This depth and breadth of experience allows us to see the interconnectedness and potential conflicts between these various programs and help providers work efficiently and effectively within the Medicaid and CHP+ systems. We plan to leverage and expand our existing relationships through the Regional Governance Council and Regional Advisory Council members, our medical directors, and specialty care specific workgroups through health alliances and other system-level entities. In so doing, we will serve as a positive and effective liaison between the Department and the RAE community, partners, and providers, promoting the vision and the success of the ACC Phase II implementation.

Our expertise across multiple Medicaid programs has enabled us to support providers in navigating and resolving barriers that may arise within the Medicaid system. In particular, our status as a MA site, our internal utilization management operations, our experience with attribution and PCMP status, and EPSDT expertise have contributed to unparalleled combined knowledge and competencies. As the RAE, we will continue to be a valuable centralized source of guidance and support for PCMP, behavioral health, and specialty providers.

Our history in serving the Colorado Medicaid and CHP+ populations has resulted in longstanding, positive provider relationships in the communities we serve. We are frequently the first call a provider makes when trying to get a public sector question or concern addressed. We will continue to ensure that any provider who contacts us (including those outside of Region 3), receives the appropriate assistance in determining which members are attributed to their practice, and help them understand and manage new attribution processes. We will utilize the Department's attribution algorithm and data and provide individualized information and feedback in a format most useful to each provider. The effort of comparing provider patient panels with current attribution lists offers many opportunities for rich discussions about Medicaid eligibility variations, member utilization patterns and a strong connection to the utility of the data provided by the Department in the new BIDM system.

PROMOTING USE OF CLINICAL AND OPERATIONAL TOOLS AND EVIDENCE-BASED PRACTICES

We have a long history of developing and disseminating practice support tools and resources and promoting evidence based practices. Our care coordination model incorporates best practices and proven techniques to deliver care coordination services at the point of care and is continually updated with new research and information. Practices can utilize the current care coordination readiness assessment tool to evaluate their current capabilities and as a guide to develop the needed functions. Our provider engagement team is ready, willing, and able to provide support and training on billing, utilization management and ways to engage in e-consult, learning collaboratives and other initiatives in the region. Our clinical Quality Performance Advisory Committee (QPAC) is responsible for the adoption and dissemination of clinical guidelines, self-management tools, point of care applications, and other tools to support the delivery of excellent clinical care. These resources

are available on our website and are also distributed through a variety of other mechanisms. The Regional Governance Council and Regional Advisory Council will be responsible for recommending the creation and/or adoption of clinical and operational tools that will support the goals of the RAE and will inform the dissemination of those tools to the broader region. Selected examples of specific practice support tools and resources are listed in the sections below.

PROVIDER TRAINING

Our provider engagement team offers a robust menu of training on a variety of program-specific, clinical, administrative, policy-related, and other informational subjects listed in Requirement 5.10.6.2. We have developed trainings that integrate information across programs (RCCO, BHO, etc.) to deliver comprehensive and user-friendly materials to providers. As the RAE, we will expand these training offerings to cover all topics required in the contract and update them as the program evolves. We will continue to use a variety of methods, including webinars that providers can access at their convenience, educational articles in our provider newsletter (e.g., information on SIM and CPC+, immunization schedule changes, Medicaid benefit changes), on-site events on a specific topic requested by a practice (e.g., cultural competency, telehealth strategies, team-based, integrated care), and quarterly provider and community meetings. Some examples of recent RCCO training topics are alternative payment models and the interface between the criminal justice system and primary care.

We are committed to continuous evaluation and improvement of provider training efforts and will develop additional, novel mechanisms to deliver training efficiently. Our provider support and practice transformation efforts align with the RAE training plan and will achieve and sustain the goals of the RAE and the identified needs of the region's practices. This plan will include:

- Orientation for new providers and interested community members
- Biannual trainings on all topics required in the State contract
- Specialized training on topics identified through regular training needs assessments, designated regional priorities, practice transformation activities, and consultation with the Department.

We will conduct an annual training needs assessment to identify Region 3 providers' training priorities. These findings will be aligned with priorities emerging from regional planning efforts, practice transformation activities, population stratification analysis, performance outcomes, and the Department. The annual provider training plan will address a prioritized agenda arising from this comprehensive assessment. The annual RAE training plan will become a key component of the provider support strategy and practice support plan discussed above. The table below outlines a sample of an annual training plan.

RAE Sample Annual Provider Training Plan			
Topic	**Target Audience**	**Content**	**Duration/Delivery Format**
Onboarding orientation	New providers	• Health First Colorado policy & structure • ACC 2.0 goals and requirements	1½-2 hrs. Webinar/ in-person

	Other interested stakeholders	• COA roles & services	
Required training	All network providers	• Eligibility and application process • Access to Care Standards • Cultural responsiveness • Quality improvement initiatives • Other topics as required • Program updates & changes	Bi-annual webinars; bulletin updates
Cultural competency	Practices as requested	• Ethnocentrism and the acculturation continuum • Awareness of cultural differences, bias and stereotypes • Health disparities in ethnic groups • Cultural issues regarding the disability community	2 hours on-site training
Telehealth technology and implementation	Practices interested in implementing telehealth solutions	• Benefits of telehealth • Telehealth programs • Integrating telehealth and care coordination • Implementation issues (e.g., billing, coding • AccessCare structure and services	Webinar, on-site training
Multi-payer projects	SIM and CPC practices Other projects as appropriate	• Integrated care implementation • Reporting requirements • Application assistance • Data aggregator tools • Data analytics and metrics	On-site training
Integrated care for substance use disorders (SUD) into primary care	Practices interested in integrating SUD services	• Prevention and early intervention • SBIRT and other screening tools • Brief interventions • Telehealth strategies • On-site SUD treatment • Referral & linkage strategies • Non-Medicaid (MSO) SUD services • Billing and coding for SUD	On-site training

This annual plan will be fully developed upon award and regularly revised based on the annual needs assessment described above. In addition, topics may be added to or removed from the annual plan mid-year to adapt to policy modifications and emerging issues that may require advancements in provider knowledge and skills.

We will maintain a record of training activities which will be submitted to the Department upon request. Participation in these trainings will be included in the provider profile so that we can analyze the impact of

trainings and identify opportunities for additional training, or for updating and improving content and delivery methods to better meet educational goals. The information obtained from the evaluation process will be used as an input to the development of the annual training plan.

DATA SYSTEMS AND TECHNOLOGY SUPPORT

We support practices along all points of the continuum of implementing and utilizing health information technology (HIT) systems and data. In addition to having established expertise in assisting practices adopt Altruista's GuidingCare tool (The Colorado Access care coordination tool is further described in Offeror's Response 16—Care Coordination), we have collaborated with the Department and its contractors to understand the Business Intelligence and Data Management (BIDM) and interChange systems. As a result, we offer providers a ready resource in their adaptation to these new systems. In addition, as a BHO contractor, we have an in-depth understanding of the CCAR, mentioned above, as an important behavioral health tool and deliver provider training and support in CCAR administration and reporting. We are fully prepared to help our PCMPs understand when and how to incorporate the CCAR into the primary care setting. We have provided training on Altruista's GuidingCare, the CCAR, PEAK and other tools for more than ten years and have continually updated and improved these materials for our provider network. As a Practice Transformation Organization, we are well prepared to provide assistance and training for the multi-payer aggregator tool for SIM and CPC practices and have been providing similar levels of support for PEAK across our RCCO, BHO, SEP, and CHP programs for years.

Our recent work to complete the health infrastructure survey for our current RCCO and BHO regions has yielded an unprecedented level of detail about each practice's electronic health record system, capabilities, participation in various HIE and HIT activities and their ability to move further along the data sharing continuum. The regional HIE strategic plan provides specific details about our plans to migrate practices along their own journey to full health exchange capabilities. This regional plan includes the activities of the regional Health Information Exchange: CORHIO, the current PCMP and behavioral health practices, provider specific associations, independent practice associations, and other programs such as SIM and CPC+.

Support for Network Providers on Managing and Utilizing Data

We are well equipped to educate and inform network providers about data reports and systems available to them and the practical uses of these reports within their own practices. We have current and in-depth knowledge of regional network providers and their varying data systems and technology support needs. We also have more than 15 years of experience analyzing both physical and behavioral health data and understanding the nuances of each type of data and how to merge them to see the utilization of care for the whole person. We know which practices already have advanced data systems and in-house technology support. We know which providers are already accessing/generating their own practice-level reports and, rather than needing help with interpretation, may want consultation on how to implement population health strategies to deal with their known patient panel characteristics. For such practices, our RAE support may include leveraging data sharing contracts with the Colorado Department of Public Health and the Environment (CDPHE). As the first (and currently only) RCCO (and RAE, going forward) with such data access, we can help practices leverage a more complete complement of data to inform whole-person care at a population level. This is described in more detail

in Offeror's Response 21—Data and Analytics and Offeror's Response 22—Data Management and Claims Processing.

As a long-standing partner with all types of practices, we know that no matter how attractive or user-friendly a data portal is, it can be just another competing priority in a busy clinic. Some practices may not have the capacity to change their business or clinical processes even when practice level data is analyzed, aggregated and reported for them. We have learned that these practices often need additional support to interpret their data and identify priorities for change, guidance in developing an action plan and selecting evidence based practices, and expertise implementing the action plan. We know that the advanced capabilities of our data and reporting systems must be paired with meaningful individualized data interpretation support. Our provider support strategy centers upon individualized help with data and technology use and interpretation paired with collaboratively-focused suggestions for improvement. We make these recommendations with an understanding not only of each provider's strengths, needs, and patient characteristics, but also of the opportunities for strategically aligning data and HIT efforts across multiple initiatives such as developing a data and technology strategy that supports RAE performance outcomes (e.g. KPIs) as well as SIM and CPC efforts.

How we will support individual providers with data and analytics

Providers can access support for managing and using data through one consistent COA contact within the provider engagement team. This team serves as a conduit to all internal departments, including business intelligence (BI). Providers work with their COA provider support representative to determine data needs, and their COA representative collaborates with BI team members to ensure transmission of, and support in understanding and using, desired data. The provider's experience is seamless as the provider engagement team facilitates internal collaboration. The medical directors and clinical leads can also be brought in at any time to assist in the clinical interpretation of information and support in working through specific practice or population needs.

Our focus in supporting providers' data management and use is to engage them by providing data in raw or analyzed form which helps meet their self-identified goals as well as the RAE goals. We will also support providers who need data and analytics help by deploying rapid feedback on outcomes. Through rapid data access and guidance on interpretation and use, we will provide assistance in their iterative efforts to monitor progress on identified quality metrics. As the RAE, we will:

- Help providers understand their population and individual members through whole person datasets that include:
  - Behavioral health claims and clinical data
  - Physical health claims and clinical data
  - Pharmacy data
  - Social determinants of health data
  - Dental data
  - Long-term supports and services data
  - Demographics
- Produce curated analytic reports taken from the above data sets that present information in a meaningful and quickly actionable format such as our P3 reports.

> *In response to consistent feedback from PCMPs regarding their challenges navigating SDAC and manipulating data into accessible, practice specific trend information, we developed our Provider Practice Profiles (P3 reports). These reports took practice-specific information from the SDAC, provided trend comparisons, created practice-type comparisons (private pediatric practice to private pediatric practice, FQHC to FQHC, etc.) and formatted the information in a series of easy to understand charts, graphs and infographics. These two-page reports are reviewed at quarterly PCMP meetings and allow practices to show practice toward their goals and compare their performance to their peers. The reports also direct practices where to go for further information and statistics. The P3 reports are being redesigned to utilize the new TRUVEN BIDM platform.*

- Provide claims data or stratified population information to help providers identify the most appropriate interventions, with the highest likelihood of efficacy, for their member panel.
- Provide, or support providers in interpreting population stratification reports that point to actionable provider or system level interventions ensuring appropriate support for subpopulations of members with chronic conditions, as well as flag individual members for appropriate level and types of care coordination.
- Promote access to the state web portal (BIDM) and provide training on using the Department's and COA datasets to improve the practice.
- Obtain feedback from providers to drive continual refinement and minimize practice fatigue.
- Simplify data collection, interpretation and application for providers by illuminating overlap and alignment opportunities across provider priorities, RAE state and regional priorities, and SIM, CPC, MACRA, and other national and local initiatives.
- Support providers in KPI successes and incentives through drill-down reports that identify drivers of KPI performance and reward incremental steps toward achieving the goals.
- Facilitating opportunities to merge state and plan level data with EHR data.
- Provide ongoing technical support for initiatives such as: centrally administered care coordination and population health campaigns that leverage digital delivery mechanisms supporting individual provider's population management efforts.

As we enhance our existing data architecture to best utilize ongoing improvements to State systems, we are preparing to offer support to providers in implementing new data systems and processes that are embedded in provider workflows, to simplify data sharing and interpretation. For example, a large proportion of our provider network uses EPIC EHR. We are developing processes to create interfaces between RAE-level data and EPIC so that care coordination data, risk assessments, social determinants of health data, screenings, and other information are shared appropriately. Our focus in enhancing our IT infrastructure is to offer an array of tools from which providers of any size can benefit, supplemented by high touch analytic support for providers.

Supporting the regional provider network with analytics

For more than 20 years, we have actively recruited and engaged leaders of key practices and health care systems to participate in collaborative regional forums such as the Quality and Performance Advisory Committee (QPAC). Chaired by Colorado Access, the QPAC convenes these leaders to learn about and showcase innovations related to quality and performance improvement, particularly data-driven best practices. QPAC is comprised of

representatives from large health care systems in the network, such as Children's Hospital Colorado, small and large PCMPs, behavioral health providers, and social services providers, as well as member representatives. Recent topics have included FQHC initiatives to increase postpartum visit rates, pediatric practices' successful approaches to increase well child visits, and population-based campaigns on cervical cancer screening. QPAC also provides community input regarding adoption of clinical guidelines and implementation strategies in the region. We use short, online surveys to solicit feedback about topics and aims. As the RAE, we will continue to support this QPAC structure and also leverage our practice transformation team for individualized provider education and support. QPAC's network provider representatives will collectively review and guide adoption of clinical guidelines, and collaboratively identify evidence-based guidelines of focus. We will encourage our providers to engage in standards of quality care and practices endorsed by AMA and other guidelines. QPAC's collaborative structure facilitates critical buy-in to regional data collection and reporting decisions. It also provides a regular forum for providers to learn to interpret data and reports and translate them into quality improvement actions at the practice level.

The RAE governance structure (Regional Governance Council and Regional Advisory Committee) will offer another important venue for the dissemination of provider- and system-level data analyses focused on provider performance and quality improvement. These committees will operate within the COA **Health Transformation Framework**, which focuses on system-wide and panel-level analyses, to support development of the regional common agenda and selection of priority goals and objectives. Working in partnership with QPAC, our governance structure will support quality and transformation at both the system and practice levels.

Raw Claims Data Extracts

As the current RCCO, we have established a process to share raw claims data with PCMPs. We will continue this process as the RAE and incorporate the appropriate behavioral health data. In the current process, a provider requests a raw claim extract from COA and is asked to demonstrate their ability to accept and analyze that information. Once both COA and the PCMP have agreed upon the format and timing of the data feeds, a data sharing agreement is executed delineating appropriate uses of the data: to support care coordination and achievement of program goals; not to be used for marketing, business development or other purposes; not to be used to refute KPI or other performance metric calculations. The PCMP begins to receive data for their attributed members only, including physical health and behavioral health data. Upon award, we will explore with the Department the feasibility and value of incorporating additional data, such as long-term care, into these feeds to determine if that further enhances the ability of the PCMPs to achieve the desired health outcomes for their patients.

Facilitating Clinical Information Sharing through EHRs and HIEs

We are currently working with the Department to conduct a thorough HIT/HIE assessment of providers across the network, for both physical and behavioral health. This assessment is creating a comprehensive inventory of the types of EHR being used, how providers are leveraging their EHR and managing data exchange, and how they are accessing/using clinical alerts and quality measures data. This baseline effort positions us to serve as the RAE, because it produces a system-wide understanding of current gaps and strengths in our population of providers that we can use to prepare for the future. Specifically, the assessment allows us to strategically plan for systematic solutions to support gaps, leverage strengths for regional and statewide data exchange, and measure

and improve upon health outcomes in informed and collaborative ways. This baseline assessment will also allow us to develop a regional strategic plan to move the health care system further along the continuum of health information exchange. With this detailed knowledge of the physical and behavioral health care system capabilities, we can develop customized and targeted provider supports, connect practices that are using the same EHRs, and develop peer learning collaboratives that bring similar practices together to solve shared problems.

We are currently expanding our provider data systems to increasingly leverage existing system capacities and build new opportunities to store and report upon the enhanced set of provider level data needed, as a RAE, to manage a population of providers in an informed and systematic manner. We are building a 360-degree view of providers through a practitioner data set that includes details on 1) providers' training, specific medical interests, gender, and language; 2) site specific details such as accessibility for specific groups, and extended hours; 3) information about providers' participation in various statewide programs such as CPC+ or SIM; 4) integration information including the practices IPAT scores; and 5) EHR and HIE integration current status and their capability in the future. This comprehensive dataset provides a powerful new way to understand, target and drive transformation at the practitioner, practice, and system level.

PRACTICE TRANSFORMATION

Throughout our 22-year history, with our partner providers we have generated a strong record of successful practice transformation initiatives through our RCCOs, BHOs, and other health plans. These initiatives have encompassed a broad range of activities, from improving business processes and health information systems to integrating physical and behavioral health. Our efforts have supported practice innovations focused on both **administrative and clinical systems**. They have been aimed at helping practices and health care organizations **produce organizational efficiencies and cost containment, as well as improved business processes, clinical performance, and quality of care.** Several examples of our successful practice transformation initiatives are described throughout this section.

The RAE model of treating the physical and behavioral health populations as an integrated population will be a new challenge and opportunity for providers. As the RAE, a key practice transformation goal will be adaptation to this framework. We will continue our focus on helping practices develop and implement strategies that optimize member outcomes and conserve public resources. We will use a flexible, targeted approach to transformation centered on achieving the RAE's priority goals and on our partner providers' identified needs. We have the capacity and expertise to offer a wide range of assistance, from informal consultation to guide a single improvement project to broader, more formal efforts through the State Innovation Model's (SIM's) Practice Transformation Organization (PTO) process. As a RAE, we will use this capacity strategically to produce outcomes that contribute to the Quadruple Aim: improved experience of care, better population health, reduced per capita health care costs, and improved experience of providing care. Our responses to the requirements in this section offer detailed information about our plans to create and deliver a transformed healthcare system in Region 3.

To guide our RAE transformation efforts in Region 3, we will employ two sets of complementary strategies designed to support practice transformation at the system and regional levels; and improve performance at the

practice level. The strategies listed in the model are based on an analysis of expert sources that describe the elements needed for practice transformation. These sources include the State's ACC Concept Paper and draft RAE/ACC RFP, the State Innovation Model (SIM),[1] the federal Comprehensive Primary Care Initiative (CPC+)[2] and Transforming Clinical Practice (TCPI)[3] Initiative, the National Committee for Quality Assurance (NCQA)[4], and other experts in practice transformation and implementation science.[5,6]

These various transformation models generally differentiate between the essential strategies that must be implemented by an individual practice or health care provider versus the supportive functions usually performed by organizations such as payers, public agencies, and transformation consultants and coaches. In our model, we define the RAE's role as not only an entity providing transformation support to individual provider organizations, but also a backbone organization that promotes achievement of state and regional ACC aims. Our transformation approach focuses on meeting practices where they are and also ensuring that efforts are primarily aimed toward achieving ACC aims and specific regional goals. To accomplish this, the RAE will perform the following functions:

Planning	Identification of regional and practice-level goals and strategies; implementation support and monitoring for the planned transformation activities
Population-based management/collaborative initiatives	Selection of priority regional populations (e.g., members with chronic medical conditions and social risk factors) and development of collaborative initiatives targeted toward these populations across practices in the region.
Strategic partnerships	Development of partnerships across practices and the regional health neighborhood to facilitate shared resources and knowledge
Data and informatics	Guiding quality improvement and address social determinants of health that have been identified as priority areas

[1] Colorado State Innovation Model, Framework for Integration of Whole Person Care "Building Blocks" and "Payer and Public Program Functions," SIM Overview Slide Deck.pdf available at www.colorado.gov/healthinnovation

[2] Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative, Payment Model, Core Set of Functions/Elements of the Practice Redesign Model, and Strategies to Support Practice Redesign, https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html

[3] CMHS/Center for Medicare and Medicaid Innovation – Transforming Clinical Practice Initiative (TCPI) Practice Transformation Networks (PTNs) - 2014 Announcement, "Required Activities for Practice Transformation Networks," https://innovation.cms.gov/Files/x/TCPI-FOA-PTN.pdf

[4] NCQA, Advanced Patient-Centered Medical Home Recognition, "Six Standards for Becoming an NCQA-recognized Patient-Centered Medical Home, https://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf

[5] **G**uiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. "8 Change Concepts to Support Transformation" Edward H. Wagner, Katie Coleman, Robert J. Reid, Kathryn Phillips, and Jonathan R. Sugarman February 2012. The Commonwealth Fund http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patient centered_med_home_v2.pdf

[6] Natural History of Practice Transformation: Development and Initial Testing of an Outcomes-Based Model. "Key Elements of Practice Support." Katrina E. Donahue, MD, MPH, Warren P. Newton, MD, MPH, Ann Lefebvre, MSW, CPHQ and Marcus Plescia, MD, MPH Annals of Family Medicine May/June 2013vol. 11 no. 3 212-219

Data sharing	Development and coordination of inter-organizational data linkages and exchanges across RAE practices and/or other organizations to support collaborative initiatives and strategic partnerships
Learning communities/education	Training, tool kits, consultation and coaching to facilitate knowledge sharing and uptake of innovations and best and evidence-based practices at the practice, organizational and regional levels
Coordinated care across organizations	Development of and support for strategies that facilitate coordination of care for members with complex needs across practices and related organizations in the members' health neighborhood
IT support	Provision of consultation and technical assistance for practice's to collect, produce and analyze practice-level data needed for individual practice and regional transformation activities
Alternative payment models	Development and provision of value-based payments to incentivize progress toward priority transformation goals, including use of the State's Primary Care Alternative Payment Methodology

As a RAE, we will combine the strategies listed above with support and consultation to our partner providers to help them implement the essential strategies primarily associated with individual practice transformation efforts. These include:

Leadership/Change management support	To promote integration, innovation and change. This includes assessing the organization's readiness for change; available support for transformation; recruiting, training and supporting practice champions; and developing budgets that support organizational redesign and integration activities.
Attribution	Identifying the members for whom each provider is responsible, as their medical home, and developing and maintaining continuity for these patients with their care teams.
Enhanced access	Ensuring that members have ready access to care at all times.
Member engagement & activation	Engaging members and families with the practice and their care; centering members as the hub of the care team as fully informed partners and active decision-makers
Team-based care	Deploying collaborative teams of clinicians and trained non-clinicians (including lay health workers) to deliver the entire array of preventive, acute, and chronic care services needed by members
Evidence-based care	Using the current best research evidence, combined with clinical expertise and patient preference, to deliver proven treatment interventions and other health care practices
Population health management	Implementing interventions designed to improve health outcomes for a defined group of people. Examples include systems of care tailored

	specifically for those with a particular diagnosis (e.g., diabetes, depression) and or risk factor(s) (e.g., low income, young pregnant women).
Integrated physical and behavioral health care	Linking primary care and behavioral health through integrated service delivery (e.g., a behavioral health specialist as member of the primary care team), or through co-location, inter-organizational arrangements and/or technological solutions such as telehealth. Interventions include screening, brief interventions, warm handoffs, and provider consultation.
Care coordination	Strengthening and maintaining connections among primary care, behavioral health, specialty providers and other community services, supports and resources, ensuring adherence to a common care plan.
Performance measurement and data driven quality improvement	Using computer-based technology to measure performance and produce data that guides improvements.
Business practices and workflow redesign	Assessment and re-configuration of business and clinical workflows to incorporate new processes while increasing efficiency
Efficiencies and cost management	Addressing inefficiencies to reduce and/or manage clinical and administrative costs (e.g., reduction in utilization of low-value services).

Examples of COA's Success in Supporting Practice Transformation

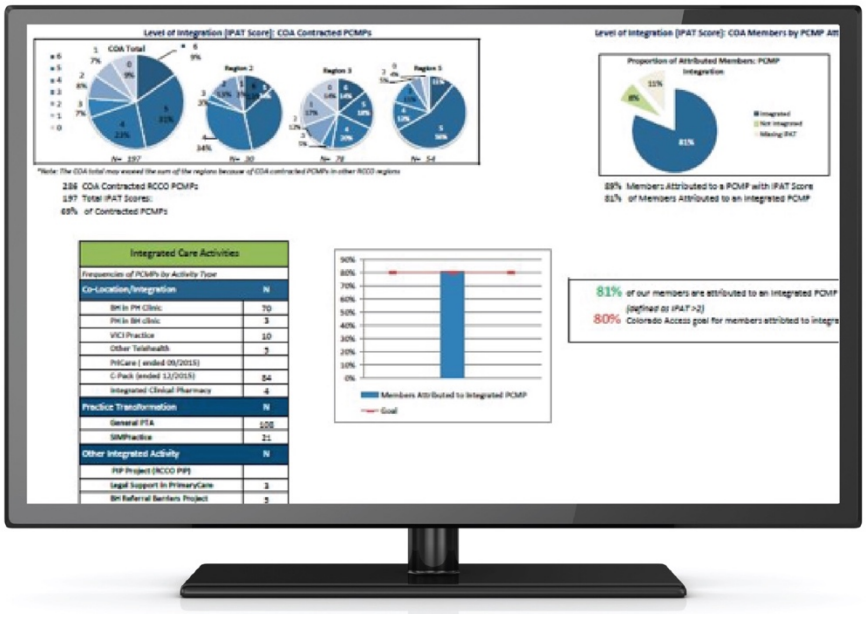
These descriptions include outcomes (where available) and how they fit within our practice transformation model outlined above.

Example 1: Assessing Practices' Level of Integration

- **System-Level Strategies:** data/informatics, data sharing
- **Practice-Level Strategies:** engaged leadership, performance measurement and data-driven quality improvement, team-based care, integrated physical and behavioral health care, care coordination

The Integrated Practice Assessment Tool (IPAT) was developed to assess a practice's level of integration as defined by the Standard Framework for Levels of Integrated Healthcare adopted by the SAMHSA/HRSA Center for Healthcare Integration. In 2016, we measured IPAT scores for its RCCO Patient Centered Medical Home (PCMH) network practices to develop a snapshot of the progress toward integration. Figure 17.3 below illustrates the high numbers of practices with an IPAT score of three and above (indicating practices operating at co-located/collaborative and integrated levels), as well as high proportions of attributed members who access these practices. This outcome indicator demonstrates the success of COA and our network providers in moving toward full integration and serves as a baseline for future RAE transformation efforts.

FIGURE 17.3 SYSTEM-WIDE SUCCESS IN ACHIEVING INTEGRATED CARE



Example 2: Pay for Performance Program (P4P)

- **System-Level Strategies:** Planning/facilitation, strategic partnerships, learning communities, alternative payment models
- **Practice-Level Strategies:** Engaged leadership, empanelment, performance measurement and data-driven quality improvement, team-based care, integrated behavioral and physical health care, evidence-based care, member engagement, enhanced access, care coordination

In 2016, we allocated a portion of our RCCO pay-for-performance incentive payments from the Department to fund practice transformation initiatives in seven pediatric practices across Regions 2, 3 and 5. These projects were intended to test a variety of different transformation strategies that could potentially be replicated in other practices. Because these P4P projects are not scheduled for completion until late 2017 or 2018, only limited outcome data are currently available. However, in interim reports submitted in spring 2017, most practices reported substantial progress toward their goals. Following are brief summaries of each project:

- **Doctors Care, Region 3 (Littleton)**: Project goals include empanelment, member engagement, and care coordination. Interventions include a new patient engagement process that includes contact with a health navigator prior to the scheduled well visit, revision of the patient satisfaction survey to focus on the patient's experience of care, training for staff to establish a patient-centered culture, and creation of patient-centered medical home materials such as a welcome packet.

- **Suman Moraka, MD, Region 3 (Aurora)**: see box below.
- **Rocky Mountain Health Centers Pediatrics, Region 3 (Aurora):** Goals related to access to care, member engagement, integrated behavioral health and primary care, performance measurement and quality improvement.
- **Horizon Pediatrics, Regions 3 and 5 (Thornton and Denver); Lowry Pediatrics, Region 5 (Denver); and Sapphire Pediatrics, Region 5 (Denver)**: Integration of behavioral health with primary care is the primary focus of this collaborative initiative, which involves four pediatric practice sites and two community mental health centers. The practices are sharing a behavioral health clinician from the Mental Health Center of Denver (MHCD), co-located at each practice at least one day each week and available for informal consultations when not on-site. Interventions include screening for depression and ADD/ADHD and care coordination including warm handoffs to the community mental health center when needed. Project outcomes include determining the financial sustainability for a behavioral health clinician in a pediatrics practice, increased identification of and treatment for behavioral health conditions, increased referrals to specialty behavioral health care, and changes in IPAT scores.
- **The Children's Health Place, Region 2 (Greeley)**: Project goals include empanelment and patient engagement, with the primary outcomes being increases in the number well child visits and reductions in missed appointments.

A Successful Transformation - How A Small Practice Integrated Care with Help from the COA's Pay for Performance Incentive: Suman Moraka, MD, *a pediatrician who practices in Aurora, has used her pay for performance payment from RCCO Region 3 to develop a collaborative, integrated team which incorporates a bilingual health coach and behavioral health care coordinator. The team implemented a variety of clinical and administrative interventions (e.g., nutrition and lifestyle education, expanded hours to reduce ED visits) to impact outcomes such as: increased member involvement, increased depression screening, integrated care, improved management of asthma and obesity, increased well child visits, reduced emergency department visits, and member satisfaction. They incorporated biofeedback and stress management techniques into their treatment to reduce stress and empower patients and parents to become partners in their own care. Preliminary results are showing reductions in obesity and depression symptoms, increases in well child visits, fewer ED visits and greatly improved member satisfaction.*

Example 3: Provider Performance Portfolio (P3) Process

- **System-Level Strategies**: data/informatics, data sharing, population-based management/collaborative initiatives
- **Practice-Level Strategies**: performance measurement and data-driven quality improvement, population management, efficiencies and cost containment

The development and implementation of the P3 reports are described above. In addition to supporting regional efforts, P3 reports form the foundation for individualized practice transformation support activities. Our provider engagement team makes regular, in-person visits to assist in report interpretation, discuss performance issues, and identify targets for practice transformation efforts. As the report also includes a list of each practice's top 10 highest cost members, these discussions often center on strategies to implement interventions that will contain

unnecessary costs. We are currently revising the P3 report and follow-up process, incorporating feedback from providers and anticipating changes required by the RAE. As a RAE, we will build on the P3 process, using an enhanced report which will draw from BIDM data and include greater emphasis on integrated care and other regional priorities that will be developed through the RAE's common agenda.

Conclusion

We have demonstrated the ability to lead, innovate, support, and collaborate with our partners on broad-scale practice transformation efforts and to achieve measurable outcomes from these efforts. We are the only Medicaid program entity in Colorado with this experience, breadth of resources and tools, and level of transformation success. We are poised to accelerate this success under the enhanced flexibility of the RAE model.

Data-Informed, Individually-Focused Practice Transformation Strategies

With support from statewide initiatives such as SIM, CPC+ and TCPI, as well as activities conducted through our RCCOs and BHOs, a significant number of our network providers have been and/or are currently involved in a variety of formal and informal transformation activities.

As the RAE, we will continue to capitalize on this expertise and experience to advance practice transformation both within practices and across regional health neighborhoods and communities. The foundation built by these pioneering practices will help advance the region's common agenda. With our Region 3 Governance Council, we will design collaborations and mutually reinforcing practice transformation activities that benefit from the existing strengths of our network providers.

We will use data-informed approaches to identify network providers' strengths and characteristics in order to help them design and implement transformation interventions that support ACC 2.0 goals and their own priorities for practice improvement. In 2016, to prepare for the forthcoming ACC 2.0 initiative, we completed an inventory of all RCCO PCMPs in Region 3. This inventory has allowed us to develop a regional characterization of the network of PCMP practices. Through it, we can identify, for example, which SIM practices have achieved which of the ten building blocks of the SIM transformation model; which practices have any type of embedded behavioral health care; and how each practice scored on the IPAT. We will use this information to create a baseline from which we can identify regional and practice-specific strengths and weaknesses and target transformation efforts based on these factors.

As the RAE, we will also implement a population health, data-based orientation to help each practice characterize and stratify its own population. These may include cultural, linguistic, socioeconomic, geographic, environmental, and clinical factors. Finally, our provider engagement team works closely with network providers to identify their goals for improving business processes, implementing administrative efficiencies and other organizational transformations that may benefit from our assistance. The information from these efforts will allow us to develop strategies to support practices through trainings, coaching, learning collaboratives, and other resources tailored to regional needs, individual practice strengths and patient populations, as described above in the training plan.

Our practice transformation approach will be especially well suited to providers that are striving to align their transformation efforts across a variety of state, federal and local initiatives. These organizations may be looking

for knowledge and innovation support to solve specific problems that can benefit from the breadth of our expertise in integrated physical and behavioral health, administration, value-based payment and clinical implementation. Through our practice transformation program, we will leverage our expertise with cross-program, whole-person care and implementation science to help practices meet their self-identified goals based on the characteristics of their populations and their practices' clinical and administrative strengths and needs. One of our major areas of expertise is physical and behavioral health integration. Thus, consistent with the SIM program's long-term goals, our practice transformation strategies as a RAE will emphasize health care integration, as well as disability and other social determinants of health that impact our members. In addition, as described in more detail below, we will focus on providers (particularly smaller practices) that are interested in improving their clinical and administrative performance as a PCMP, but do not have a formal arrangement with a Practice Transformation Organization.

COA's Expert Practice Transformation Team and Resources

We have the expertise, experience and resources to lead and conduct the practice transformation work of the RAE. The core practice transformation team members are described below. Organizationally, this team is linked with the provider engagement team to maximize the effectiveness of provider-facing efforts and streamline the experience for providers.

Elise Cooper, practice transformation facilitator, has strong professional expertise in health care efficiency and performance enhancement. Her approach is founded in Lean/Six Sigma methods and using data to establish and meet attainable performance goals. As a project manager with Massachusetts General Hospital, Elise helped to transform ambulatory, pediatric, pediatric surgery, cardiology, and gastroenterology departments. She engaged department leadership, leading teams in the review of outcomes data in order to identify performance improvement priorities, opportunities, process changes, and measurable indices of success. Elise's experience in working with both large health care systems and community-based health organizations equip her with the skills to provide flexible support tailored to the strengths, needs, and goals, of our varied provider partners.

Chase Gray, program director of care coordination, has seven years of professional experience in practice transformation efforts in Colorado and nationally. Her specific expertise is in leading practice facilitators, system re-design and implementation, working with primary care and integrated care systems, physician and executive leadership consulting on Patient Centered Medical Home (PCMH) and Accountable Care Organization (ACO) implementation, and value-based payment models, including extensive experience with HealthTeamWorks. She is knowledgeable regarding the PCMH accreditation programs and has implemented programs based on many practice transformation models. She has also worked closely within practices and systems, establishing training protocols for clinical and non-clinical workers in new skills needed to implement PCMH/ACO models.

Shelby Kiernan, practice transformation program director, has more than 23 years of experience successfully developing and managing programs in social services and education contexts. She leverages the ability to facilitate positive relationships and teamwork, gained as a licensed marriage and family therapist, proven successes across health care, human services and education environments, working with diverse populations and groups to achieve measurable goals. Shelby is a diplomatic and insightful team-oriented people developer, consistently recognized for her ability to help others reach their highest potential.

Aaron Brotherson, director of provider engagement and strategy, has an extensive background in provider network management and building robust provider engagement teams. Additionally, Aaron has expertise in connecting providers to appropriate resources, including practice transformation resources, data for improvement, and other providers facing similar issues.

Integrated and Team Based Care Expertise. As part of Colorado's Medicaid Community Behavioral Health program for more than 20 years, we have established a strong core competency in behavioral health and the integration of physical health care with these services. Several COA staff members are published authors and recognized experts in behavioral health integration. Driven by an extensive knowledge of national research, we have conducted several internal analyses to better understand the interplay between physical health and behavioral health in our membership. One key finding is that overall medical costs are **two to three times higher** for members with behavioral health challenges. In addition, we know that these members may face significant obstacles, including stigma, in accessing member-focused care. As a result, we have a long history of prioritizing and expanding primary care medical home (PCMP) based care integration and team-based care.

Supporting this core practice transformation team are our population health and care coordination teams, quality improvement, BI, IT, and other departments, as well as our medical directors. Our physician leadership includes specialists in pediatrics, family medicine, emergency medicine, and psychiatry. All are active practitioners in the community and effective at engaging physicians and other clinicians in practice transformation efforts.

Efforts to Improve Efficiency and Cost Management by Reducing Over-Utilization

An important goal of our RAE will be to provide the right service to members at the right time and in the right setting. Achieving this at both systematic and practice levels will reduce overutilization and low-value service options. At a systems level, we employ a population management strategy that includes a service utilization ratio. This ratio used to track service utilization at the systems level. At the practice level, we will use it to provide practices with comparative data for their own population versus others using the P3 process described earlier in this section. At the member level, we will use the service utilization ratio to target appropriate care coordination interventions. Our provider engagement team will play a critical role in supporting practices in their transformation efforts related to achieving appropriate, efficient and effective service utilization patterns. As above, we will share this and other practice-level data in the manner, and with the associated interpretation and use support, that best meets the strengths and needs of each practice.

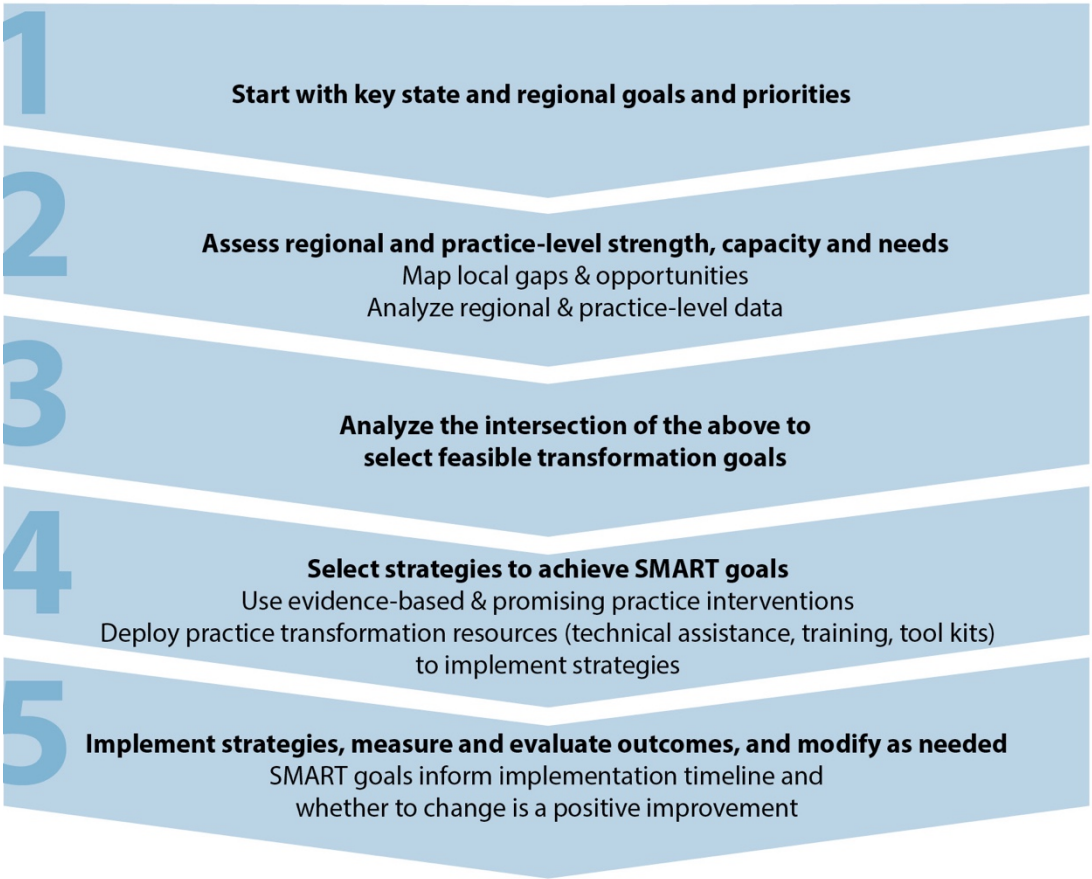
North Suburban Medical Center in Thornton offers an example of how we have used data to support practices in their efforts to reduce over-utilization and improve efficiency. Providers in this hospital's emergency department noticed a large increase in non-English speaking women who were arriving at their ED in active labor but with no history of prior obstetrical care. After an investigation, they determined that many of these women actually had received prenatal care from Clinica Family Health (Clinica). North Suburban Medical Center asked for help from our population health department, which reviewed COA claims data to validate their concerns. We found that between April and October of 2015, 148 patients had arrived at North Suburban Medical Center with no record of prior OB care, and almost 40% of those patients had indeed received prior OB care from Clinica. An inter-agency group from Tri County Health Department, North Suburban Medical Center, Clinica Family Health, and COA traced the root of the problem to the closing of St. Anthony's Hospital, where Clinica patients had

traditionally gone for delivery. When St. Anthony's closed, there was no new system set up to support records-transfer for delivery elsewhere. The assembled group was able to execute the needed agreements to share data and patient records so that North Suburban can access records for Clinica's prenatal patients. The hospital providers now have complete pregnancy records - including high risks, complicating factors, and medical history – and have made efforts to match patients with a provider who speaks their language. Staffing plans can also be made based on expected delivery dates that they know in advance. This collaborative effort involving COA and partner providers has not only improved efficiency, but also greatly improved the quality of care for these perinatal patients.

Developing Practice Transformation Plans

Our successes in practice transformation are based on helping practices identify and implement *feasible* transformation goals that are well aligned with their strengths, population needs and operational strategies. Above, we described our model for facilitating and supporting practice transformation at the regional and individual practice levels. We will operationalize this model at both the regional and individual practice levels through the structured planning process illustrated in Figure 17.4 below.

FIGURE 17.4 PRACTICE TRANSFORMATION PLANNING PROCESS



Our work with a small, culturally diverse Denver based clinic is a good example of developing a practice-specific transformation plan and supporting feasible goal attainment. Our data analysis showed that this practice has a population with high needs and complex health and social situations. Its funding streams are unique based on its predominantly Native American patient population, and it has a dedicated but very small team of providers. There is an on-site behavioral health clinician, and, because of the complex needs of the patient population, virtual psychiatry services were also desired. The practice is also preparing to move to a new EHR system. The clinic identified these two system changes, virtual psychiatry and EHR, as their priorities for practice transformation. To support this clinic, the ACS team spent many hours working collaboratively with the clinic on workflow processes that would best make this project feasible in the midst of a challenging environment. By establishing strong processes for team based care and identifying ways to support workflow and encounter documentation as the new EHR process was established, the team was able to prepare the practice for virtual care integration. Attempting to implement a new care team, specialist, technology, and documentation process without this preliminary work could have been frustrating for the practice, more difficult to maintain, and less likely to deliver whole-person care. However, educating providers about the best practices surrounding these feasible transformation goals, and providing technical assistance to support these changes produced a successful and transformational outcome for this practice.

As the RAE, our practice transformation team will work with network providers in similar ways by: assessing their strengths, opportunities and needs; developing realistic transformation goals; linking them with needed resources; and instituting systems to measure and evaluate outcomes.

Coordination with Existing Practice Transformation Organizations and Activities

In 2016, we became an approved Practice Transformation Organization (PTO) by the University of Colorado's Health Extension System (CHES) under a contract with the Colorado SIM program. PTOs support system transformation by deploying facilitators and coaches to partner with practices and communities to implement strategies designed to improve health outcomes. Our status as a designated SIM PTO will serve as an important part of our RAE's practice transformation efforts. At the same time, we recognize that some network providers or provider systems are themselves designated PTOs and that these and many additional providers are already working on a variety of transformation efforts. For example, several of our practices are SIM Cohort One practices and are already paired with other PTOs. Further, many practices are involved not only with SIM activities, but also with many other transformation initiatives such as CPC+. We will complement, not duplicate, these services and make maximum use of the expertise and efforts of other agencies. We do not view this as a competitive environment and instead, seek to optimize existing resources and avoid duplicating services.

We recognize that practices are dealing with many competing demands: federal, state and local initiatives, changing policies, new payment methods, etc. This may lead to diminished interest, investment, and resources to undertake additional transformation work on the part of the practice. The RAE must avoid overburdening practices and make successful efforts to align activities, increase efficiency, and demonstrate the value of transformation for practices. We will partner and utilize existing strong relationships with other community entities who also participate in transformation work, including UCHealth, the University of Colorado School of Medicine department of family medicine, HealthTeamWorks, Colorado Children's Healthcare Access Program (CCHAP), and others. Working together, we will strive for a common regional agenda, aligned objectives, and shared resources.

As described above, our practice transformation program is flexibly designed and driven by providers' individualized priorities and needs. We will build on long-standing, relationship-based trust with practices and identify opportunities for synergistic overlap and alignment.

Example of COA's Partnership with an Existing PTO

Our long-standing partnership with Colorado Children's Healthcare Access Program (CCHAP) is a good example of how we are currently interfacing with other Practice Transformation Organizations. CCHAP is a mission-based, grant-funded agency formed in 2006 in response to the growing issue of care access for Medicaid children with Medicaid and the paucity of private practices serving Medicaid youth. CCHAP aims to improve children's services by working directly with pediatrics practices, helping them to function as pediatric medical homes and submit Medicaid claims. CCHAP even became a MA site to streamline enrollment applications for Medicaid youth and also supports providers through advocacy work. CCHAP has served as an important partner throughout the RCCO program, leveraging its strong relationships with pediatric practices, extensive experience in Medicaid billing and coding, ability to support practices in care coordination, and position as a trusted neutral party. CCHAP is able to identify systemic issues for pediatric practices and work on their collective behalf with COA to develop solutions. Through a formal contract, we rely on CCHAP to help practices develop practice-based, on-site care coordination. CCHAP has also supported practices in aligning RCCO KPIs with other initiatives such as SIM and the Enhanced PCMP (ePCMP) program. CCHAP currently serves on both the state PIAC and on our regional PIAC groups.

CCHAP is currently supporting 15 Cohort One SIM practices, some of which are network providers. For these and other practices, CCHAP serves as a practice facilitator/coach, technical assistant, and source of information/education. CCHAP is currently focused on two pediatric initiatives: increasing access to and utilization of pediatric well visits (highlighted below) and increasing postpartum visits**:**

- **Pediatric Well Visits:** As the RCCO contractor in Regions 2, 3 and 5, we have a KPI goal of 60% for annual well visits for children 3-9 years old. We worked with CCHAP to develop a solution to meet this goal in each region. We provided CCHAP with practice level data, and together we identified practices that were close to the 60% goal, were motivated to improve their results, and had sufficient membership such that focused efforts could impact the regional goal. CCHAP worked with six practices to review subpopulation characteristics (e.g., proportion of unattributed members, proportion of healthy but not seen, and missed appointment rates for patients age 3 to 9 years old) and coached them on evaluating their data and generating solutions. Coaching involved analyzing the availability of open appointments, process flow, and competing priorities that potentially limit access to well child visits. CCHAP then worked with the practices to develop strategies likely to improve their performance, including the following areas:
    - Reconciliation of the attribution list
    - Billing and coding issues
    - Engaged leadership and commitment to improve
    - Level of family engagement
    - EHR capabilities including data analytics and reporting
    - Current processes to perform well visit when child is in for acute care visit, as appropriate
    - Quality improvement activities within the practice

As both a RAE and a PTO, we are committed to supporting the existing relationships that our practices have with CCHAP. We know that our continued collaboration and alignment, through both formal contracts and overlapping missions, will ensure that these practices have a PTO experience that is aligned with both regional and state efforts.

COA's Flexible, Tailored Practice Transformation Approach

Finally, with a system-level perspective, we understand the need to tailor approaches for large network providers differently than for small providers. A data-based understanding of patient populations and sub-populations, evidence based practices, and outcome measurement will be common to our approach with every practice. We know that large practices have access to a variety of resources (e.g., administrative and billing supports, clinical tools and HIT, capacity/ economies of scale to support behavioral health staff) that many smaller practices do not. These practices may benefit from our assistance in aligning their activities across various initiatives to reduce practice burden.

We will promote a dual approach to practice transformation by offering both formal, structured support and informal assistance tailored to practices' individualized requirements. Because we are already established in the region, we understand not just the differing regional characteristics of the regional membership, but also the differing strengths and needs of each of practice in the provider network. Systematic health care transformation depends on the success of practices and their ability to improve the quality, cost, and patient experience of care without being overburdened or fatigued.

Training, Learning Collaboratives and Other Resources

As outlined above, we are committed to using learning collaboratives, training/toolkits and other educational approaches as key components in supporting practice transformation for network providers. For example, we currently partner with Peer Assistance Services, who are experts in intervention and prevention services, to train providers in SUD screening. We use the practice engagement and assessment processes described above to identify needs in SUD screening and leverage already established community resources to provide technical assistance for these screenings. As a RAE, we will deploy these approaches strategically, based on the gaps, needs, priorities, and stated transformation goals set for the region and for individual practices.

One of the principal methods for identifying priority topics for learning collaboratives, training and other resources will be the common agenda process led by the Regional Governance Councils described in Offeror's Response 8—Governing Body and Conflict of Interest Plan. These leadership groups will be closely involved in developing regional transformation goals and in planning interventions, such as training, that will be used to support achievement of these goals.

PROVIDING FINANCIAL SUPPORT TO IMPROVE CARE PROVISION

With more than 20 years of experience in implementing Colorado's administrative and risk-based Medicaid contracts, we are well prepared, and have the existing experience, to make administrative/performance payment directly to PCMP network providers. We are pleased to support the provision of medical home level of care, and to incentivize improved outcomes through these new payment structures. Our contracting department is experienced in maintaining Medicaid contracts under at-risk, direct provider payment and third

party payment structures, and has existing accurate and efficient processes through which we pay not only behavioral health, but primary care providers.

We have already gained unique and invaluable experience with a variety of administrative and performance based alternative payment models (APMs) including:

- A full-risk Medicaid Managed Care Organization contract (please see Responses 18 and 19 for detail)
- A primary care partial risk capitated APM collaboration between Colorado Access and Kaiser Permanente (Access KP)
- An integrated primary care APM
- An APM used as a nudge strategy to improve KPI outcomes
- A value-based primary care per member per month (PMPM) APM
- An inpatient care, bundled APM
- A care management based primary care APM
- Risk sharing with community mental health centers
- BHO Performance incentives

Our experiences and lessons learned across these varied APMs have informed the COA Value-Based Payment (VBP) model – designed to support the delivery of high quality primary care and incentivize both practice and system-wide transformation. We anticipate that the alignment of these payments in a thoughtful and meaningful way will lead to improved outcomes and achievements of the KPI goals in the region. **In this section, we detail some of these relevant experiences and describe the COA VBP.**

Key APM Experiences

The Access KP program primary care partial risk capitated APM is an initiative with the State of Colorado, Colorado Access, and Kaiser Permanente (KP) that is currently implementing and evaluating a novel, partial-risk capitation model. In this program, we hold the contract with the Department which covers approximately 2,000, mostly ambulatory, service codes. The delivery and risk for these services is delegated to KP, for which KP receives a monthly capitation. This Access KP risk-based model replaced the RCCO contract in Region 3 for clients attributed to KP as their PCMP. The program aims to reduce unnecessary/avoidable emergency department (ED) and inpatient utilization by strengthening members' relationships with primary care and by putting primary care providers at risk for quality outcomes. KP is responsible for the services covered by the designated CPT codes, and all other services are billed to the Department. The program launched in July of 2016 and involves approximately 22,000 Medicaid members attributed to KP. This membership represents approximately 10% of the region's enrollment. Through this program, that is the only one of its kind in the state, we are making payments directly to KP as a PCMP. The experience establishing these contracting and payment arrangements between the Department and KP will provide a glide path for future direct administrative and performance payments to our PCMP partners.

Integrated Primary Care APM. In 2017, we have implemented an APM to forward integrated behavioral and physical health care within the primary care setting. We have engaged six primary care practices who receive an enhanced behavioral health capitation payment for providing integrated care to members. The enhanced rate formula is administered through our behavioral health organization (BHO) contract for a set of allowable integrated services that range from diagnosis to behavioral health assessment and psychotherapy. Providers receive an encounter rate that is higher than the normal fee-for-service (FFS) rate for each of these allowable and documented integrated care encounters. The providers submit an annual cost report every six months to justify the encounter rate. The encounter rate is re-evaluated based on actual paid claims compared to total costs to deliver an integrated model of care (including behavioral health clinician salary and benefits, credentialing, education and staff development, administrative costs, etc.) annually.

APM as a KPI "Nudge" Strategy. We developed and implemented a highly successful enhanced rate, Pay-for-Performance model that has improved the rate of Well Child Checks (WCCs) in the CHP+ population over two years. We initiated this program in seven federally qualified health clinics (FQHCs) in January 2015 by providing an additional PMPM to practices that met target metric for WCCs. We chose to implement this program in FQHCs as these providers have extensive patient knowledge and existing administrative infrastructure to increase member outreach – a practice associated with increased rates of WCC appointments made and kept. To date, this program has elicited considerable enthusiasm and involvement from the top leadership of the FQHCs and demonstrated the potential for cost-savings and improved health outcomes with the application of a targeted payment reform model.

An Inpatient, Bundled APM. We also have risk-based contracts with a number of acute and subacute inpatient facilities across multiple physical and behavioral health programs. We also have numerous bundled payment contracts, otherwise known as diagnosis related groupings (DRGs). For a set of established physical or behavioral health care episodes and clinical profiles, we pay the provider up front for member care; typically for a guaranteed period of inpatient care. Research has shown that this type of bundled contract can often be much less expensive than a typical fee-for-service daily rate, so it is advantageous to the payer while driving accountability for outcomes at the site of care. It is also beneficial to the provider, because they are given the flexibility to allot the resources they see as necessary for a member's treatment. It provides an incentive for the provider to treat and discharge members successfully and efficiently. If member treatment concludes in less than the specified timeframe, the provider keeps the savings, and if treatment takes longer, the provider pays the cost. We have also implemented the DRG model within the context of physical health rehabilitation.

Care Coordination-Based, Primary Care APM. We have a number of value-based contracts with network PCMPs that focus on the delivery of care coordination services. For example, we have delegated agreements with practices that provide onsite care coordination, rather than relying on our plan-based care coordination. Delegated providers receive a PMPM payment through contracts individualized to accommodate the unique set of care coordination services offered by each practice. This supports particularly efficient coordination for members attributed to larger providers who may see RCCO, BHO, SEP, and/or CHP+ members – including members who may need care coordination that addresses behavioral and physical health services as well as long-term care accommodations. Delegated practices can provide integrated care coordination that meets all of these member needs within their primary care home, under one overarching COA agreement. These delegated opportunities leverage the ability of network providers to support members with locally-based comprehensive

care coordinated services across primary and specialty providers, fulfilling a COA goal to provide services as close to the member as possible. A small number of our delegated, large practices serve a large proportion of members in each region. We understand that having a variety of care coordination options best supports a diverse provider network, member choice, and improved care coordination and access. In the RAE model, these contracts will be evolved to convert a proportion of the PMPM payments to be at risk if the provider does not achieve the agreed upon KPI outcomes or other specified goals.

Performance Incentives. In fiscal year (FY) 2017-18, the Department initiated a performance incentive program with the BHOs to convert 4% of total capitation to performance payments. To earn this performance incentive, BHOs need to meet qualifying metrics and a defined set of performance measures. We are currently working with our partners to implement shared incentives worth $7.5 million in FY18. Upon award, we will seek opportunities to expand this to include RAE KPIs.

We view these value-based models as a way to expand the bounds of payment reform in order to bring the most value to State healthcare expenditures. Having a variety of models at our disposal will allow us to customize an APM strategy for each of our PCMPs and our behavioral health care partners that meets their unique needs and encourages their transformation to a more value-based model. Our early and ongoing participation in such models demonstrates our commitment to partnering with the Department and our provider network to develop innovative and collaborative solutions that ensure sound stewardship of public funds.

Managing APMs through Change

We have also demonstrated solid leadership in managing VBP contracts during times of transition. When the Department changed MMIS vendors early 2017, Colorado Access and partners had just implemented the Access KP program. As the nexus for eligibility, encounter and capitation files moving between the Department and KP, the IT and project management team at COA took the lead in guiding all of the statewide MCOs in the development of the 820 Capitation, 834 Enrollment, and 837 Encounter files. There were multiple agencies and vendors involved in this process, in addition to thousands of providers, hundreds of thousands of members, and millions of dollars. In order to execute this transition perfectly our IT and project management teams implemented a process to identify and describe upcoming developments, support anticipatory accommodations, help interpret potential requirements, develop primary and contingency plans, and, perhaps most importantly, gather all of the issues from the MCOs around the state for presentation to the Department for consolidated review and processing. These efforts by the COA teams ensured a maximally successful MMIS to interChange changeover for all of the MCOs statewide and helped to avoid potentially catastrophic setbacks.

Contracting with Network Providers: Administrative/Performance Arrangements

We are a licensed HMO with the ability to administer and contract all forms of APMs from administrative management to direct full-risk models. We have operated a full-risk behavioral health organization (BHO) since 1995, and partnered with the Department to pilot a full risk Colorado Regional Integrated Care Collaborative (CRICC) enhanced care coordination model prior to the statewide adoption of the RCCO administrative program. Prior to that, we managed a number of full risk physical health contracts with the Department, as well as CMS. This diversity of expertise in the Colorado landscape will be an invaluable asset as we embark upon ACC 2.0.

In addition, we have leveraged our position as the BHO and RCCO in Regions 2 and 5 to establish contracts with our PCMP providers to make enhanced, performance based payments for integrated care. Our existing contracts

through this initiative detail an enhanced rate formula that is paid directly by COA. This contract is administered through our behavioral health organization (BHO) program and provides for an enhanced rate for a specific set of stated, allowable integrated services. This model is described in more detail in Offeror's Response 20—Support of Primary Care-Based Behavioral Health Services.

We see the move towards value-based purchasing as a critical opportunity to improve the quality of care, member experience, and be a responsible steward of public funds. As a result, in 2015 we created the role of director of payment reform. This position is responsible for understanding the payment reform landscape at the federal, state, provider, facility and system level. Additionally, this position ensures that VBP contracts at Colorado Access are evidence-based, and align wherever possible with other initiatives such as MACRA, CPC+, SIM and others. Given the complexity and fast-moving context of payment reform, this position works in a dynamic fashion with Colorado Access leadership and our provider support department to ensure that we, and our providers, are managing and maximizing value-based purchasing to the greatest extent possible.

Principles of the COA VBP Model

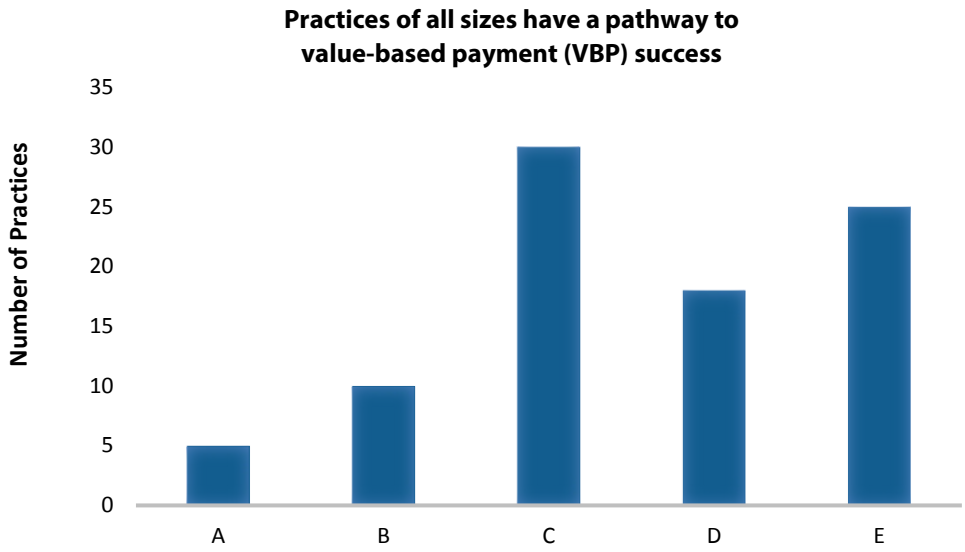
Under the leadership of the director of payment reform, we have already developed a VBP model for the administrative PMPM outlined in the RAE RFP, so we are ready to implement innovative payment models immediately upon successful RAE award. This model will leverage the understanding of, and relationships with, the PCMPs in our region, as well as with our health neighborhood partners – with whom we have been working for more than 20 years. In a departure from standard care management delegation agreements common in ACC 1.0, this new and more sophisticated model will take into account the nuances and needs of both the providers and members served by the contract and will advance the statewide desire for value-based purchasing in primary care.

The principles of the COA VBP model are designed to meet or exceed current and future KPI targets and support transformation at the practice and system level. We have developed this VBP model with the following considerations: KPI goals must be met; performance must continually improve; providers will have patients attributed or assigned with whom they have no historical relationship; practices are being asked to participate in many different and/or competing payment reform models; and the RAE model and implementation must be complimentary to these factors. Our VBP model has been informed by our experience with care management delegation activities in ACC 1.0, as well as our history with BHO and managed care contracts and our 20 year history with the Medicaid provider community in the region. The literature shows that successful models align provider and payer incentives, have valid data and robust data sharing; allow for flexibility in care delivery; provide adequacy and predictability of payment; create accountability for elements of cost and quality that the provider can control; provide some element of risk for practices; and incentivize and reward performance improvement in pursuit of an ultimate goal. These elements of successful program design, coupled with the specific requirements of the RAE contracts, and up to date information on the evolution of other payment models (SIM, CPC+, etc.) will be incorporated into the model by the regional governance council and then implemented at a detailed level with each PCMP and in the region.

Multiple Pathways to VPB Success

Similar to the Department's Advanced Payment Model tracks, we have identified five potential types of value-based payment arrangements for practices in the region. These arrangements will continue to evolve over time,

but currently provide a starting point for the VBP model implementation. This model ensures success for all types of practices.

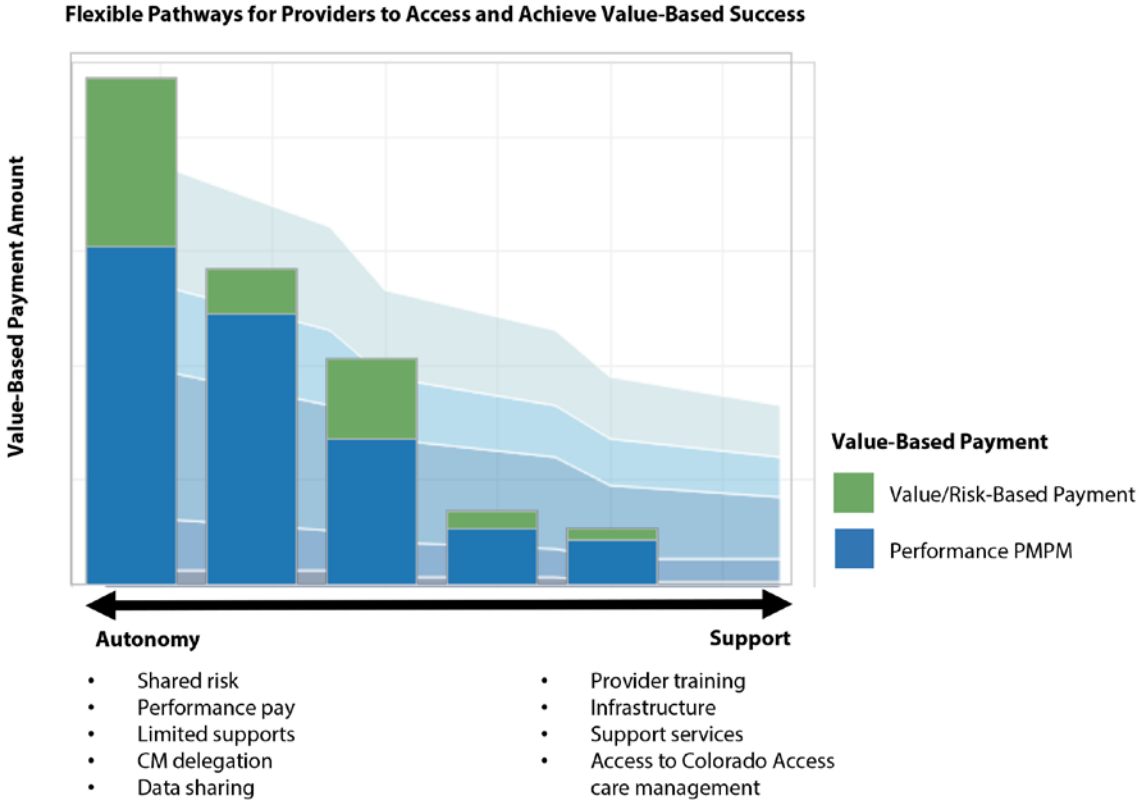


Type A includes custom risk-based VBP arrangements such as the Access KP program in Region 3 or the Medicaid + Choice program in Region 5. Participation in this type would be limited to Department supported risk models and programs. Practices would not be able to "opt in" to this type independently. Type A would have the most automated and robust data sharing arrangements as these entities would be expected to have the capabilities to independently accept, analyze, and act upon information to drive the desired outcomes.

The second type of payment arrangement, Type B, is for practices that have a high volume of attributed Medicaid members, infrastructure to support on-site care management, team based care, internal quality improvement activities, and the ability to manage some level of financial risk and a history with delegated contracts. Type B practices would need to have demonstrated experience with achieving external KPI-like goals and a willingness to continue to improve their performance over time. The key drivers in this type would be a higher base PMPM for the practice to support these efforts and a performance based risk structure that would be evaluated and paid quarterly. If agreed upon metrics are achieved, the practice would receive an upfront performance based payment, if the metrics are not achieved, then the practice would experience some recoupment of payments until improvements are made. These Type B practices would have a robust data sharing agreement with us that could include access to raw claims data, summarized information on metrics of interest, detailed information on hospital data, and other information from the local HIE. Type B practices would require the least amount of direct support from COA and thus, have the potential to participate in higher dollar performance payments.

The third type of practices would be those that have experience with care management delegation, some internal performance improvement infrastructure, and a desire and ability to manage some level of risk, Type C. Practices in this type may have had challenges in operational execution of performance projects, variability in

outcomes achieved or other issues. Type C practices will require some direct support from COA to address operational or structural challenges within the practice and assist the practice in achieving the stated goals and objectives of the program. Practices in this type would have access to a wide variety of data and analysis to support their efforts. We will assist Type C practices in receiving and leveraging data into actionable information. Specific data sharing arrangements would be developed for each practice based on unique needs. In this type, practices would receive a PMPM from COA, some direct pay for performance tied to agreed-upon metrics (KPIs or process metrics related to the KPI outcomes), and some additional risk based ability to earn additional incentives to be paid on a retrospective basis once outcomes have been achieved. The pay for performance component would be tied to incent and reward small, but meaningful improvements versus supporting infrastructure. The overall goal of Type C is to move practices towards Type B so they can share in more upside risk and have more dependable funding streams.



The fourth type is for practices that are focused more on mission than finances. These practices would not have care management fully delegated to them but would have the option to develop and implement some elements of care management on- site, with the support of the full COA care management model. Type D practices would receive a lower PMPM and be eligible to participate in the performance incentive pool as they achieve desired outcomes. We would regularly provide these practices with information on their attributed patients as well as their performance against the KPI metrics and would have access to more detailed data, based on their desire and ability to utilize the information. We would provide a higher level of support at the

practice level to help the practice maintain or improve their performance and help them move to the third type if that is the practice's desire.

The last type, type E, would be for practices that have very low Medicaid attribution or are small practices without a desire to transform (i.e. rural practices with older practitioners or specialty practices like refugee centers). These practices would be eligible for the lowest PMPM payments and could participate in the performance inventive pool - but both would be optional. The type E practices would have the full COA care management support for attributed members and would be able to work with us on practice transformation and other practice supports as they desired. We will provide them with performance data and encourage them to participate in regional efforts as appropriate. These practices would be encouraged to progress into types D through A - but would be able to remain within their current type as long as they continued to meet a minimum standard of KPI performance and delivered high quality care to their patients.

Members of the medical neighborhood would also be eligible to share in incentive dollars earned by the region. How neighborhood providers would participate in the regional KPI performance pool would be determined by the regional governance council and would be validated and confirmed by the regional advisory council. This participation would likely vary by the KPI and relative contribution of the members of the medical neighborhood to the achievement of the goal. This model would evolve as KPI performance was improved within the region, as new payment reform programs emerge, and as the Department's needs under the ACC 2.0 model grow.

Administrative Payments

As the RCCO, we have worked to direct administrative PMPM resources to practices through value-based models, pay-for-performance lump sum allocations, and delegated arrangements. We have also used some of the administrative flexibility to develop and implement system-wide solutions to meet member and provider needs. A strong example of one of these solutions is our enterprise-wide virtual integrated care initiative (VICI), discussed above, through which, network providers can access on-demand behavioral health consultation and some direct care service for members, at no additional cost to practices or members. This system-wide solution efficiently uses fewer resources than would be needed to establish this type of behavioral health access for individual practices – particularly small practices. As the RAE, we are prepared to build upon these experiences and successes and will distribute at least 33% of the administrative PMPM payment to our provider network. We are prepared to offer $2 PMPM to network providers and make additional value-based PMPM funding available through payment structures that meet current and evolving ACC needs, as described in the previous response. We will continue to work collaboratively with our regional governance councils and our network providers to implement a regional strategy to evolve administrative payments over time, tying a greater proportion of the dollars to value and aligning with other Department alternative payment methodologies.

Our long history with the Department shows our willingness and dedication to being a nimble entity – we know that the only way to support ongoing system transformation and improvement is to evolve and transform internally as well. The work we have already done to develop the regional governance council has fostered buy-in and shared ownership for regional outcomes. We will leverage the governance council and an engaged network to negotiate payment arrangements and ensure that payment strategies meet providers and health neighborhood participants, large and small, where they are. We have additional experience making administrative and performance based payments to providers of our CHP+ and BHO networks. **Our cross**

program experiences not only enhance our ability to successfully implement a variety of payment and incentive structures, but it also brings the benefit of lessons learned to our regional networks and the state as a whole. The experience of managing rural, frontier, urban and suburban populations of providers has given us particular expertise in understanding how both implementation and ability to meet desired outcomes with administrative/performance payments are differentially impacted by regional variables.

Pay for Performance (P4P)

We will share incentive payments made to the RAE with PCMP network providers and health neighborhood participants in a way that maximizes provider performance and regional health outcomes. As a RCCO, we have used the flexibility of these RCCO-earned incentive dollars to foster provider-level innovation and infrastructure development. The ongoing P4P program is an example of our dedication to supporting practice-based and identified approaches to maximize performance. In 2015, we were awarded performance incentive funds under our RCCO agreements by the Department for meeting or exceeding performance targets in one or more of the three current key performance indicators (KPIs). To further the successes of the ACC Program and recognize the assistance of the PCMPs in achieving these performance targets, we made up to $50,000 available to individual PCMPs to aid with projects that focus on the ACC program goals, performance metrics, and/or strategies, including but not limited to integrated care, member activation and/or satisfaction, postpartum care, care for members with chronic conditions, attribution and connection to a medical home, etc. We awarded RCCO P4P Project funds to six PCMPs who applied for, and were awarded funding for projects involving their clinic's behavioral health integrated care program and collaboration with the Mental Health Center of Denver. The six projects were primarily focused on developing new infrastructure and processes for the facilitation/provision of behavioral health in the pediatric primary care setting. Project components included: depression screening, supported referral, establishing on-site behavioral health care, and developing chronic disease registries.

PRIMARY CARE ALTERNATIVE PAYMENT METHODOLOGY (PRIMARY CARE APM)

COA: Playing a Key Role in Administering the Primary Care APM

We are pleased to see the Department transform its approach to primary care payment, and we are well prepared to continue our role in administering the primary care APM. Our leadership team has been an active participant in the workgroup meetings that have been organized and led by the Department to help build out the Department's new Primary Care Track One APM models under ACC 2.0. As the RAE, we have the knowledge, relationships and infrastructure to effectively assess all of PCMPs and ensure accurate payments.

We are already well-versed in assessing PCMPs using the Department's ACC 2.0 criteria and guidelines, stratifying our population of providers into basic, enhanced and advanced payment categories, and simultaneously monitoring outcomes/areas of impact. As an accountable entity, we take seriously the need to ensure that efforts to shift providers from volume to value, give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system – to indeed meet those goals and improve care quality and efficiency. To maintain member focus and responsible stewardship of public dollars, APM efforts must not be implemented simply to meet evolving policy desires, but instead, with continual assessment of their actual impact upon the quadruple aim. We will continue to

effectively assess eligibility for Track One participation, evaluate PCMPs' achievement on the new structural criteria, and provide the Department with eligibility and performance reporting.

Our strong provider relationships, as well as our experience as a Colorado APM leader, mean we are able to manage PCMP questions and concerns regarding the assessment and certification determination. Our provider engagement team ensures convenient and streamlined access through which providers can contact a central, well-known point of contact who will work internally to comprehensively answer all provider questions. We are prepared to reassess every PCMP at a minimum of every three years or based on a substantial change in a PCMP practice or at provider request. Further, we are already well versed in assessing all proposed outcomes and areas of impact. We know that pediatric practices often have specific questions or concerns as they engage in Medicaid initiatives. To support pediatric practice engagement in the ePCMP program, we leverage our contract with CCHAP, a community partner that has particularly strong relationships with pediatric practices in Colorado. We contract with CCHAP to collect ePCMP quality metrics from pediatric practices as part of a streamlined, already existing, practice presence. This ensures that the ePCMP experience is well aligned with other initiatives in these pediatric practices. While working with providers to collect ePCMP data, CCHAP is also engaging providers in discussions with practices about how the ePCMP factors connect to initiatives like SIM and how they can build on their current ePCMP experience to prepare for future payment models.

Our provider engagement team is currently in the process of collecting documentation to re-certify ePCMPs originally certified during FY 2014-15 and PCMPs to be certified for the first time during FY 2016-17. Upon RAE award, this ensures efficient implementation in our regions. Our ongoing experience sets forth a successful glide path for contracting, certifying, and administering the evolving APM. Additionally, our experience with at risk Medicaid contracts means we are savvy with a variety of risk models and are well prepared to meet current and future needs of the Department by participating and administering payments across zero, partial, and full-risk structures. Our provider data allows us to identify practices with particular attributes and interests that may align them with new opportunities or programs.

Leveraging Proven Provider Engagement to Support Practices

As the RCCO for three regions, we have partnered with the Department to deliver Medicaid funds to participating SIM Cohort 1 and 2 practices as well as the CPC+ participating practices. As the vendor with the direct relationships with these primary care practices, we, as the RCCO, were asked to develop and execute contracts with the specified providers to outline the payment methodologies, lay out requirements for participation and receive and evaluate the required outcome information. To date we have paid out more than $2 million under these programs. Further, as the only three-region RCCO, we also have a unique understanding of how the new PCP Track One APM model may impact both large and small providers in rural and urban areas. Our ability to share this perspective with the Department has contributed to a model designed for success with Colorado's varied providers. Further, our close involvement in developing this new model prepares us, as a RAE, to immediately deploy a sophisticated system of provider assessment and certification, supported by data-sharing and existing forums for ongoing collaboration with the Department, providers, and health neighborhood partners.

As a longstanding partner to the State and a sound steward of public dollars, we have enthusiastically participated in this program, and encouraged and supported network provider partners in taking this important

initial step towards alternative, value-based payment models. Initial evaluation metrics show that the cost of care for members attributed to ePCMPs was approximately $100 PMPM less than for members attributed to non-ePCMPs across all three of our RCCO regions. This difference is substantial, and particularly promising given that patient panel characteristics were matched across ePCMP and non-ePCMP practices.

Finally, we have in-depth knowledge regarding the database structures needed to support the flexibility and rapid, data-based decision making required for true APM innovation and success. We are building a provider database to store and efficiently access the full set of data needed to manage and stratify a population of providers across structural and performance competencies, HIT/HIE capabilities, specialty offerings, language and cultural competencies, enhanced offerings (e.g., extended hours of operation) certification criteria, VBP contract performance, etc. By leveraging existing provider database technology, sophisticated algorithms will match our data element to national sources to identify and correct invalid, incorrect, incomplete, and outdated data. This ensures a continually updated and accurate source of provider data to support APM efforts - as well as fully informed provider population management and member choice.

Capitated Behavioral Health Benefit

LEVERAGING EXPERIENCE TO ADMINISTER THE CAPITATED BEHAVIORAL HEALTH BENEFIT IN COLORADO

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 settings
c. Ensure compliance with federal managed care regulations

For more than 20 years, we have successfully managed capitated benefits for both behavioral health and physical health. We have served as the contractor designated to administer and deliver the capitated behavioral health benefit for Medicaid members in Denver since the program's inception in 1998. In 2014, we assumed responsibility as the Behavioral Health Organization (BHO) in northeast Colorado. Since 2009, we have served as the Administrative Services Organization (ASO) for the BHO in the East Metro Region, working closely with the designated contractor for this region, Behavioral Healthcare Inc. (BHI). In addition to BHOs, we currently manage or have managed several other full-risk capitated benefit programs that include the behavioral health benefits, such as Child Health Plan *Plus* (CHP+) and Access Advantage (a Medicare Advantage plan), throughout the state. This broad experience, combined with our current role as the Regional Care Collaborative Organization (RCCO) in Regions 2, 3, and 5, uniquely equips us to advance the Accountable Care Collaborative (ACC) program to the next level. As the only health plan with demonstrated knowledge and skills in administering both behavioral and physical health care for Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, members in these regions, we are prepared and eager to ensure that the capitated behavioral health benefit is fully integrated into the Regional Accountable Entity (RAE), while also ensuring the delivery of all required behavioral health services and program components.

As the incumbent BHO in Regions 2 and 5, we receive a capitated payment for all required behavioral health services for Medicaid members. We ensure access to all covered behavioral health services, are accountable for delivering evidence-based practices and improved health outcomes, and ensure appropriate utilization of behavioral health services. As a leader in the field, we have worked closely with the Department of Health Care Policy and Financing (the Department) and other BHOs in the state to enhance the delivery of high-quality services, expand access to care in innovative ways to a variety of community settings, increase member choice, and use multiple strategies to drive integration of physical and behavioral health care. As a RAE, we will continue to advance these efforts, further integrating the services delivered through the capitated behavioral health benefit with the entire ACC program. Through these activities, we will make a strong contribution to the achievement of the ACC Phase II goals and position the state for further progress as we move through future phases of the ACC program.

Our success in managing these capitated health benefit contracts, many of which have been in effect for more than 20 years, demonstrates our company's ability to assume the comprehensive risk of providing all covered, medically necessary inpatient and outpatient behavioral health services to all enrolled members in a diverse array of geographic service areas, under a variety of capitated payment systems. Moreover, we have

demonstrated a commitment to flexibility, innovation, and partnership with the Department to achieve broad program goals by aligning diverse programs and formats.

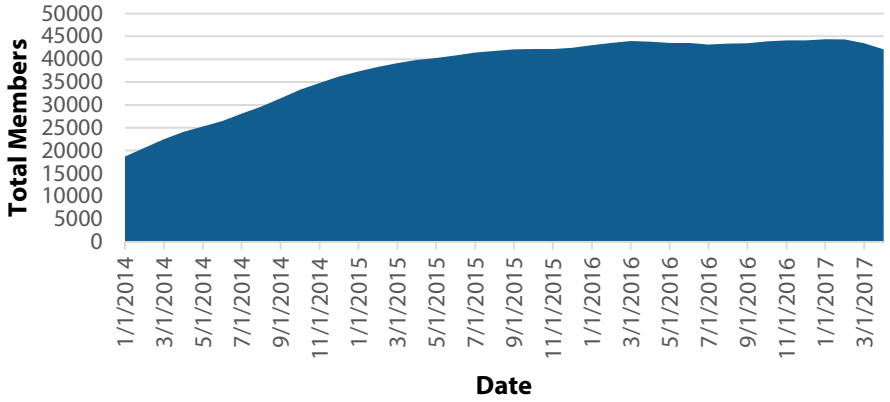
As the RAE in Region 3, we will receive a capitated payment for each member, assume comprehensive financial risk as described in the contract, and provide, arrange for, or otherwise take responsibility for the provision of all medically necessary covered behavioral health services. We agree to reserve the capitated behavioral health benefit for the appropriate behavioral health services identified in the RFP and will not divert these funds for physical health responsibilities. Finally, we will continue to utilize our strategic care management (care coordination) practices, described throughout this proposal, to administer the capitated behavioral health benefit and ensure that network providers are employing practices that drive quality care and support strong consumer experience protections, also described in Offeror's Response 16—Care Coordination.

Increasing Access to Behavioral Health Services

As the Region 3 RAE, we will maintain and expand access to a robust behavioral health care system that delivers and oversees a comprehensive offering of behavioral health services for Medicaid members. In response to Medicaid expansion in Colorado, we substantially increased access to services system-wide, including Region 3, and particularly for behavioral health. Our approach emphasizes access and member choice and a diverse range of high quality services and evidence-based treatments. Behavioral health services will be delivered by a broad provider network, encompassing community mental health centers statewide, federally qualified health centers (FQHCs), school-based health centers (SBHCs), hospitals and residential facilities, substance use disorder (SUD) providers and a large number of private nonprofit, specialized care organizations, individual and group-based practices, and other essential community providers. This extensive network will assure the availability of providers with the capacity and expertise to serve our members and maximize member choice and convenience. A growing number of network providers deliver mental health, SUD, and primary medical care in integrated settings.

Although we have not been the designated BHO responsible for behavioral health in Region 3, the following graph illustrates our ability to increase access to these services. It describes our success in expanding behavioral health services in the Denver region over the past three years.

TOTAL MEMBERS SERVED FOR BEHAVIORAL HEALTH SERVICES IN THE DENVER REGION (2014 TO PRESENT)

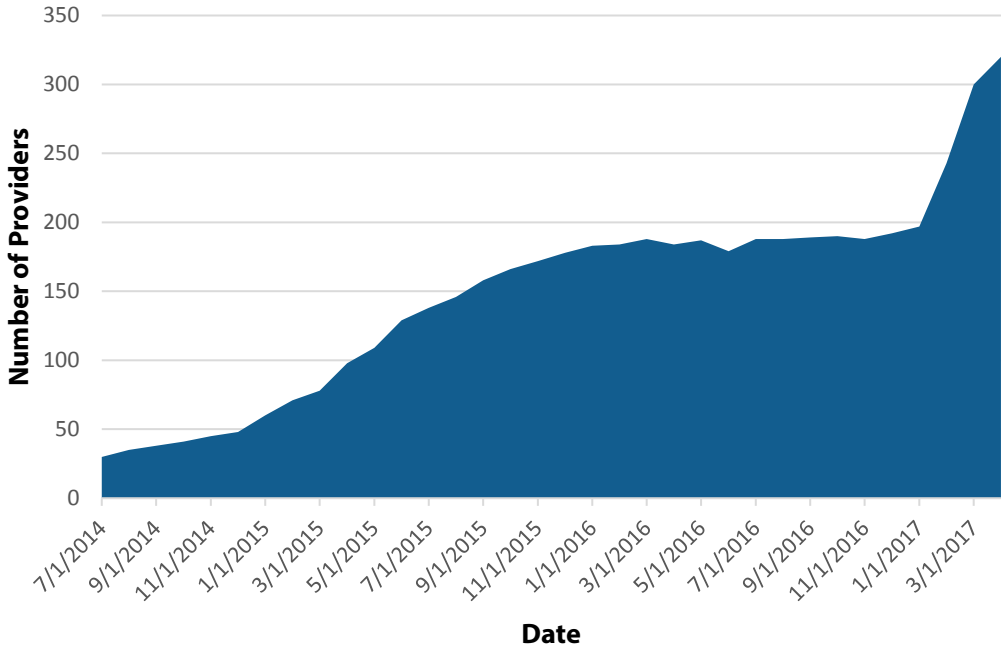


As this Denver graphic shows, we served 18,704 members in January 2014. By January 2017, our services increased by 130% to reach 37,324 members. This expansion translates to a penetration rate increase in the Denver region from 11% in January 2014 to nearly 16% in the first quarter of 2017. We have supported this increase in access by expanding the network of behavioral health providers and increasing the delivery of care in community settings, primary care settings, and through a variety of other innovations. During the time interval above, contracted network behavioral health providers (outside community mental health centers) increased by 30%. In addition to expanding the network beyond the community mental health centers, we have supported providers in increasing capacity. The Mental Health Center of Denver (MHCD) increased capacity for an additional 1,900 adults with the opening of their Recovery Center in 2012 and continues to build. In 2016, they opened the Dahlia Campus for Health and Well-Being in the far northeast neighborhood of Denver, which served nearly 1,300 people for behavioral health services in its first year. In 2016, MHCD served nearly 12,000 unique members, and they are on track to increase that by almost 1,000 members this year. We have also worked closely with Denver Health and the Colorado Coalition for the Homeless to expand their capacities for behavioral health services, and in 2016, they served 10,355 and 2,095 unique members, respectively.

Increasing Access to Substance Use Disorder (SUD) Services

Recognizing the critical and increasing need to support members with substance use disorders (SUD), we have also worked to expand access to providers who offer SUD services to members. In 2014, providers served approximately 500 members, and by January 2017, they served nearly **5,000 members,** a ten-fold increase. The following graph illustrates the substantial increase of network providers submitting claims for SUD services.

TOTAL PROVIDERS WHO SUBMITTED CLAIMS FOR SUD SERVICES



Several providers are leading innovative programs to increase access to SUD services. For example, Mile High Behavioral Healthcare (MHBHC), a leading provider of evidence-based behavioral health and SUD treatment, has eight intervention and treatment programs for members with co-occurring SUD and mental health disorders. They serve nearly 8,000 individuals per year, including more than 1,700 homeless and runaway youth and young adults, at sites located in both Region 3 and Region 5.

In response to the significant increase in the use of heroin, pain medication, or other opioids, several providers, including the Community Reach Center and the Addiction, Research and Treatment Services (ARTS) program (part of the University of Colorado Department of Psychiatry), offer a Medication Assisted Treatment (MAT) programs which provides member with a variety of pharmacological, behavioral, and psychosocial treatments. The ARTS program, guided by the latest in scientific evidence concerning effective treatment interventions, specializes in Buprenorphine products (Suboxone and Vivitrol) and Methadone treatment for opioid use disorders. The program also uses medications for alcohol use disorders, including Naltrexone and Vivitrol, at clinics located in Aurora, Denver and Arvada. Another long-time partner, Arapahoe House, is the state's largest SUD treatment provider. Arapahoe House is a major provider of MAT services, and also offers adult and adolescent members a full array of SUD treatment services in locations in Aurora, Littleton and Thornton. Services for individuals with co-occurring mental health and substance use disorders are a particular specialty of Arapahoe House.

Increasing Access for Members with Intellectual and Developmental Disabilities

We will incorporate lessons learned from the recent and ongoing Cross-System Crisis Response Pilot Program to improve the delivery and coordination of behavioral health services, and increase access for individuals with intellectual and developmental disabilities. We participated in the gap analysis of service offerings, conducted by JFK Partners in 2014, and this report led to House Bill 15-1368. This pilot program was created to provide crisis intervention, stabilization, and follow-up services for individuals with co-occurring disabilities and mental or behavioral health conditions, and who need supports not covered by waivers or the current behavioral health care system. The pilot program went live in August 2016, and we await early data for analyses to inform our future strategies for supporting this population of members.

We also will look to The Children's Hospital and Aurora Mental Health Center, both of which have long-standing expertise serving members of all ages with intellectual and developmental disabilities, for leadership on increasing access. Aurora Mental Health Center's Intercept program, a collaborative effort with Aurora Public Schools, is a notable example of this organization's focus on members with these special needs.

Fully Integrated and Seamless Experience

We will integrate functions of the capitated behavioral health benefit into the broader ACC at every level:

- The Colorado Access board of directors includes members who provide behavioral health services, physical health services, and both.
- Similarly, the membership of the Region 3 Governance Council includes behavioral health, primary care, and specialty medical providers.
- Our Regional Advisory Council will be inclusive of all provider specialties, community stakeholders, and advocates.

- Our staff organizational and programmatic structures have evolved over time to be inclusive of the capitated behavioral health benefit and the ACC. We will continue this evolution to a new staffing model that is fully integrated (as described in Offeror's Response 4—Organizational Structure and Key Personnel).

As the contracted RCCO in Region 3, we have worked closely with BHI, the East Metro Region's BHO, to integrate the two programs for mutual benefits. Care coordination activities are frequently integrated across programs so that members have a seamless experience and redundancy is minimized. Our quality, compliance, data analytics, population health, and operations staff members also work closely with BHI to assure that these activities are coordinated across BHO and RCCO contracts. The RAE model builds upon our current efforts and moves toward a fully integrated, more streamlined, efficient, and seamless system, one in which members have access to behavioral health services without barriers or delays. With RAE outcomes and incentives more fully aligned, we will make use of future opportunities to invest in behavioral health services that strengthen health outcomes. Our vision for this system includes all of the following principles:

- Comprehensive whole-person care plans
- Universal behavioral health assessment and access to brief intervention within a PCMP
- Sharing of information and streamlined referrals between systems of care
- Supporting PCMPs in behavioral health integration

Comprehensive Whole-Person Care Plans

As the RAE, we are committed to a comprehensive system of establishing whole-person care plans (service plans) with each member because we know that positive health and life outcomes depend on multiple aspects of care, including physical health, behavioral health, and social determinants of health. Our providers and care coordination teams create smart treatment or goal-setting plans that connect members to a PCMP, behavioral and specialty health care providers, and community resources that support recovery and resilience, such as substance use disorder support groups and access to permanent supportive housing.

Our partner, Mile High Behavioral Healthcare (MHBHC) serves the Denver and tri-county region of Arapahoe, Douglas and Adams counties. MHBHC's Beat the Street is an integrated program designed to address the complex needs of homeless and runaway youth, including many who have previous or current involvement with social services and/or criminal justice systems. MHBHC's clinical team partners with Urban Peak's outreach/case management team and housing resources to provide a full continuum of services for youth experiencing homelessness and needing physical and behavioral health and SUD treatment. Serving more than 50 youth per year with comprehensive care plans, the program aims to achieve sobriety and permanent housing for 80% of their clients within 12 to 16 months.

In addition to our collaborations with MHBHC, our care managers work with providers to create whole-person care plans. Described more fully in Offeror's Response 16—Care Coordination, we have a registered nurse (RN) care manager embedded in the emergency department (ED) at UCHealth (UCH) in Aurora. Through the Super Track program, this care manager works with members who present in the UCH ED to coordinate their social and mental health care and increase collaboration with their health care providers, thereby reducing unnecessary ED utilization. These members are identified through a monthly list, provided by UCH, of members who have interacted with the ED RN. Interventions include education on appropriate ED use; connecting those who

remain unattributed to a primary care medical provider (PCMP) and scheduling a follow-up appointment; assessing barriers to medical, behavioral health, social care, and motivation levels; and development of care plans. RN care manager interventions, including development of whole-person care plans, are delivered directly in the ED. Members who require interventions beyond the 48 hour follow-up are referred to the our internal care management team for more intensive care management interventions and connections to the members' PCMP or other specialty providers. The relationships our care managers have built with these providers over the course of their tenure ensures that members have seamless access to the care they need, when they need it.

Access to Behavioral Health Services in a Medical Home

Medical homes (PCMPs) offer a model of care that offer a seamless experience for members because they are primary access points to both primary and behavioral health care. Most members view their PCMP as their primary point of contact within the health care system, and there are often lower levels of stigma and fewer barriers to access if the PCMP serves as the entryway into behavioral health services. In a medical home, members receive routine screening for mental health and substance use disorders. Persons with positive screening findings receive additional assessment and, when needed, brief intervention. When a behavioral health clinician is needed, but not physically present in the PCMP office, we are able to leverage the use of telehealth in clinics, including on-demand access to a behavioral health clinician, SUD specialist, and/or psychiatry consultation.

At MCPN in Aurora and Englewood, for example, our members have access to behavioral health care in their primary care medical home, as they do at the Be Well Primary Care Clinic in Littleton, which is operated as a collaboration between MCPN and AllHealth Network. Littleton is also home to Doctors Care, a large pediatric provider which offers integrated behavioral health care in its primary care clinic. All members receive behavioral health screenings, and when necessary, see a behavioral health clinician who is co-located at the clinic. Salud Family Health Centers, Clínica Tepeyac, and the Refugee Wellness Center, strive to remove barriers to behavioral health for all of their clients by emphasizing the importance of culturally competent, whole-person care in a primary care setting, and providing avenues by which members can access a full spectrum of services to meet their needs.

Currently, 81% of RCCO members have access to behavioral health services in their PCMP clinic. Alternatively, members with serious mental illness, and/or substance use disorder, have access to medical assessment and primary care services within their principal care setting, typically a community mental health center (CMHC).

Information Sharing and Streamlined Referrals

The seamless, coordinated member experience is enhanced through medical record-sharing and streamlined referral processes between providers. For persons requiring higher-level or ongoing behavioral health specialty care, warm transitions are made between the PCMP and the behavioral health specialist rather than referrals. This increases the likelihood of follow-up, improves the member experience, and reduces duplication. Our streamlined referral mechanisms promote direct feedback from behavioral health to the medical home, ensuring continuity of appropriate care for members. We use several mechanisms to facilitate access to specialty behavior health services when intensive services are more than can be provided in a primary care clinic:

- Co-located behavioral health: Offering more intensive behavioral health services in the same location as a primary care clinic can reduce barriers for members, who access care in a familiar location where front office and ancillary staff are the same.

- Care coordination: Care coordinators in PCMP settings are essential to assisting members in navigating and accessing behavioral health services at other sites and proactively manage communication between the providers.
- Tele-behavioral health services: On-demand access to virtual specialty behavioral health services is a new and innovative approach to increase behavioral health service delivery in PCMP settings.
- Enhanced, streamlined referrals: The embedded behavioral health clinicians and care coordinators are well connected to the rest of the behavioral health system and frequently facilitate access to more intensive services at the CMHCs or the broad network of specialized providers.

Supporting PCMPs in Behavioral Health Integration

We work closely with primary care practices to increase their capability and capacity for integrated behavioral health services. The array of options available to practices includes:

- Practice Transformation Support: We have adopted the SAMHSA Center for Integrated Health Solutions[1] standards for integrated behavioral health and primary care. We assist all network PCMPs to work toward these competencies, especially enhanced PCMPs. Our provider engagement team, including practice transformation facilitators and staff with expertise in behavioral health, works with practices to achieve the nine core competencies:
    1. Interpersonal communication
    2. Collaboration and teamwork
    3. Screening and assessment
    4. Care planning and care coordination
    5. Intervention
    6. Cultural competence and adaptation
    7. Systems oriented practice
    8. Practice-based learning and quality improvement
    9. Informatics
- Practice Transformation Organization (PTO): We are an approved SIM PTO and will work with select SIM-participating practices.
- Integrated Behavioral Health Clinicians: We collaborate with primary care clinics to support fully integrated behavioral health clinicians. We currently have contracts with 72 primary care clinics that directly provide behavioral health services.

[1] Hoge M.A., Morris J.A., Laraia M., Pomerantz A., & Farley, T. (2014). Core Competencies for Integrated Behavioral Health and Primary Care. Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions.

- On-Demand Telehealth: Through AccessCare Services (ACS), a subsidiary of Colorado Access, we offer virtual on- demand psychiatric and clinical behavioral health services to selected practices.
- Project ECHO (Extension for Community Healthcare Outcomes): We support Project ECHO and have offered consultation on topics through this platform.
- Electronic consultations: Through ACS, we will offer electronic consultations and store-and-forward consultations.

Since we launched our Innovations Program for Integrated Care in 2014, we have made significant progress toward integrating behavioral health and physical health and creating a more seamless experience for members and providers. In 2014, we did not have any behavioral health contracts for services in primary care settings; now we have 72 behavioral health contracts with behavioral health clinicians working in primary care. We discuss this work more in-depth in Offeror's Response 20—Behavioral Health in Primary Care. We share and are strongly committed to the Department's goals of integration, systems alignment, and member and family-centered care that create a seamless experience for providers and members. We have demonstrated our commitment, and the commitment of our partner providers, to integration through numerous innovative integrated care initiatives.

Utilizing our incentive funds for meeting key performance indicators (KPIs), we supported the integration of behavioral health-focused staff into three Region 3 pediatric/family medicine practices: Doctors Care in Littleton, Rocky Mountain Health Center in Adams County, and Dr. Suman Morarka in Aurora. Funds from our Pay for Performance (P4P) grant program provided a variety of necessary supports to integrate these PCMP practices. New services included depression screenings for teens and new mothers, the introduction of health navigators and life coaches to offer socio-emotional support, and a biofeedback program to help teens and parents reduce stress. These collaborations illustrate our commitment to supporting PCMPs to make these transformations, for their practices and our members, that align with the vision of the ACC.

A) OUR COMMITMENT TO THE KEY PRINCIPLES FOR BEHAVIORAL HEALTH SERVICES

We are committed to delivering care that is sensitive to and understanding of the unique needs of members, while supporting and encouraging their independence. Through a myriad of community partnerships and our multi-tiered care coordination system, we sustain a system of care delivery guided by the following six principles:

1. Recovery and resilience
2. Trauma-informed
3. Least restrictive environment
4. Cultural responsiveness
5. Prevention and early intervention
6. Member and family centered care

Recovery and Resilience

We recognize the significance of recovery and resilience in the overall well-being of members and have pioneered the concepts of recovery and resilience in Colorado. To accomplish these aims, we collaborate with many providers and community organizations that focus on empowering members to improve their life

outcomes through positive behavioral changes and skill-building. Together, we have developed administrative structures and clinical services based on these concepts and have provided active support for the recovery-oriented activities offered through local, peer-run, advocacy, and other community organizations. We were the first behavioral health managed care organization in the state to employ consumers and family members as staff, and we continue to expand our focus on recovery and resilience.

Recovery Training and Support Programs

Peer education and coaching models have become central to the recovery movement. Peer support has proven successful in reducing hospitalizations, diminishing exacerbations of symptoms, as well as increasing treatment compliance and coping skills for persons with addictive and mental health disorders. Many providers offer programs that utilize the strengths of peer specialists. At Addiction Research and Treatment Services (ARTS), for example, their adult SUD outpatient program uses a peer education and coaching model. ARTS offers peer education services that address independent living skills, advocacy and crisis management, self-help, and vocational supports, among other topics.

Ten Health and Resilience Factors

1. ***Stress management***
2. ***Healthy eating***
3. ***Physical activity***
4. ***Restful sleep***
5. ***Service to others***
6. ***Support network***
7. ***Optimism based on positive expectations***
8. ***Cognitive skills to avoid negative thinking***
9. ***Spiritual beliefs and practices***
10. ***A sense of meaning and purpose***

Our peer support specialists are trained in the Whole Health Action Management (WHAM) peer support program. WHAM is a training program and peer support group model developed by the SAMHSA-HRSA Center for Integrated Health Solutions to encourage increased resilience, wellness, and self-management of health and behavioral health among people with mental illnesses and substance use disorders.

The WHAM training is a two-day, in-person peer support training that guides participants through a person-centered planning process to set a whole health and resilience goal. The program outlines ten health and resiliency factors, including stress management and healthy eating, to help a participant create a concise whole health goal, which can also be added to a treatment plan. The program provides skills to enhance self-management, including eight weeks of WHAM peer support groups and a weekly action plan to create new health habits.

Supporting Youth and Their Families through Recovery and Resilience

Rocky Mountain Youth Clinics (RMYC) is a provider partner committed to delivering services and supports that build resilience for children and their families through a variety of avenues. As a pediatric practice that understands the impact of recovery and resilience, particularly for low-income children, RMYC engages with parents and caregivers to educate them on effective ways to respond to and take care of their developing children. They screen all new mothers for postpartum depression and if a mother screens positive, their medical providers and behavioral health consultants take extra time to understand her situation and needs. They may offer a connection to individualized treatment, an invitation to a support group offered in their clinic, and/or connections to community-based resources that can assist with recovery. Helping mothers recover from postpartum depression and build resilience allows them to be more responsive to their children who can then develop into more resilient adults.

Trauma Informed Delivery of Care

More than half of the adult population in the United States reports exposure to at least one traumatic event in their lifetime, and this member population is at higher risk for trauma exposure. Left untreated, the effects of trauma can affect a member's willingness to seek and trust providers or engage in self-care and their own recovery process. With our community partners, we recognize the multitude of ways in which members may experience trauma in their lives. Treatment modalities that are responsive, sensitive, and compassionate toward member experiences with trauma are associated with better health outcomes and higher levels of member engagement. Our providers offer a diverse array of trauma-informed approaches to care, including:

- **Aurora Community Mental Health Center:** recently implemented an intensive in-home therapy team that works with child welfare involved youth and families with higher mental health needs using Trauma Systems Therapy. In other settings, this evidence-based model has demonstrated effectiveness in reducing use of community resources and hospitalizations. Research has shown reductions in Medicaid costs by nearly half. We will be tracking the outcomes of this new program closely to determine the potential for replication in other areas of Region 3 and throughout our provider network.
- **Trauma-informed approaches and evidence-based practices** – In addition to Aurora Mental Health Center, all of the large behavioral health service providers in our region (e.g., AllHealth Network, Arapahoe House, ARTS, Community Reach Center, Mile High Behavioral Healthcare, etc.) have integrated trauma-informed approaches into all of their programming, and frequently offer training to community agencies such as human services departments and law enforcement on trauma awareness and the impact of trauma on members and other clients. These providers have well developed programs for children, adolescents and adults that deliver trauma-informed, evidence-based interventions such as Eye Movement Desensitization and Reprocessing, Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and the Trauma Recovery Empowerment Model for men and women.
- **Healthy Environments and Response to Trauma in Schools (HEARTS) program**: is a collaborative effort involving Aurora Community Mental Health Center with Aurora Public Schools. Begun in 2013, HEARTS is a whole-school, multi-tiered preventive intervention program for creating trauma-informed, culturally competent, safe, and supportive schools. Three tiers of programming focus on training for all school staff, consultation to help staff members implement practices throughout the year, and wellness and mental health services for students, families and staff. Evaluation results have shown increases in teacher and staff knowledge about trauma and use of trauma-sensitive practices, as well as improvements in students' ability to learn and spend time in the classroom. HEARTS is continuing implementation in Aurora Public Schools and will expand to Cherry Creek School District this fall.

Least Restrictive Environment

We believe in the principle of working with members and their families to access care in the least restrictive environment possible. While inpatient care may be necessary at times, we rely on members and their care teams to safely and efficiently move them back into their communities, where they can access high quality care from multiple community services and supports. Two of the many ways in which we demonstrate our commitment to care in the least-restrictive environment are our initiative to increase our network of providers willing to provide home-based services, and our embedded hospital-based care coordination program.

Home-Based Services: Over the past two years, we have successfully increased access to home-based services for children and adolescents through an intensive services model. We offer enhanced rates to providers who agree to implement an evidence-based in-home intervention model. This model is an effective alternative to inpatient hospitalization and offers the advantages of keeping families united and children and youth in their homes and communities, rather than in institutional settings. This approach to care also encourages the building of adaptive skills that are directly applicable to the home environment. Currently, we have a network of 133 providers delivering intensive in-home services, and in 2016, 3,244 members received services within their own home environment.

Hospital-Based Care Coordination: Another example of our commitment to moving members out of restrictive levels of care is our embedded care coordination program. In Region 3, we have care managers who are outplaced at UC Health and at Colorado Mental Health Institute at Fort Logan (CMHIFL). These care coordinators engage with members and hospital staff in the psychiatric emergency department and inpatient services and intervene to avoid unnecessary inpatient admissions and facilitate discharge to community settings as soon as safely possible. At CMHIFL, our care coordinator facilitates complex discharges by ensuring that appropriate alternative services are available in the community, including long-term care when needed, thus reducing prolonged institutionalization. In our collaboration with CMHIFL, we have been able to move difficult to place members from long term restrictive care safely back into their communities.

Cultural Responsiveness

Each of our partners makes an affirmative commitment to deliver effective, understandable, and respectful care in a manner compatible with members' cultural health beliefs, practices, and preferred language, and we support them as they continually evolve to be more inclusive in their practices and delivery of care. We offer trainings in cultural competence for our providers, highlighted in Offeror's Response 17—Provider Support and Practice Transformation, and provide interpreter services for smaller practices that have more limited resources.

Cultural competence will be an essential component of all behavioral health services delivered through RAE Region 3 providers. They will offer culturally sensitive and informed programs specifically tailored for GLBTQ adults and youth (Mile High Behavioral Healthcare, The Children's Hospital), Spanish-speaking members (Salud Family Center, Clinica Tepeyac, and Community Reach Center), persons with intellectual and developmental disabilities (Aurora Mental Health Center and The Children's Hospital), and persons who are deaf and hard of hearing (Mental Health Center of Denver and The Children's Hospital). The Refugee Wellness Center in Aurora is a notable example of cultural competence in action. The Center's health navigators are all from the primary refugee communities served. They provide live interpretation in 14 languages, offer care coordination, can speak with the refugees in their own languages, and understand their cultures. In the clinic as a whole, 24 languages are spoken by staff from 17 countries. The resulting linguistically and culturally responsive care improves health outcomes and reduces health disparities.

Prevention and Early Intervention

We recognize that some of the most effective ways to support members toward recovery and overall well-being require collaborative community efforts to improve public understanding of mental health and substance use disorders, while normalizing both as treatable health issues. This destigmatizes mental health and substance use issues, encouraging members to seek supports and remain engaged in their recovery. All three of the

community mental health centers in our region offer Mental Health First Aid, a widely-recognized prevention program that has been implemented throughout the nation and around the world. The course teaches participants the risk factors and warning signs of a variety of mental health challenges. Research has shown that the training program reduces stigma, enhances behavioral health literacy, and improves behavioral health literacy. Training is available both for adults and youth, and programs are open to the public or offered to specialized groups such as law enforcement staff, educators, or business organizations.

Another example of our approach to prevention and early intervention is the adoption of the Healthy Steps for Young Children (HSYC) program at Rocky Mountain Youth Clinics (RMYC). HSYC is a nationally recognized, evidence-based program for children birth to age three, in which primary care providers and behavioral health specialists work closely with families to provide a whole-person and whole-family preventive model of health care. Beginning with well-child visits, this initiative allows behavioral health clinicians at RMYC to partner more closely with high risk families, coordinate screening activities, and problem solve with parents for common and complex childrearing and health challenges. The behavioral health clinicians are trained to provide tailored guidance and referrals, on-demand support between visits, care coordination, and home visits when needed. By working with parents in this primary care setting, RMYC is normalizing behavioral health care as a routine component of child and family wellness.

Finally, many Region 3 providers are focusing prevention efforts on school-aged children and adolescents. As previously mentioned, the HEART program at Aurora Mental Health Center seeks to mitigate the impact of trauma and preserve safety using a whole school approach. AllHealth Network's Smart-Girl is a prevention and enrichment program designed to engage middle school girls (and more recently, boys) in activities that develop their socio-emotional skills. Together, students develop healthy responses to the challenges they face, and learn how to successfully navigate adolescence.

Member and Family Centered Care

We have embraced the concept of member and family-centered care since the creation of Colorado Access. We were the first BHO in the state to employ peer and family specialists to facilitate member engagement and ensure that preferences and best interests are communicated and heeded. The largest providers are now enhancing the involvement of members and families in their care plans by implementing the collaborative documentation process. Through this mechanism, members not only participate in developing and monitoring their plans, but also collaborate with their providers to document each care session.

B) COMMUNITY-BASED SERVICE DELIVERY

As we discuss above, through our broad and diverse provider network, members receive services in a wide variety of community-based venues. These services are delivered by a broad array of providers and in a variety of settings, including community mental health centers statewide, FQHCs, school-based health centers, hospitals and residential facilities, other essential community providers, substance use disorder providers and private nonprofit, specialized care organizations and individual and group-based practices. This extensive network assures the availability of providers with the capacity and expertise to serve our members and maximizes member choice and convenience. We will continually work to increase access to and support providers who deliver behavioral health, substance use disorder, and primary medical care in integrated settings.

C) COMPLIANCE WITH MANAGED CARE REGULATIONS

We ensure compliance with all applicable federal managed care regulations. As a current BHO contractor in two regions, we have a proven track record in complying with Medicaid managed care regulations and effectively meeting the wide range of requirements, including but not limited to member materials, provider directory, grievances and appeals, network adequacy, and overpayments. As the RAE, we will continue to implement and update a comprehensive compliance plan for the capitated behavioral health benefit part of the contract. Our compliance plan is also described in Offeror's Response 24—Compliance.

Our chief compliance officer and our in-house legal team actively monitor regulatory and contract changes and update our program, policies, and processes, as necessary. New managed care regulations (the "Mega Rule") went into effect in 2016, the first comprehensive update to the regulations since 1991. Ensuring compliance with the new rules has required a significant effort internally and collaborative work with the Department. Our ability to comply with federal managed care rules is evidenced by our performance on contract compliance audits. These audits, conducted by the Department's External Quality Review Organization (EQRO), focus heavily on our compliance with federal regulations. We have demonstrated high levels of compliance with managed care regulations in these external audits with scores historically meeting or exceeding 91%.

Behavioral Health Delivery System

We have a long history and proven track record of working with our community partners to create a seamless network of behavioral health services that delivers high quality, evidence-based care and maximizes member choice. Our comprehensive system for whole-person care is founded on core principles of recovery and well-being and ensures accessibility and choice for a wide range of covered and waiver services. Below we describe how we will provide Covered Services and 1915(b)(3) Services as the Regional Accountable Entity (RAE) in Region 3.

OFFEROR'S RESPONSE 19

Describe the Offer's process for providing or arranging for the provision of each Covered Service and how the 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 Offer'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 Services Organizations, and the Department of Child Welfare, to maximize available resources and outcomes for its Members.

THE COLORADO ACCESS BEHAVIORAL HEALTH NETWORK

Our behavioral health network is broad and diverse. We have more than 2,900 network providers statewide in locations that are, on average, just over one mile from each member (99.7% are within five miles). **Since 2011, our behavioral health provider network has increased by 208%.** In 2016 alone, this network expanded by more than 17%. We continually seek and secure additional providers to meet a growing and diverse membership. While many members choose to seek care from the mental health center(s) in and near Region 3, we maintain a large network of providers who offer specialized services for special issues and to unique populations. Examples include:

- Aurora Mental Health Center (AuMHC) is a place for recovery, resilience, and well-being, known as a model for innovative and effective community behavioral health care. AuMHC serves more than 20,000 clients each year. Highlights of AuMHC's comprehensive and groundbreaking work include:
  - The Intercept Center program for youth with developmental disabilities and mental health conditions
  - The Colorado Refugee Wellness Center
  - Healthy Environments and Response to Trauma in Schools (HEARTS)
  - Homeless Service Programs
- The Asian Pacific Development Center is a specialty provider for Asian members, including those who speak Chinese, Korean, Vietnamese and other Asian languages as their first language.
- Metro Community Provider Network (MCPN) is a health home that provides a full spectrum of integrated care, including physical, behavioral, and oral health, pharmacy, and connections to community services.

They also provide support services for individuals living with HIV/AIDS through their MCPN Ryan White HIV Clinic.

- AllHealth Network, a health neighborhood, provides recovery services to individuals and families, as well as special populations, like offenders, and those experiencing crisis.
- Children's Hospital Colorado (CHC) delivers specialized, evidence-based services for children and adolescents, such as those with co-occurring mental illness and developmental disabilities, eating disorders, mood/anxiety disorders, and disruptive behaviors.
- Community Reach Center (CRC) offers comprehensive health and specialty programs for children, adults, and seniors, and offenders, including an Autism Spectrum Disorder Program, and Eye Movement Desensitization and Reprocessing (EMDR) therapy programs for members who have experienced trauma.
- Specialty substance use service providers include Arapahoe House, Addiction Recovery and Treatment Services (ARTS), AllHealth Network, Mile High Behavioral Healthcare, and Community Reach Center.

STATE PLAN SERVICES

As a current Behavioral Health Organization (BHO) contractor, we maintain a robust provider network to assure sufficient capacity, access, and member choice for all the required State Plan Services outlined in Section 5.125.6 of the RFP.

Individual Psychotherapy: We offer a wide range of individual therapy services including many evidence-based therapies such as motivational interviewing, cognitive behavioral therapy, trauma recovery and empowerment model, and dialectical behavioral therapy. Our network also includes providers and services that are tailored to unique clinical groups and populations. Community mental health centers such as CRC, AuMHC, and AllHealth have designed a full spectrum of individual services and outpatient treatment teams specializing in care for specific clinical groups, including outpatient early childhood teams, child and family teams, adult teams, and senior teams provide individual services to the community at large.

Individual Brief Psychotherapy: Individual brief therapy is available to members, as appropriate, from a wide range of providers, including in primary care settings, and will continue to expand.

To increase ease of access, we do not require authorizations for routine outpatient care

Group Psychotherapy: Group psychotherapy is well established as a fundamental part of strength-based, recovery and resilience care. Group therapy is available to members of all ages, as clinically appropriate, and is a major component of treatment programs in partial hospitalization care, residential treatment, and inpatient services. Our largest providers—Children's Hospital Colorado, Arapahoe House, University of Colorado Hospital, and Mile High Behavioral Healthcare (MHBHC) —use a variety of evidence-based group therapy models to address a broad range of issues, from managing a specific medication, to nutrition and wellness. Selected examples of group psychotherapy available in our network include:

- MHBHC offers their Project Recovery Program in which adult members participate in group therapy designed to address addiction, mental health, and trauma issues. This program serves 500 individuals per year.
- AuMHC offers group therapy through their Intercept Center program, a collaboration between Aurora Public Schools, and serves children with developmental disability, in addition to a diagnosable health condition.
- AllHealth Network provides group therapy services for children that explore particular themes—like gardening or recreation—which can help bring a sense of normalcy to children challenged by emotional and behavioral disorders
- ARTS offers group therapy, including seeking safety, life skills groups, anger management, moral recognition therapy, and relapse prevention, among others.

Family Psychotherapy: Family therapy is an empirically based model that views the family as a unique social system with its own structure and patterns of communication. We offer family therapy as an integral part of all therapeutic programming for children and adolescents. Care coordinators promote the inclusion of family members in all treatment processes, with an emphasis on family therapy interventions whenever clinically appropriate. Some providers, such as CRC, offer family therapy with a specific focus, including therapy for families with children who have an autism spectrum disorder diagnosis (offered through their Autism Spectrum Disorder Treatment Program), and family therapy for young adults experiencing symptoms of psychosis (offered through their Prevention and Recovery in Early Psychosis Program). Additionally, ARTS recognizes the extensive support in the SUD research literature for the conclusion that, to the extent that families are involved in a client's treatment, outcomes are substantially improved. ARTS offers a variety of family therapy services, including problem solving strategies for acute marital/family crises, and successfully navigating co-occurring mental health and SUD challenges with family members.

Behavioral Health Assessment: Assessment is the first stage of treatment and is required for each member who requests an assessment or behavioral health services. Providers implement an extensive behavioral health assessment processes that yields a comprehensive understanding of the member's current needs and problems, personal history, health, level of functioning, strengths and resources, and goals for treatment. We ensure that providers have the ability to deliver timely assessments for all members and do not require prior authorizations for assessments at any network provider.

Medication Management: Our large behavioral health provider network delivers timely access to medication management services and includes psychiatrists, nurse practitioners, and registered nurses with prescriptive authority. We also coordinate closely with PCMPs regarding psychiatric medication management for members who are receiving psychiatric medications in that setting (usually based on member preference). Our multi-pronged approach ensures that there is adequate capacity to meet all members' medication needs, offer choice, and utilize psychiatrists efficiently. We are proud to offer members one of the largest networks of psychiatrists in the state, with 300 prescribers statewide. We are supplementing this robust network by expanding access to telehealth options for medication management. Using a virtual solution can increase access where there are

gaps and expand choices and options for members, who may find it more convenient or accessible for their treatment.

Outpatient Day Treatment: Day treatment programs for children and adolescents are effective for those who do not respond to outpatient programs or for whom home-based services are not appropriate. Day treatment is less costly than hospitalization and residential placement, does not disrupt the youth's living situation, and does not require that the youth be removed from their community or peer group. Programs that combine an educational curriculum, cognitive-behavioral therapies, parent skill-building and psychopharmacological treatment are most effective. We will continue to ensure that medically necessary day treatment services are available to meet member and family needs. Further, through care coordination and utilization management, we will ensure that day treatment is part of a resilience and recovery-focused care plan that emphasizes the return to a lower level of care, as soon as appropriate. Our network consists of core providers who offer specialized programs such as:

- CRC Outpatient Day Treatment Program serves children from kindergarten through 12th grade. The program has capacity for eight elementary and 16 secondary students. It offers IEP services in addition to research based, trauma informed interventions students diagnosed with mental health disorders and/or behavioral disorders.
- AuMHC provides child and family intensive outpatient (CFI), in partnership with human services agencies, to deliver effective and supportive mental health services to youth in foster or kinship care.
- AllHealth offers their evidence-based intensive outpatient program for adolescents who are dually diagnosed with both mental illness and substance use disorder (SUD). This program integrates treatment for both SUD and mental health issues, focusing on treating each member's underlying mental health and or SUD at the same time.

School-Based Services: Together with network behavioral health providers, we have expanded access to behavioral health services for children in school-based settings. In many cases, behavioral health care is co-located with primary care in integrated school-based health clinics (SBHCs). We ensure that students placed out of county have access to local school-based clinicians through our statewide behavioral health network that includes all community mental health centers. Our school-based strategy builds on the contributions of school-employed nurses, social workers, and psychologists already delivering services in local public schools. Careful coordination with classroom teachers and behavioral staff prevents duplication and ensures that the students most in need of treatment services receive them.

Two examples of providers supporting schools with behavioral health services are Aurora Mental Health Center (AuMHC) and Community Reach Center (CRC). Aurora Mental Health Center's (AuMHC) school-based program provides comprehensive mental health treatment for school-aged children in Aurora and Cherry Creek Public Schools, as well as some schools in smaller rural districts in Adams and Arapahoe counties. They serve large populations of Spanish-speaking youths, in addition to many students who have significant trauma history. Currently more than 550 children are receiving services from AuMHC's school-based program, and most of them are Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, members. Similarly, CRC has approximately 60 school-based therapists (SBTs) offering services in Adams School Districts 1, 12, 14, 27,

and 50. SBTs work in elementary – high schools and offer case management, individual therapy, family therapy, psychoeducation, coaching, and group therapy services to students/families in their home schools.

School-based services are effective because students who need care are more likely to access services when they are available in their schools. Another benefit is that children and adolescents receiving school-based services are more likely to be able to remain in their school and home. For children with the highest needs, we make intensive home-based therapists available in school settings to create behavioral bridging opportunities across the various environments in which the child functions. This active outreach into the community provides young members and their families with appropriate services at the time and place where they are most needed.

Targeted Case Management: We ensure that targeted case management is delivered to members who need it; most high-volume network providers offer it. Case management is an individualized, collaborative process to assist and support a member in gaining access to needed services and supports and/or develop skills to meet their own needs.

We emphasize a strengths model of case management.[1] The strengths model is a recovery-focused, evidence-based practice that provides specific tools (e.g., strengths assessment, personal planning, and group supervision) designed to enhance the recovery outcomes of members. An important principle of this approach is identifying and mobilizing natural supports in the community to help the member reach their recovery goals. With the Strengths Model, a key outcome is that members learn strategies for reducing dependence on treatment providers.

Providers such as the Synergy adolescent outpatient program at ARTS utilize strength-based models of case management in their assertive community care (ACC) and multisystemic therapy (MST) programs. ACC focuses on linking the individual with community resources, while MST aims to impact the varied systems involved that influence a youth's behaviors. Additionally, CRC has built a specialized case management team offering case management to members enrolled in any service the center provides. Case managers are trained in Feedback Informed Treatment (FIT), a model for consumers of all ages and their providers to gauge if the session was helpful in supporting the consumer's treatment goals. They use this model in each session to ensure that interventions are targeted and effective. Case management can occur in any setting: residential, outpatient clinics, schools, by telephone, in member's homes, or other community-based environments. Services include activities that help members gain access to needed medical, social, educational, and other services by offering an assessment of needs, service plan development, referrals and linkage, and monitoring and follow-up.

Rehabilitative Services: Rehabilitation is a pillar of the recovery and resilience model. Its guiding principle is empowering members to determine and achieve their own goals. It is also an effective way to maximize community resources by helping members work toward self-sufficiency. Supported employment, linked closely with other rehabilitation services, has been shown to improve opportunities for competitive, and, most importantly, permanent employment.[2]

[1] Fukui, S (2012) Strengths Model Case Management Fidelity Scores and Client Outcomes, Psychiatric Services (63), 7.
[2] Bond, GR. Implementing Supported Employment as an Evidence-Based Practice. Psychiatry Serv. 2001 Mar;52(3):313-22.

We offer rehabilitation services through a variety of programs in the East Metro Region. Through CRC, for example, members can access a variety of rehabilitation services including:

- **Older Adult Specialized Services (OASiS):** Provides intensive home and community-based services to people age 60 and older who are struggling to maintain symptom stability, currently residing in a skilled nursing facility, are at imminent risk for hospitalization or placement in a skilled nursing facility. The program's focus is to help individuals and their families stabilize and engage in their recovery. Based upon a needs assessment, OASiS can also serve adults under the age of 60 on a case-by-case basis.
- **Psychosocial Rehabilitation Services:** A cluster of services aimed at restoring consumers' functional capabilities by focusing on ways to increase community living ability as well as the ability to carry out activities associated with daily living. The team provides an array of services designed to help consumers capitalize on personal strengths, develop coping strategies, and to develop a supportive environment, allowing consumers to function as independently as possible.

Substance Use Disorder Assessment: We are committed to expanding routine screening for substance use disorders and ensuring that comprehensive, evidence-based assessment is conducted for those who screen positive. Our Quality Performance Advisory Committee has endorsed the Alcohol and Substance Use Screening, Brief Intervention, Referral to Treatment (SBIRT) guidelines and the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition. To increase substance use disorder screening and assessment, we have directly supported PCMPs to implement SBIRT, improve their ability to conduct effective brief interventions, and link the practices directly to behavioral health specialists for members identified for more comprehensive assessment and treatment planning.

Members with substance use needs are assessed using the American Society of Addiction Medicine (ASAM) criteria and are assigned the appropriate ASAM level of care depending on the extent of their substance use, nature of related problems, and comprehensive treatment needs. Providers develop and review treatment recommendations with the member and support access to appropriate services in their community. Our large network of more than 540 providers for substance use disorders includes a range of options for all ASAM levels and allows members choice.

Alcohol/Drug Screen Counseling: Alcohol and drug screening activities are most effective when coupled with counseling regarding health risks of substance use, health benefits of abstinence, and safe levels of alcohol consumption. Screening allows for positive reinforcement, highlighting strategies for success, and providing information about relapse. All network substance use disorder providers offer monitoring services, which include biological specimen (urine, hair, saliva, breath, and sweat) collection and testing. Results are available online to providers. They are promptly shared with members, any relevant providers in the member's health neighborhood, and/or family members included in treatment and for whom there is appropriate authorization. We will ensure that members have access to substance use disorder counseling services that are provided along with screening.

Medication Assisted Treatment (MAT): Opioid/narcotic replacement therapy for members with opioid dependence is available through a comprehensive network of providers including Arapahoe House, ARTS, AllHealth, and Mile High Behavioral Healthcare. Methadone administration is combined with evidence-based

individual and group therapy to help individuals identify triggers and develop skills to avoid future relapse, as well as urine drug screening, utilizing results to help members address their drug use.

Buprenorphine and naloxone are effective alternatives to methadone treatment. Expanding access to these alternatives to methadone that can be administered routinely in physicians' offices has greatly increased access to MAT. Buprenorphine is available through providers such as ARTS and Mile High Behavioral Healthcare. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), 37 of our Region 3 network PCMPs are DATA 2000 waiver to prescribe combination buprenorphine/naloxone (Suboxone). We ensure that MAT treatment is combined with the appropriate counseling and behavioral therapy.

Social Ambulatory Detoxification: The primary goal of detoxification programs is to monitor individuals who are under the influence of drugs and/or alcohol during a withdrawal period and provide a safe environment and daily living needs. Service is delivered until withdrawal symptoms are no longer present, usually from 12 to 72 hours. Behavioral health and safety assessments are included, and motivational counseling is provided with the goal of engaging the member in ongoing treatment. Our network includes Aurora Mental Health Center's 30-bed facility in Aurora, and Community Reach Center's recently opened 28-bed facility in Commerce City.

Emergency and Post Stabilization Care Services: Emergency services are available to all members in need of immediate treatment. They may obtain care without an authorization when they reasonably feel they are experiencing a psychiatric emergency. It is preferable for members to receive emergency care from network providers, and we maintain a large network to make this as easy as possible for them. However, in the case of an emergency, services are covered statewide for hospital emergency departments or other crisis service providers to evaluate and stabilize the member's health situation. This availability is accessible, without prior authorization, regardless of whether the provider is a network participant.

We recognize our responsibility to pay for and coordinate any unscheduled, immediate and/or specialized services for members with a psychiatric emergency, including situations in which they are co-occurring physical health issues. We further acknowledge financial responsibility for post-stabilization care services obtained within or outside of our network when these services are pre-approved, and without pre-approval under the special circumstances defined in the RFP requirements.

The components of our crisis network in East Metro network are:

- The Colorado Access Member Crisis Line operated under contract by Rocky Mountain Crisis Partners
- Colorado Crisis Services statewide hotline through phone or online chat function
- Colorado Crisis Connection walk-in clinics and crisis stabilization units (offered by Community Reach Center in Adams County)
- Aurora Strong Resilience Center
- AllHealth Network 24/7 Crisis Intervention Line and Acute Care Campus Crisis Center

Inpatient Psychiatric Hospital Services: Our philosophy is to treat members in the least restrictive appropriate setting, ensuring member safety and promoting recovery and resilience. We utilize clinically sound, evidence-based approaches to reduce the need for inpatient services, provide effective community alternatives, and

ensure an appropriate length of stay when hospitalization is necessary. Since the BHO program's inception, inpatient expenditures decreased from 53% percent of total behavioral health expenditures in 1992 to less than 7% by 2010[3].

Our network includes all inpatient psychiatric hospitals in Colorado, with specialized services across the age span. Our partnerships with hospital providers promote member-centeredness, efficiency, trauma-informed approaches, early discharge planning, and recovery promotion. We maintain productive relationships with the largest safety net hospitals in Colorado that provide behavioral health services - Denver Health and Children's Hospital Colorado. We also have a strong relationship with the Colorado Mental Health Institute at Fort Logan, which serves as a critical resource for Medicaid inpatient services for adults. We will continue to work closely with these key community hospitals, as well as the other major inpatient providers in the area, including Porter Adventist Hospital, the Medical Center of Aurora, Highlands Behavioral Health, West Pines Behavioral Health, and Centennial Peaks Hospital, to ensure that members have access when needed and that the hospitalization is consistent with their overarching recovery plan.

A) NON-STATE PLAN 1915(B)(3) WAIVER SERVICES

The hallmark of Colorado's Community Behavioral Health Services program for the past two decades has been the comprehensive nature of the services available as a result of the 1915(b)(3) waiver. As the RAE for Region 3, we will continue to provide the full array of waiver services required by the RAE contract. Below, we have provided a high-level overview of some key waiver services. Please see Appendix S for comprehensive detail on our non-state plan 1915(B)(3) waiver services.

Vocational Services: Meaningful life activities such as education, volunteer service, and paid employment are key components in recovering from mental illness. We recognize that people with serious behavioral health disorders want and need employment. It helps members focus on their abilities rather than their disabilities and contributes to residential stability. Members describe employment as a means of enhancing their self-esteem and developing a sense of pride from being productive members of society.

Because people with serious behavioral health disorders face significant challenges in obtaining and retaining employment, they often need more services and support than is offered in traditional job training and placement programs. Best practice employment programs offer transitional employment, supported employment, and individual placement and support. These programs must be appropriate for persons of all ages, from adolescents and young adults preparing for future full-time employment, to older adults whose goals might be part-time or volunteer work.

- **Community Reach Center's Vocational Services Program** -The vocational services program offers a variety of services designed to help clients develop skills necessary for a successful job search, as well as skills that will help them to manage their symptoms once they are on the job. The vocational services team

[3] Colorado Behavioral Health Organizations Bend the Cost Curve While Increasing Access to Care for Medicaid Beneficiaries, Fact Sheet, June 2011. The Altarum Institute.

works closely with each members' therapists, so they are aware of the member's symptoms and challenges. Once employment is secured, the vocational services team continues to provide support as needed, such as helping to improve communication between the member and their employer or coworkers, and helping the member to develop skills for coping with the symptoms of their illness while they are at work.

- **AllHealth Network's Opportunities to Work Program** – This evidence-based program offers supported employment called individual placement and support (IPS), and helps people with mental illness find and keep jobs, while simultaneously providing employers with access to motivated employees.
- **Other Vocational Programming** - Several substance use disorder providers in our network (Arapahoe House, ARTS and Mile High Behavioral Health) offer vocational services to members, including specialized services for women and youth. AuMHC also offers vocational services through their community transitions program for offenders with mental illness re-entering the Aurora community from jail or prison.

Intensive Case Management for Adults: Approximately 50% of intensive case management services are provided in the community. Case managers help identify and bolster natural supports in the community and refer and link to services and resources such as housing, benefits, education, employment, primary care, crisis services, and social support networks. We will ensure access to intensive case management for adults with serious mental illness through our mental health center partners and other network providers. For example, our partner, the Community Reach Center (CRC) offers intensive case management services to adults, in partnership with a variety of intensive outpatient programs including Assertive Community Treatment, the Prevention and Recovery in Early Psychosis program (PREP), and the Justice, Accountability, and Recovery (JAR) Program. In addition, CRC therapists may request intensive case management for any member receiving services at the center.

Intensive Case Management for Children: Our care coordinators work collaboratively with the parents of children with serious behavioral health needs to determine the most appropriate service delivery approach. Case management has been identified by the U.S. Surgeon General as an effective model for coordinating service delivery and ensuring continuity and integration of services. It helps children and families improve daily-task functioning, family stability and independence, and reduce out-of-home placements.

In many cases, families with children needing intensive case management will be engaged in one of the home-based programs described in the previous section. These include a range of evidence-based approaches, including multisystemic therapy and other intensive case management models delivered by partners such as ARTS, AuMHC and the Community Reach Center. CRC offers intensive case management to children through their In-Home Resiliency and Support Services (IRSS) and their Autism Spectrum Disorder Treatment Programs. In addition, any CRC therapist treating any child may request intensive case management services at any time through the center's case management team.

Prevention/Early Intervention Activities: We deliver a wide range of activities that promote positive behavioral health and deliver screening and early interventions for potentially at-risk populations. These activities are delivered by Colorado Access and by network providers, often in partnership with community

agencies and groups. The efficacy of prevention and early intervention services is highly dependent upon awareness of cultural factors and addressing relevant linguistic or other culturally bound differences.

- **Colorado Access Prevention/Early Intervention Activities** - Our population health department delivers a range of health promotion and prevention interventions, further described in detail in Response 15 – Population Health Management. Examples of services to promote positive behavioral health in the Medicaid population include:
  - Member newsletter: This publication is distributed periodically to members and provides information about the member crisis line, support groups, and physical exercise. Many topics are suggested by members.
  - Health resource fair: This annual event attracts more than 30 providers and resource organizations and more than 300 members.
  - Peer services wellness and support groups.
  - Perinatal Mental Health Initiative: This activity provided pediatricians, primary care provider (PCP) practices, and OB/GYN practices with perinatal depression screening tools and resources to detect and treat perinatal depression. We hosted a learning collaborative that included community mental health centers, providers, and public health educators. Providers received webinar training on topics including: "Safe and Effective Use of Psychiatric Medications in Pregnancy" and "Strategies for Treating Depression and Anxiety during the Perinatal Period."
- **Network Provider Prevention/Early Intervention Activities** - Network providers also deliver a broad range of prevention and early intervention activities for a variety of target populations, including several that are integrated into primary care settings. Some examples include:
  - Mental Health First Aid (MHFA): CRC, AllHealth Network, and AuMHC offer this evidence-based program that teaches community members how to identify signs of mental illness in others and provides step-by-step guidance on strategies to help persons who are undergoing behavioral health crises.
  - Teen Marijuana Program: Mile High Behavioral Healthcare offers a 10-week program focused on reducing marijuana use among youth, offered in partnership with Cherry Creek Public Schools
  - The Healthy Environments and Response to Trauma in Schools (HEARTS) program, led by AuMHC professionals, is a whole-school multi-tiered preventive intervention program for creating trauma informed, culturally sensitive, safe, and supportive schools.
  - Early psychosis prevention and recovery: CRC offers a Prevention & Recovery in Early Psychosis (PREP) Program, a multidisciplinary treatment team approach for youth and young adults 15 to 25 years of age who have been experiencing symptoms of psychosis for more than one week and less than one year. Services offered by the PREP team include individual, group, and family therapy, case management, psychosocial rehabilitation, psychosocial education, psychiatric services, peer support services, and supportive employment and education services. PREP is an intensive community-based program that can meet consumers wherever they are in the community, such as schools, hospitals, a doctor's office, a residential facility or any of Community Reach Center's outpatient locations.

- Drug and alcohol prevention: The Parent Support Network is a coaching service offered by the Partnership for Drug Free Kids and the Community Reach Center to parents who are struggling with a teen who is considering or using drugs and alcohol. It includes five one-hour telephone sessions with a parent coach who has personally experienced the challenges of teen substance use and a resource book entitled The 20 Minute Guide for Parents.
- AllHealth Network's Smart-Girl is a prevention and enrichment program designed to engage middle school girls (and more recently, boys) in activities that develop their socio-emotional skills. Together, students develop healthy responses to the challenges they face, and learn how to successfully navigate adolescence.

Clubhouse and Drop-in Centers: Member-run services, including clubhouses and drop-in centers, are essential components of an effective psychosocial rehabilitation program, addressing social needs and promoting recovery of members with serious mental illness.[4] We have consistently heard from members, their families, and key community stakeholders such as NAMI-Colorado and Colorado Mental Wellness Network that individuals should be able to participate in activities that give their life meaning and prepare them to be active, productive members of the community. We have configured our network to offer members the opportunity to pursue meaningful life activities and to give peer support to other members through a variety of recovery-based services. Members also have access to a wide variety of clubhouses and drop-in centers across the East Metro area, including Community Connections in Aurora, the Rainbow Drop-in Center in Thornton, and S.T.A.R. Reach Clubhouse in Littleton.

Residential: Residential services provide structured 24-hour care for members with high-intensity needs. Although an essential goal of ours is to preserve the member in a family or independent living arrangement, we recognize that this will not always be possible. This is particularly true for members who might be at risk of hospitalization if a supportive and structured setting is not available.

- **Adult Residential Services** - Our large provider network offers members many residential treatment options. For example, Community Reach Center operates four residential treatment homes throughout Adams County for adults 18 years of age and older. Placement is based on illness acuity and the client's ability to care for her or himself. Services include: medication monitoring and education; case management using the Psychosocial Rehabilitation Model; individual and group therapy; empowerment and life skills training; substance abuse treatment; and an intensive treatment program, designed to improve functioning, reduce symptoms, and avoid relapse and hospitalization. Community Reach also offers the following semi-independent and independent living residences for qualifying clients:
  - KIVA I & KIVA II are long-term transitional apartments shared by Center clients of the same sex. The goal of KIVA I & KIVA II is to prepare clients for independent living, offer life skills training, and maintain the client's awareness of their mental health condition.

[4] Torrey, W.C., Mead, S., & Ross, G. (1998). Addressing the social needs of mental health consumers when day treatment programs convert to supported employment: Can consumer-run services play a role? Psychiatric Rehabilitation Journal, 22(1), 73-75

- Shelter+Care provides Rental Assistance Documents to clients through Colorado's Supportive Housing and Homeless Program (SHP), providing they are receiving treatment at the Center.
- HUD Section 8 offers permanent, independent living situations to clients through SHP. Once enrolled in the program, clients are eligible for housing vouchers through Colorado Department of Local Affairs even after their treatment ends.
- Coronado HUD 202 Residencies are six units set up for semi-independent shared living.

Aurora Mental Health Center operates seven residential facilities, supporting adults with mental illness to live as independently as possible, including the Fitzsimons Recovery Apartments that provide homeless adults with mental illness with permanent supportive housing, including case management.

- **Child/Adolescent Residential Services** - Our large provider network offers a wide range of residential service options for children and adolescents, with 11 in-network facilities statewide. We contract with all of the major therapeutic residential childcare facilities in the region including, Savio, Shiloh House, and Tennyson Center for adolescent members. Residential services for younger children include The Tennyson Center for Children and Mount St. Vincent. Specialized programming for older adolescents transitioning to adulthood is available at Third Way Center. We also contract with providers such as Jefferson Hills (New Vistas program) and Griffith Centers for Children, which have expertise in dialectical behavioral therapy.

  We collaborate closely with Developmental Pathways, North Metro Community Services and Rocky Mountain Human Services to develop residential programming for children and adolescents with complex clinical needs. These partnerships have resulted in the identification of several providers that offer comprehensive service arrays for young members and their families, including those with co-occurring developmental disabilities and mental illness.

Assertive Community Treatment (ACT): Assertive Community Treatment (ACT)[5] is a core component of our intensive case management service array. With the Mental Health Center of Denver, we jointly sponsored the first full-fidelity Colorado ACT team that was funded by a BHO. Our pioneering research on this team confirmed that the ACT **model can be effectively utilized within a managed care environment to create positive member outcomes while containing costs.**[6]

We support full-fidelity and high intensity ACT programs, provided through the Community Reach Center. ACT services are available to adult and older adult members who require intensive case management and meet the program criteria. ACT is an evidenced based practice designed for people who experience the most severe symptoms of mental illness, have challenges taking meeting basic needs, and typically experience homelessness, substance use issues and legal system involvement.

Approximately 70% of services on these teams are provided in the community. This intensive intervention includes: outreach and engagement through strengths-based case management, medication evaluation and

[5] Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, *37*, 392-397.
[6] Thomas M, Bremer R, Engleby C (2004). Assertive community treatment in a capitated managed care system.Princeton, NJ: Center for Health Care Strategies.

monitoring, benefits acquisition and management, group therapy, supportive housing, and linkages with primary care. One of the most important services is assistance in locating and maintaining stable, safe, affordable housing to support the member's recovery goals.

Recovery Services: By addressing members' needs in all life domains and recognizing the impact that mental illness and substance use disorders have on these domains, recovery-oriented services can equip members with the ability to translate treatment into life success. Services that promote illness self-management, relapse prevention, individual and family empowerment, and linkage to social and community support networks are essential components of an effective system of care for members with behavioral health issues. The following sections describe our ongoing commitment to recovery and intent to carry this forward into the RAE.

- **Colorado Access Peer Support Services Program** - Our peer support services program is a key element of our recovery-oriented services. In partnership with Behavioral Healthcare Inc., we have three peer support specialists integrated into our team of care coordinators. They receive referrals from care coordinators, members, and providers. Peer support specialists utilize their lived experience to model recovery. Peer support specialists are experienced in multi-system issues and help members and families negotiate the complexities of interfacing with potentially fragmented systems.

  Peer specialists are rigorously trained and reciprocally serve as trainers for others. They are trained to tell their own stories, when it is helpful, to inspire and encourage others. They complete rigorous classroom training and intensive internships that provide qualifications that meet or exceed the requirements outlined in the Peer Specialist Core Competencies (RFP Appendix Q). Peer support specialists receive ongoing training, including the Basic and Advanced Leadership Academies training offered by the Colorado Mental Wellness Network. They regularly participate in team trainings on clinical and community issues and care coordination and are trained in the use of our care coordination documentation system. They receive instruction in confidentiality requirements, member rights, and the grievance and appeal process. The peer support specialists are trained in trauma-informed care, and their services are based on SAMHSA's guiding principles of recovery.

- **Peer Mentors at Community Reach Center, ARTS, and Aurora Mental Health Center**: CRC has a peer specialist team consisting of four peer specialists with a variety of lived experiences including substance abuse, depression/anxiety, family issues, and psychosis. The team is able to serve members of all ages. Similarly, AuMHC's Homeless Services program utilizes peer mentors and includes trauma-informed and harm reduction perspectives to support homeless individuals. In the ARTS Peer Education Services program, members have access to learning advocacy and crisis management, independent living skills, and self-help strategies, in addition to a variety of other topics. Peer mentors in each program provide assistance, support and advocacy to consumers, identifying life choices and helping clients overcome obstacles to achieving their goals. Focusing on the consumer's strengths, peer mentors serve as role models and promote personal growth, development and recovery.

- **Peer Recovery Support Coaches** - Peer recovery coaching is a form of strengths-based support for persons with addictions or in recovery from alcohol, other drugs, codependency, or other addictive behaviors. Recovery coaches work with persons with active addictions as well as persons already in recovery. They help clients find ways to achieve abstinence or reduce harm associated with addictive

behaviors. Recovery coaches can help a client create a change plan and find resources for harm reduction, detoxification, treatment, family support and education, local or online support groups. Advocates for Recovery provides training in this model, and providers in our network such as Arapahoe House, ARTS and Mile High Behavioral Healthcare incorporate recovery coaches into their regular programming.

Respite Services: Respite care can assist caregivers who deal with daily challenges in caring for a person experiencing behavioral health challenges. This service provides time off for family members and may occur in a variety of settings. These include day care centers, home or even in a residential setting. When used appropriately and intermittently as part of a comprehensive treatment plan, respite services can help keep people in their homes and reduce the need for emergency services, inpatient admissions, and out-of-home placements.

We offer the following respite care services to meet the need of members:

- Respite care for children in homelike settings or alternative residential facilities
- Respite care for adolescents, ranging from homes to residential facilities
- Adult and older adult respite care in the home, alternative care facilities or residential facilities

We contract with Aurora Mental Health Center for in-home respite services. Respite providers, who are often behavioral health clinicians, are screened and trained by Aurora Mental Health Center. When in-home respite services are not available or appropriate, we have a robust network of residential providers to offer short term or single overnight respite stays. Respite services may be planned and scheduled on a regular basis or unplanned and organized within less than 24 hours to avoid an out of home placement, emergency visit, or hospitalization.

Evaluating the Effectiveness of Waiver Services: We routinely evaluate the effectiveness of all the provided through our network. This evaluation is summarized in our annual quality report from regular reports that include access to care, network adequacy, grievances and appeals. It also includes input from our Member Advisory Council.

B) UTILIZATION MANAGEMENT

At Colorado Access, our utilization management (UM) philosophy recognizes that members have individual and often complex physical health, behavioral health, and social needs. While a core function of a UM program is the authorization of services, the focus for our program is access to the right care, at the right time, and in the right setting. We ensure that services are provided in the most appropriate, cost effective and least restrictive setting. We emphasize community-based, individualized, culturally sensitive services designed to enhance self-care and shared decision-making among members, their families and providers. Most outpatient services, including intensive in-home services do not require prior authorization.

This approach creates collaborative partnerships with providers and hospitals that maximize care options and outcomes for members. Our UM program works collaboratively with community physicians, hospitals, outpatient treatment providers, ancillary vendors, and care coordinators (both internal and external). UM is also considered a tool to continually measure, evaluate, and improve the delivery of health care services in order to

achieve the optimum value from the States' resources while better serving members' needs. As a result, we can identify areas of under and over utilization in order to better manage the population within the health care continuum and provide the most appropriate levels and types of care. This is achieved while providing an excellent customer experience for members and providers.

Our UM program meets the required program elements outlined in the RFP. It operates under our chief medical officer and senior medical director, both of whom are licensed physicians board-certified in psychiatry. Written criteria and guidelines are developed and adopted with physician involvement and in accordance with nationally recognized standards. The program is designed to ensure timely access to care without impeding access to needed services. Each element is described in detail in the sections below.

Utilization Management Program, Policies, and Procedures: Our UM program includes and addresses all elements of the policies and procedures required by the RFP. Our policies and supporting documentation can be produced to demonstrate:

- Utilization management program description
- Annual review and evaluation of UM program
- Development, modification, review and application of UM criteria
- Monitoring over and under utilization
- Peer review of quality of care concerns
- UM decision making, including staff training and position qualifications, inter-rater reliability and appropriate qualifications for practitioner reviews and denials
- Turnaround time requirements and adherence monitors for: timeliness of UM decisions based on medical necessity; timeliness of prior authorization, concurrent review and retrospective review decisions, and timeliness of expedited reviews
- Data communications of UM determinations with providers and members and for obtaining clinical information and UM criteria
- Evaluation of new technologies and new applications of existing technologies
- Required contract and triage documentation
- Delegation management and oversight documents and policies, if applicable

Our UM program description, policies, and procedures outline our program goals, structure, scope, processes for information sources, and roles and responsibilities. Our collective documentation reflects evidence of medical director leadership in key aspects of the UM program, such as denial decisions and criteria development. It also demonstrates how staff members making UM decisions are supervised. Additionally, the program description documents mechanisms to ensure members have appropriate access to services across the network, with controls in place to authorize services in a timely and efficient manner to meet the member's health care needs.

While the UM program is collaborative in nature, participation in our UM program is a contractual obligation of all network behavioral health providers. This includes adhering to policies, procedures, and standards; identifying and addressing barriers to the provision of quality care; reporting complaints and/or quality of care concerns; participating in auditing processes; and providing access to or copies of clinical records or other documents, as requested by Colorado Access. Clinical denial rates remain within accepted standards, demonstrating that we are not overly restrictive in denying requests for higher level of care. In 2016, in our Denver BHO, we denied 13% of service requests. Only 2.3% were appealed. Low appeals rates typically demonstrate a provider's agreement with our decision.

Integrating UM with our care coordination activities sets a higher standard for UM-processes that allows us to effectively review, authorize, and monitor behavioral health services. On this framework, we have significantly enhanced the activities of our staff members and providers beyond their traditional roles. Our model continues to evolve as an innovative, proactive plan for both promoting a population-based approach distinguishing the behavioral health needs of sub-populations, including child, adult, elderly, disabled, and foster care members. Our focus is to be outcomes-oriented and to utilize technology solutions to promote health information exchange, electronic health records, and predictive modeling tools for increased analytical capabilities in support of UM and care coordination.

We believe that effective managed care is about managing the care, not managing the benefit. When done correctly, managing the member's care results in a more efficient use of resources. Our UM team works closely with our care coordination team to effectively manage member clinical and social needs on a real-time basis. Care coordinators meet with members and providers in the community to facilitate improved aftercare plans or make referrals to other services, as necessary. Care coordinators and UM staff collaborate with one another, with outpatient providers, and with members and families to develop optimum service plans. Care coordinators and UM staff members also consult with medical directors, as needed.

Our Utilization Management Team

Our UM team consists of experienced medical and other clinical staff. Its senior leadership group is comprised of the chief medical officer, chief operations officer, senior medical director for behavioral health, and associate medical directors.

The director of our UM program is a board-certified psychiatrist with extensive experience in most levels of care as well as experience specific to utilization management. He has added board certifications in addiction medicine and forensic psychiatry. He maintains collaborative relationships with psychiatrists and behavioral health providers throughout our community. The director has the following responsibilities:

- Daily operating authority for UM program activities, including pre-certification and referrals, concurrent review, case management and health programs
- Oversight of delegated UM activities as they arise
- Oversight for UM policies and procedures, development, and implementation
- Oversight of all UM quality improvement activities

Our UM staff members include seven licensed behavioral health clinicians. The team has an average of more than 16 years of behavioral health experience, and an average of nearly seven years of tenure at COA. They are responsible for traditional functions such as prospective, concurrent, and retrospective review for services and benefits that require authorization. The UM program is aligned with care coordination to support individualized services plans that deliver holistic, member-centered care. If a member requires multiple services, the UM team coordinates providers and agencies so that the authorized services support the plan and are closely monitored. Because the UM team and care coordinators work closely with one another and are aware of the member's needs, potential alterations to the provider's treatment plan can occur in a responsive and seamless manner.

Annual Review Criteria

Our UM program ensures that utilization determinations are based on written criteria and guidelines that are developed or adopted with involvement from practicing and national recognized standards. We apply standardized, nationally accepted criteria (McKesson InterQual®) to review prior authorization requests for medical necessity. The Performance Improvement Advisory Committee (PIAC) regularly reviews evidence-based guidelines that support the UM program. These criteria are described in more detail in the sections below. Criteria are updated annually and then reviewed by our medical directors for comments and acceptance.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

We coordinate with physical and behavioral health care providers who may recommend care for children and adolescents under the provisions of Early Periodic Screening, Diagnosis, and Treatment (EPSDT). When providers identify evaluation and treatment needs of pediatric members, the UM and care coordination staff members identify resources to meet those needs, initiating the EPSDT authorization process through the Department of Health Care Policy and Financing (the Department), and coordinating with community partners to ensure the services are received.

Enhancements to the Utilization Management Process

The use of innovative technology solutions increases program efficiency. We use the GuidingCare system from Altruista Health as the technology platform to support care coordination, utilization management, grievance and appeals, and customer relationship management (CRM) so that all member-related interactions by our clinical and customer service staff members are captured in the same integrated tool. This promotes improved coordination and allows UM to be informed by a more robust array of member-related information, ensuring that the services being authorized are clinically appropriate and not redundant. Our state-of-the art technology also shortens turnaround time for medical director reviews and supports monitoring performance and adherence to requirements. InterQual® is integrated into the system.

Colorado Access Authorization Process

We require prior authorization for higher-level, intensive behavioral health services such as inpatient, partial hospitalization, day treatment, residential services, and respite care. Providers will submit authorization requests through our web-based provider portal, which will be operational in September

2017. It will allow communication and document transfer between UM staff and requesting providers. Authorization requests will be processed through efficient electronic notification.

After an approval determination has been made, GuidingCare generates an authorization that automatically issues an authorization letter that is immediately mailed or faxed to the provider.

Routine Outpatient Care

The following services are included in the category of routine outpatient services and do not require authorizations:

- In-home services
- Screening and assessment
- Individual and group therapy
- Physician services and medication management
- Case management
- Psychosocial Rehabilitation
- Clubhouse
- Drop-in center
- Vocational services

These services represent the least restrictive and least intensive levels of care and constitute the basic care accessible to all members requiring specialty behavioral health care. Because routine outpatient services do not require prior authorization from Colorado Access, members have access to services without impediment.

As a current BHO contractor in Colorado, we currently meet all the requirements outlined in Section 5.12 of the RFP. Compliance with these requirements is evidenced by our annual contract compliance audits conducted by The Department's External Quality Review Organization (EQRO). Since 2014, our annual contract compliance audit scores related to UM functions have averaged 91%.

C) SERVICE PLANNING, COORDINATION AND CARE TRANSITIONS

We are fully prepared to meet the RAE requirements for service planning, coordination, and care transitions, building on our long experience as a BHO and deep experience in the local communities. Our network providers and care coordinators ensure a seamless experience for members, delivering the right care at the right time and setting. Care plans are person-centered, holistic, and based on members' prioritized needs, including a comprehensive view of physical health, behavioral health, and social issues.

Intake and Assessment: A comprehensive assessment is the foundation of an effective member-centered service plan. Our current policies and processes ensure that members receive a comprehensive individual intake

and assessment according to their needs, including adherence to the access standard's timeframes and clinical situation. Network providers must adhere to the specified appointment access standards or contact a care coordinator at COA if they do not have appropriate appointment availability.

The assessment provides an opportunity for the provider to discover care coordination needs. Members with multiple behavioral and/or physical health disorders or who are involved with various social services and/or criminal justice agencies will require emphasis on these areas in the service plan. The intake and assessment process informs needed linkages to help members across all needed services, not just behavioral health care. Whenever possible, providers complete the intake assessment in the member's primary language and with accommodation for any hearing or visual impairment. We will utilize our entire provider network, and develop new contracts with providers of choice, if needed, to ensure that language and/or cultural differences do not create unnecessary barriers to treatment.

- **Provision of Medically Necessary Services for Diagnostically Complex Individuals** - We assure that all members receive a high-quality intake and assessment, regardless of the nature or complexity of the individual situation. Clients with service access challenges such as the frail/elderly, those in long-term assisted living or nursing facilities, and individuals with physical disabilities will receive the same level of quality intake and assessment. Depending on the situation, members may be offered intake appointments onsite in-person or by telephonic or telemedicine platforms, all conducted with the same quality standards.

  Many members present with co-occurring behavioral health diagnoses, some of which are covered by Medicaid, and some of which are not. We will provide medically necessary services for the covered diagnosis and will follow the written criteria approved by the Department for assessing and treating members with co-occurring non-covered diagnoses such as autism, traumatic brain injury, and developmental disabilities. Our long-standing relationships and formal MOUs with providers that specialize in serving members with these diagnoses (e.g., Developmental Pathways, North Metro Community Services, Children's Hospital Colorado, and Developmental Disability Consultants) will facilitate coordination and quality of care for these members. We also have MOUs with county departments of human services to coordinate care for children receiving services through that system.

  We also recognize that a high proportion of members have co-occurring physical health diagnoses and needs. We utilize a robust care coordination system including unprecedented access to integrated mental health, physical health, and substance use information and resources to support one, integrated and holistic service plan. In addition to care coordination (further described in Response 16), our extensive provider network, including primary care, behavioral health, and medical specialists, is able to facilitate and coordinate appropriate referrals, consultation, and complex care planning.

Service Planning: We have a service planning system that is based on comprehensive intake and assessment and conducted in a member-centered, family-centered way. Service planning represents a collaborative opportunity for providers to engage members in their own care, set goals, and express preferences and needs. For most members with primarily behavioral health needs, service planning will generally occur in the provider environment (e.g., community mental health center, substance use disorder agency, independent provider office, behavioral health provider co-located in a primary care setting).

Through routine audits, we ensure that individual service plans (ISPs) meet all the requirements and are appropriate for the member's treatment setting.

For members with complex behavioral and physical health needs and/or multiple co-occurring conditions, service planning is usually embedded within the care coordination function. A primary, designated care coordinator assumes responsibility for linking providers and clinical information across systems to ensure that service plans address members' needs in a comprehensive way. Some of these members will also receive various forms of case management through the multiple systems providing services. The designated care coordinator facilitates communication and coordination among these entities in order to clarify roles and responsibilities, reduce duplication, conflicting plans, and member confusion.

Transitions of Care: We have a well-established **Transitions of Care (TOC)** model (described in Offeror's Response 16—Care Coordination) that has demonstrated effectiveness during the past five years. Adapted from the evidence-based Coleman model, this intervention is systematically applied to members who are being discharged from inpatient and emergency department settings and have characteristics that predict high risk for adverse outcomes, including hospital readmission within 30 days. This model delivers a standard set of evidence-based interventions that are modified based on member need and preferences, including: post-discharge care coordination services (minimum 30 days, longer if needed), support back to home setting/social/environmental needs, discharge care plan education and support, illness education and self-management, medication education and assistance, coordination and support for outpatient follow-up visits and medical case review from the medical director. We have care coordinators stationed in several high-volume hospitals to provide these services and initiate the seamless transition experience.

Our care coordination system also facilitates seamless transitions of care for members when there are multiple health care providers and other agencies involved and assures proactive communication, elimination of duplicative efforts, and continuity of care. In Region 3, we have developed integrated care coordination among long-term services and supports (LTSS), HCBS, and other programs focused on physical and behavioral health, as we manage Single Entry Point (SEP) and Regional Care Collaborative Organization (RCCO) contracts for Adams, Arapahoe, Douglas, and Elbert counties. As a result, we have been able to decrease complexity for members and providers and improve the quality and outcomes of care. Particularly for members involved in multiple systems, the primary care coordinator serves as a critical communication manager, keeping the member/family at the center of all activities and decisions, and involving providers, community services, and other agencies as appropriate. Because many community agencies who serve members also have varying elements of case/care coordination embedded in their systems, the primary care coordinator actively clarifies roles and responsibilities of each person/agency involved to eliminate duplication and prevent misaligned care plans. Additionally, we assign a primary contact person for agencies, such as county departments of human services, to address communication issues, establish workflows, and resolve problems.

Care coordination efforts to provide continuity of care for members are also targeted for:

- Children/youth in the child welfare system
- Youth moving from the child welfare system to the adult system
- Members who have been institutionalized or incarcerated

Continued Services to Members: We ensure a streamlined and seamless experience for members transitioning between RAEs or utilizing services in more than one region. As a current RCCO and BHO, we have the experience to maintain a robust process to support members transitioning into or out of the region or temporarily requiring services in a crossover manner. During these transitions, we coordinate with the designated party at the corresponding RAE to share relevant information, including the service plan and current treatment needs, and to clarify responsibilities and primary point of member contact. For those transitioning into the East Metro RAE, we will assure that any immediate needs are met, including a behavioral health crisis service if needed, and arrange appropriate referrals and linkages to behavioral health providers, PCMP, and social supports. We maintain a large statewide behavioral health provider network so that members are able to continue receiving covered services from a current provider during the transition period.

D) COORDINATION TO MAXIMIZE AVAILABLE RESOURCES

With providers, we are well connected to agencies that offer critical care and social services to members. Our partnerships and ongoing relationships with key agencies in the region, particularly for care management and at the point of care, ensures we are able to maximize the resources available to providers and members. This helps members achieve optimal health and well-being. Some of our key agency partnerships include:

- **Colorado Crisis System**: Colorado Access currently contracts with Rocky Mountain Crisis Partners to operate our 24/7 member crisis line. We are also contracted with Community Crisis Connection (CCC) and the mental health centers operating the walk-in clinics, mobile crisis services, and crisis stabilization units. Through frequent communication, we encourage members and providers to access the crisis system, as situations warrant.
- **Signal Behavioral Health Network**: As the Managed Service Organization (MSO) covering Region 3, we will coordinate with Signal Behavioral Health Network to ensure members have access to the full continuum of addiction treatment services, whether or not they are covered by the RAE or through MSO funds. COA is currently contracted with all Medicaid eligible providers in the Signal network. This allows for effective coordination of benefits at the provider level.
- **Department of Human Services**: In our existing RCCO and BHO regions, we have developed productive relationships with county child welfare departments. We often work collaboratively on difficult cases through the Department's Creative Solutions process to develop care plans that leverage the use of Medicaid, child welfare, and other community resources. This process frequently results in innovative solutions that maximize a child's success.

Behavioral Health in Primary Care

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.

We have been an early innovator and proven leader in behavioral health/primary care integration for almost 20 years. We were a grant recipient in the Robert Wood Johnson Depression in Primary Care: Linking Clinical and System Strategies initiative from 2002-2006[1]. This program, along with funding from the MacArthur Foundation's Re-Engineering Systems for Primary Care Treatment of Depression project [2] sparked our early integration efforts in collaboration with the University of Colorado School of Medicine's department of family medicine. This progress has continued to this day: our behavioral health provider network includes licensed behavioral health clinicians delivering integrated care in more than 70 primary care practices. Our rapid expansion of integrated care has resulted in the delivery of nearly 64,000 behavioral health visits (BHO covered services) in primary care settings, serving close to 14,000 individual members since 2014. Looking at it from a member-centered perspective, 81% of current Regional Care Collaborative Organization (RCCO) membership is attributed to a primary care medical provider (PCMP) that offers integrated behavioral health services[3], representing a major advance in member access, choice, and convenience. Supporting PCMPs on their path to integration requires an individualized approach to each practice, building on its unique patient population, existing resources, provider skills, and neighborhood resources, as described in more detail in Offeror's Response 13—Health Neighborhood and Offeror's Response 17—Practice Transformation and Support. Our integrated behavioral health/PCMP network includes fully integrated models within higher volume practices, collaborative models in smaller practices, and, more recently, virtually integrated behavioral health services through telemedicine available to all network PCMPs. We work closely and flexibly with practice leadership, offer technical expertise and training, and leverage our role as a BHO to provide financial supports to a variety of practices as they move toward greater levels of integrated and sustainable financial frameworks.

BEHAVIORAL HEALTH CARE IN A MEDICAL HOME

Medical homes offer a model of care that provides a seamless experience for members as the main access points to both primary and behavioral health care. We promote universal screening for mental health and substance use issues and equip primary care practices with training, tools, and workflows to implement screening efficiently.

Members with positive screens receive more in-depth behavioral health assessments, and, when needed, brief intervention. Many practices utilize on-site licensed behavioral health providers who can deliver low acuity face-

[1] http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2010/rwjf69751
[2] https://www.macfound.org/networks/initiative-on-depression-primary-care/details
[3] Based on 2016 Integrated Practice Assessment Tool)IPAT) survey of all Colorado Access enrolled PCMP sites.

to-face services immediately when the assessment indicates the need. When a behavioral health clinician is needed, but not present in the clinic, we are able to leverage the use of telehealth, including on-demand access in the primary care setting to a behavioral health clinician, substance use specialist, or psychiatrist. The availability of telehealth is especially important in the rural areas of Region 3, where access to a behavioral health clinician is more limited.

Another approach to integrated care is delivering primary medical care within behavioral health care settings, such as a community mental health center. This approach may be preferred for persons with serious mental illnesses or substance use disorders who receive frequent or intensive services in a behavioral health setting and consider it their principle source of care.

COLLABORATIVE WORK WITH PCMP SITES

Below, we highlight examples of our collaborative work with partners to support the integration of behavioral health services in primary care practices.

Doctors Care, a large primary care partner in Region 3, wanted to increase co-located behavioral health and primary care services and move closer toward full integration. In a pilot project that began in 2015, we built on Doctors Care's experiences in the SIM Integration Project and various payment reform work groups to identify available sustainable funding streams to support direct employment of behavioral health clinicians by their clinic.

We have also partnered with Salud Family Health Centers, a federally qualified health center (FQHC), on a multi-pronged approach to increasing access to integrated care in their clinics. One component is establishing agreements to place community mental health center clinicians into Salud clinics to provide co-located integrated care services. Another aspect of this initiative is an integrated pharmacy program that provides clinical pharmacy interventions, such as medication management, in a primary care setting. The third component places on-site legal support in the clinics to help members address social/legal issues that impact their health, such as eviction from housing.

The Aurora Refugee Wellness Center is another exceptional example of integrating behavioral health services with primary care. As described previously, this center is a collaborative effort of Metro Community Providers Network (MCPN), the University of Colorado Department of Family Medicine, and Aurora Community Mental Health Center. Providers from these organizations work together to deliver integrated care to members from a widely diverse array of refugee communities. Upon arrival at the center, members are screened for mental health disorders, as well as infectious and communicable diseases (including parasites). Because the vast majority of these members have experienced trauma, screening and treatment for this condition is an important component of the center's behavioral health services. Our RCCO staff members helped facilitate the center's move from Denver to Aurora to accommodate the city's growing refugee population, and has continued to support the center's growth and integrated care activities.

We have also worked closely with PCMPs as they continue to integrate and include substance use disorder (SUD) screening as part of their routine physical and behavioral health screenings. We have conducted assessments on

providers' ability to perform these screenings, and provide the practice supports and trainings they need to gain this core competency. We also offer practices the linkages to community resources that provide SUD supports for our members. At Denver Health, for example, their primary care clinics are integrating providers who are able to prescribe Suboxone, a medication assisted treatment or MAT, so that members who screen positive for SUD are able to receive treatment immediately, in their PCMP medical home. Members with more complex needs are transferred to outpatient intensive therapies, either at Denver Health, or to other community SUD providers. As more PCMP sites are trained to recognize the signs of SUD, through routine screenings, our members will have increased access to these comprehensive services in their medical home.

COLLABORATIVE WORK WITH BEHAVIORAL HEALTH SITES

In 2009, we launched The Promoting Resources for Integrated Care and Recovery (PRICARe) project in collaboration with the Mental Health Center of Denver (MHCD) and the University of Colorado School of Medicine department of family medicine. We received a multi-year grant from The Colorado Health Foundation to pilot and evaluate this new program. Its aims included proof-of-concept, identifying and solving implementation barriers, and a financial analysis to inform future planning and scale-up. The rationale for this approach is that many persons with serious and persistent mental health and substance use challenges receive intensive and/or frequent services from their behavioral health provider. They often have difficulty accessing health care services in other settings, may experience stigma and other barriers, and require assistance in implementing recommendations into their overall care plan. This successful program ultimately resulted in MHCD being able to establish a permanent primary care service in its Recovery Center and become a PCMP.

In Region 3, we support a collaboration between AllHealth Network and MCPN in which MCPN clinicians are co-located in an AllHealth Network clinic in Littleton. In this case, MCPN serves as the designated PCMP. The Community Reach Center also offers integrated physical and behavioral health clinic for children and adolescents, Mountainland Pediatrics, which is located at a Community Reach Center site. As the Regional Accountable Entity (RAE) for this region, we intend to increase our collaborative work with these behavioral health sites to further increase integration.

TRACKING FEE-FOR-SERVICE BEHAVIORAL HEALTH SESSIONS IN A PRIMARY CARE SETTING

In anticipation of the RAE model, we have evaluated several options to track the delivery of all behavioral health services rendered by network PCMPs. We are committed to developing and implementing a process that is feasible and minimally burdensome to providers and will continue incorporating feedback from primary care practices.

Initially, we will configure our benefit claims system to pay all behavioral health services, regardless of encounter, assuming that all such claims submitted to Colorado Access (COA) are for more than six visits. A reconciliation report comparing COA-paid services to fee-for-service (FFS) paid claims data from the Department of Health Care Policy and Financing (the Department) will capture any services we inaccurately paid (i.e., for less than six visits). We will recoup those claims and instruct the provider to bill FFS. This process will allow providers

who are unable to closely track visit counts to receive payment and adjust their billing process. It will also allow providers to continue to render services without the hindrance of needing to know when to bill FFS or COA. As practices are ready, we will work with them to implement internal systems to accurately track visits, so they bill the correct payer for the outset. Some providers are able to track visit counts at the outset of the RAE contract, while other providers will not be able to accomplish this tracking within their current system without significant programming. We understand these challenges for these providers and we are equipped to support them in tracking member visit counts and offer flexible solutions.

CONCLUSION

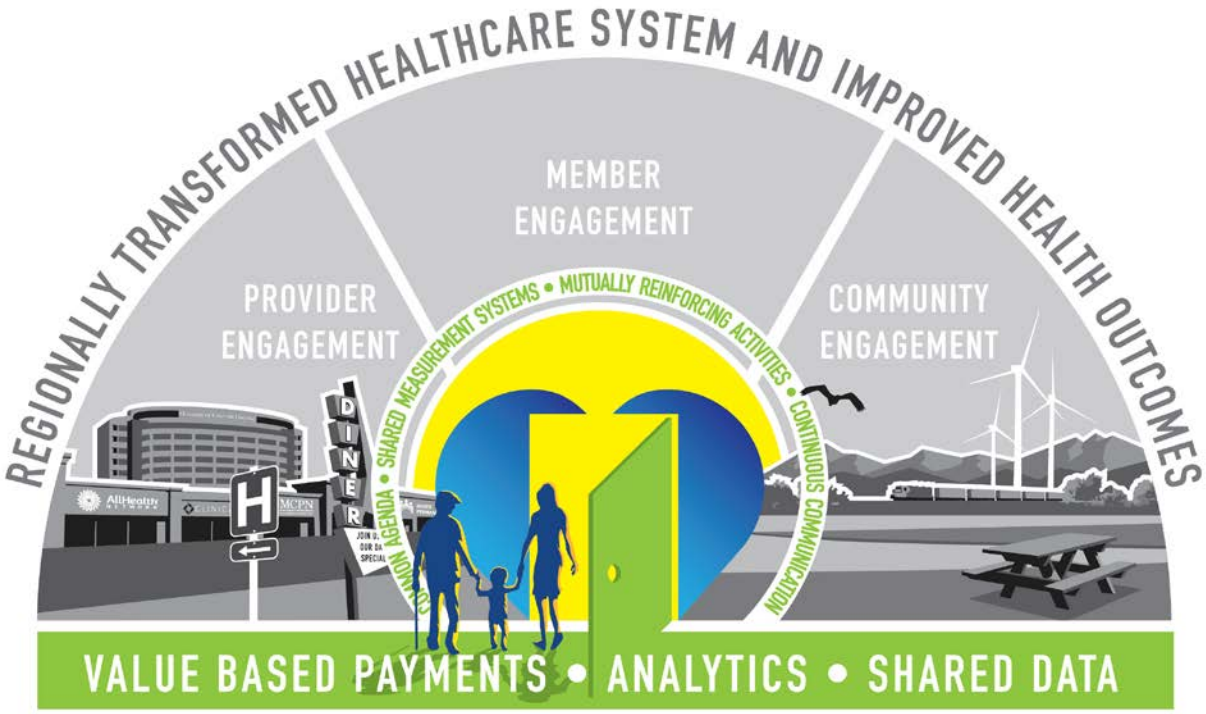
Because we have developed a transformation model to support all types of practices along a continuum of integrating behavioral health services into primary care settings, many members can get their behavioral health needs fully met in their medical home. When more intensive services are needed, PCMP sites are well equipped to seamlessly transition members to higher levels of care. For those practices beginning to develop integrated care services, our practice transformation and support team, described in detail in Offeror's Response 17—Provider Support Strategy, will deliver a variety of services and tools to move along the integration path.

Data and Analytics

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.

A DATA-DRIVEN RAE VISION



We have a 22-year history successfully implementing multiple Colorado Medicaid programs and are uniquely positioned with the strengths of both **a mature managed care organization and an innovative, data-driven transformation leader.** These complementary competencies inform our comprehensive and dynamic understanding of member populations and health care systems. We have proven mechanisms to receive, process, and utilize data and analytics; perhaps most importantly, we have a flexible approach that embraces the constant change of ongoing transformation. Effective use of data is foundational to operating the Accountable Care Collaborative (ACC) program. Colorado has made significant investments in state-of-the-art data infrastructure and processes, and we are fully prepared to interface and collaborate with the Department in the implementation of robust data processes and creation of an evolving data-driven ACC culture.

Our RAE Model uses our Health Transformation Framework (described in detail in Offeror's Response 7) to align our service offerings upon a foundation of data to create a transformed health care system and improve health outcomes. The commitment to a data-driven approach is central to developing the common agenda, shared measurement system, mutually reinforcing activities, and continual communication that will align regional partners for system transformation. Member, provider, and community engagement strategies are designed and

evaluated based on a data-driven understanding of needs and opportunities. Core health plan operations are also founded on robust data processes and integrity: membership/eligibility, credentialing, utilization management, claims, compliance, care coordination, process improvement, performance measurement, and cost control. Below we describe how we will receive, process and manage data from the Department of Health Care Policy and Financing (the Department), providers, and external entities and deploy advanced analytic techniques to achieve the aims of the Regional Accountable Entity (RAE). Our provider engagement strategy and practice support plan (described Offeror's Response 17—Provider Support and Practice Transformation) provides additional detail on how we will partner with providers to understand and act on the data and analytics.

RECEIVING AND PROCESSING DATA

Having successfully managed Colorado Medicaid contracts for many years, we have an existing technology platform that effectively receives and processes standard claims, encounters, and enrollment data files for multiple programs: Behavioral Health Organizations (BHO), Regional Care Collaboration Organizations (RCCO), Child Health Plan *Plus* (CHP+), Single Entry Point (SEP) and other programs – each with distinct and evolving formats.

Receiving Data: Unparalleled Depth and Breadth of Experience

We are well positioned to receive a wide array of data sources and formats and to integrate them into a comprehensive understanding of member populations, providers, the regional landscape, and individual member health profiles. As the Department develops Truven's BIDM to import Health Information Exchange (HIE), social determinants of health, State Agency data, Nurse Advice Line data, health needs surveys and analytics generated by the Truven Advantage suite, we are fully prepared to receive and integrate these data sets into our internal data management platform. We have robust systems and infrastructure that can absorb, process, and store data sets containing millions of records. We are also experienced in receiving and working with the prior statewide data analytics contractor (SDAC) and have incorporated 3M TREO data elements into our workflows and reporting. As the Department moves forward with Truven's analytics platform, our team has a process for incorporating new analytic data outputs, then integrating them into our work streams. The Colorado Access current data receipts are listed in the table below.

Data Source	Format
RCCO Data Received: Sources and Formats	
Colorado interChange (HP Enterprise Services)	• Enrollment data - 834 HIPAA standard format • Capitation data - 820 HIPAA standard format
BIDM (Truven)	• Roster report PCMP attribution– proprietary format • All membership report – proprietary format • Medical claims data – proprietary format • Pharmacy claims data – proprietary format • MMP KPI trends report – proprietary format • Enrollment summary report – proprietary format
CORHIO/HCPF	• ADT (Admit/Discharge/Transfer) hospital data – HL7 and proprietary format

Data Source	Format
	• Laboratory data – HL7 and proprietary format
BHO Data Received: Sources and Formats	
Colorado interChange (HP Enterprise Services)	• Enrollment data - 834 HIPAA standard format • Capitation data - 820 HIPAA standard format
Providers and Clearinghouses	• Claims data – 837 HIPAA standard format
STATE	• RX pharmacy claims – proprietary format
CHP+ Data Received: Sources and Formats	
Colorado interChange (HP Enterprise Services)	• Enrollment data - 834 HIPAA standard format • Capitation data - 820 HIPAA standard format
Providers and Clearinghouses	• Claims data – 837 HIPAA standard format
COA's Pharmacy Benefit Manager (Navitus Health Solutions)	• Rx pharmacy claims encounters – proprietary format

We also request and receive data from numerous external parties to better understand the health needs and utilization of members and to support the primary care medical provider (PCMP) network in providing effective and efficient care based on a shared knowledge of those needs. In addition, we accommodate files of common data types like .xls and .csv in order to flexibly receive data from partners regardless of their system capabilities.

Processing Data: Building Trust through Data Integrity

Data integrity is foundational to establishing trust with the Department, members, providers and community partners and is critical to transforming the health care system and improving health outcomes. We have robust processes and procedures to ensure data integrity. Our multi-disciplinary data governance committee includes representatives from many different parts of the organization including claims, eligibility & enrollment, provider engagement, provider contracting, human resources, population health, information technology, compliance, medical management, telehealth, accountable care, behavioral health, care coordination, long term services and supports, payment reform, and finance. The committee is responsible for the following activities:

- Ensuring data quality and integrity by setting standards, policies, and processes, including data issue resolution, so that the data may be used with confidence in its quality and consistency.
- Leading the creation, implementation, and oversight of the enterprise-wide information and data management goals, standards, practices, and processes
- Providing expert advice and support in relation to all aspects of information and data management including data ownership, data protection, data privacy, information usage, classification, and retention.
- Promoting data governance at an executive and senior management level.

The data governance committee oversees all data-related decisions and processes. These decisions are provided to the data steward who ensures that all data received goes through rigorous validation before being stored in the Colorado Access data warehouse to be available for reporting and analysis. We maintain an active data dictionary to ensure that data elements are well defined and have clearly articulated relationships with other elements so that, when data are analyzed and reports produced, the findings are replicable by both

internal and external parties. Data integrity, accuracy and transparency ensure actionable data and trust with partners. We will continue to evolve our data integrity processes and procedures to take advantage of ongoing improvements in technology and system-wide capacity.

We have a proven track record of ensuring and maintaining data integrity and accuracy through evolving changes in data file formats, Department requirements, compliance, and technology. Examples include:

- Transition from ICD-9 to ICD-10 codes, which necessitated updates to utilization management, claims payment, and analyses operations, as well as internal registries and stratification models
- Adoption of HIPAA new transaction requirements, successfully implemented by maintaining the ability to accept and use two sets of file formats during the transition
- Changing formats of eligibility and enrollment files, including the recent MMIS conversion to Colorado's interChange
- Supporting all HIPAA standard transactions, including the 834, 837 and 820, which were part of the transition from Xerox to HPE as the Department's MMIS vendor

We continually monitor all files for accuracy and have robust transition processes for new data formats/sources; we are therefore able to provide an early warning alert for file inaccuracies and help troubleshoot and resolve issues in partnership with the Department. These transition processes typically include a weeks-to-months effort while running duplicate transmission systems for data validation and as a safety net for enrollment or payment data. We are uniquely experienced and capable to handle data systems changes while maintaining data integrity and to engage in collaborative partnership with the Department, working across systems to anticipate, identify, address, and resolve issues.

Data Storage and Integration: Leveraging Cross-Program and Historical Experience

We maintain a centralized data repository in which all data inputs reside such that we can compile multiple types of information and create a 360-degree view of our members to support the ACC program goals. This centralized data repository allows us to maximize the use of Department data and analytics (3M/Truven) and enhance it with regionally specific information to design targeted interventions and program results.

We currently receive, produce, analyze, and distribute standard health plan data such as behavioral health and physical health claims, enrollment, clinical, credentialing, and pharmacy data, as well as numerous other types of data associated with being an accountable entity. In addition to the data receipts in the table above, we also incorporate and use the following:

- Altruista's GuidingCare: Through our care coordination platform, we have member-level information including an integrated view of member assessments, interventions, service utilization, and outcomes; in contrast to some stand-alone care coordination platforms, it is fully integrated with enrollment, claims payment, grievance/appeals, and clinical (e.g. HIE feeds) data sources. This tool is made available for use by network partners, works on mobile devices, supports HIPAA-compliant data-sharing, and is configured for role-based access permissions. This tool is able to meet the data and reporting requirements of the contract and can exchange data through HIE and with other systems.

- Admissions-Discharge-Transfer (ADT) data: We receive real-time hospital ADT data from CORHIO and have data-sharing agreements with major regional hospital partners that do not exchange directly through COHRIO.
- Social determinants data: Through our unique relationship with the Colorado Department of Public Health and the Environment (CDPHE), we receive data regarding members' social determinants of health, such as the Behavioral Risk Factor Surveillance System (BRFRS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). These surveys address lifestyles and behaviors related to the leading causes of mortality and morbidity, such as tobacco use, weight, lifestyle, and seat belt use. We are also the only health plan in Colorado receiving member-level vital statistics data from CDPHE and the only health plan actively incorporating this data with other data types in order to provide a 360-degree view of members and support more robust evaluations and analytics.
- Health First Colorado Data Analytics Portal: Through the Truven portal (formerly SDAC), we receive key performance results, population management tools, risk scores/quality measurements, state-generated analytics and other shared state measures and data sources.

Layering Data in New Ways

We continue to expand our connection to external data sources, leveraging existing, relevant and accessible sources of information to avoid duplication and improve upon our understanding of individuals, populations of members, and the regional landscape. We are layering standard data (claims, enrollment, clinical, credentialing, etc.) with newer types of data such as members' social determinants of health, provider-level performance metrics, participation in various payment reform models, and regional data trends. Our CORHIO ADT data initiative is a successful example of this type of integration. We partnered with and encouraged hospital systems to share their data through the CORHIO platform, and we were the first health plan to receive the CORHIO information for members. As a result, care coordinators at Colorado Access (COA) and at the site of care have been able to deliver interventions immediately after an emergency episode. This innovative layering approach brings a new perspective to standard data frameworks, creates a 360-degree view of members and providers, and drives program design, financial investments, and quality improvement efforts. We are currently exploring other uses for this rich source of clinical data such as identifying normal versus abnormal newborn screening tests to target appropriate preventive health messaging to new parents after discharge.

As these new, increasingly diverse data sources become available, it is essential to have the right data management foundation to receive, store, integrate, and analyze them in a meaningful way. For example, we receive a variety of member-level data; however some has a lag (e.g. claims data), and some is available only retrospectively (e.g. historical census data). The effectiveness of our population health and care coordination interventions hinges on our ability to integrate these disparate elements into a comprehensive view of our members, while prioritizing data elements that are closer to real time. We will continue to align and integrate these data sources and make strategic investments in IT and analytics resources to develop increasingly sophisticated information, leading to more timely and successful interventions. Our strong clinical and analytic teams (described Offeror's Response 4—Organizational Structure and Key Personnel and Offeror's Response 5—Sufficient Personnel) bring different perspectives and ideas into the multi-disciplinary data governance committee which contributes to the development of robust, creative and actionable data elements and reports.

Offeror's Response 22—Data Management and Claims processing includes a diagram of our data architecture which details sources and transfer mechanisms for multiple types of health care data into our enterprise data warehouse (EDW). We also describe how claims are processed through our partner and industry leader, Trizetto, using the QNXT platform.

Flexibility and Adaptability for RAE Success

It is critical to the success of the ACC that RAE contractors are flexible and collaborative regarding data and data systems. Because of our expertise and extensive history in receiving and processing data in ever-changing formats, we are well positioned to take advantage of technology advances and adapt to evolving Department priorities. We have been an effective partner to both the Department and network providers, contributing to system-level solutions that best serve members and achieve the aims of the ACC. We are fully prepared with the resources and capabilities to meet the RAE requirements and to adapt to ongoing changes. We will continue to adapt, connect old data sources to new, and improve architecture and processes that ensure data integrity, increase automation and efficiency, avoid duplication, and maximize the developing capabilities of the new state level system.

DATA MANAGEMENT AND ANALYTICS

Robust Data Management & Actionable Analytics

Our information technology (IT) department ensures the efficient receipt/storage of data from the Department and other external sources, and our business intelligence (BI) team creates reliable, actionable reports and analytics consisting of member and provider level outcomes, data needed to inform and implement alternative payment models (APMs), and combined clinical, claims, and social determinants of health data sets to guide the expansion of the health neighborhood. Further, we exchange data feeds with network providers and hospital systems and support smaller practices with actionable reports to help transform the health system and achieve population health outcomes.

Our enterprise data warehouse (EDW) is our internal database, using robust systems including Microsoft SQL Server, to manage member eligibility, provider contracts, authorization data, and claims. These data can be analyzed independently and aggregated to create powerful, actionable information at the provider and regional level. SQL Server Reporting Services (SSRS), primarily used for operational and financial reporting and analytics, is a server-based software system used to access our EDW. SSRS includes pre-defined tables and the flexibility to create customized tables and fields. Our EDW is updated nightly. A scheduler, available through SQL Server Integration Services (SSIS), allows us to generate standardized reports at predetermined dates and times. With nightly updates, near real-time reporting is available for claim status, eligibility and financial information.

The EDW is the base upon which the business intelligence team draws to support work throughout our organization, allowing them to build metrics, reports and action plans to guide their work. Our population health department utilizes the layered data within the EDW to create stratified intervention groups for targeted health promotion programs. Various operational departments use the EDW to generate standard monitoring reports for process metrics, such as call center statistics or claim processing turn-around times. The compliance and legal units use the EDW to monitor for fraud and abuse and ensure that the information is secure and

protected. Our care coordination, quality management and clinical leadership teams use the EDW to learn more about specific populations or members, create registries, identify cost and utilization trends, and monitor the fidelity and effectiveness of interventions. The BI team is responsible for delivering the information needed to support these activities. These various departments then take the information provided and develop action and intervention plans. These might include ongoing monitoring and presentation of results to our internal QI committees or external stakeholder groups such as the PIAC or the regional governance councils. Information and analytics regarding KPIs and provider outcomes are reviewed internally and then shared with practices through a variety of channels. As the RAE, we will support providers' data management and use by delivering data in raw and/or analyzed forms and through rapid feedback on leading indicators and outcomes. Through rapid data access and guidance on interpretation and use, we will assist their iterative efforts to monitor progress on identified quality metrics.

The RAE governance structure (described in Offeror's Response 8—Governing Body) will offer another important venue for the dissemination of provider- and system-level analytics focused on provider performance and quality improvement. These committees will operationalize the COA Health Transformation Framework to support development of the regional common agenda and selection of priority goals and objectives, and our data and analytics capabilities are fully prepared to support these efforts.

We successfully access and manage diverse clinical and non-clinical sets of data. Our analysts use SQL to parse and aggregate across programs and across data sets and are informed by national best practices in health care analytic and statistical methods for prescriptive and predictive models. Data from the EDW is extracted through standard queries and custom SQL searches applied to raw data and metrics efficiently created through State level platforms and shared resources. We are developing increasingly automated methods for standard queries to efficiently respond to regular reporting needs while building processes to ensure data integrity (using verification based on traditional SQL queries) and maximize BI resources for the custom queries. As described above, these custom queries are expected to grow in volume and importance in the near future; they are needed to incorporate new and growing sources of data into reports that provide context and nuance for sophisticated understanding of the region.

Tableau and Power BI are dashboard and data visualization tools that integrate with the EDW. Power BI is used for clinical and care coordination dashboard development and for population health advanced analytics through the use of SAS and the R statistical environment. Tableau is employed for interactive dashboards on costs and utilization and facility reporting. ArcGIS, a geographic information system, is used to support network adequacy reporting and develop advanced insights into member, provider, and community-based resources based on geographic distributions and spatial modeling and analysis.

We also have Extract/Transform/Load (ETL) tools to create custom extracts from the EDW so that data can be shared and loaded to other systems, such as disease registries or electronic health records. This type of data exchange will allow RAE providers to have actionable member-level information from across the medical neighborhood to better manage their attributed members' care.

The business intelligence (BI) department is responsible for company-wide reporting. Our BI director works directly under the chief operations officer, so that data and information stream directly to senior management. Senior managers meet weekly with the BI team for ongoing supervision of management staff and project prioritization. The scope of the BI department includes development and production of standard reports, ad hoc

analyses pertaining to the financial, clinical, and operational aspects of all programs, as well as advanced analytics and data visualization that harnesses multiple data sources to provide thorough insights for teams to act upon.

Our standard reporting package includes an online executive dashboard and more than 200 reports that provide information about all aspects of our operations and membership. Reports include clinical, service, and utilization measures that inform our operations and important quality functions. Reports are distributed internally to our management team and are used for ongoing process assessment, operational improvements, and monitoring. Many of our standard reports help monitor our quality improvement work plans. They are reviewed and discussed formally in quality improvement forums and, more informally, by the management team.

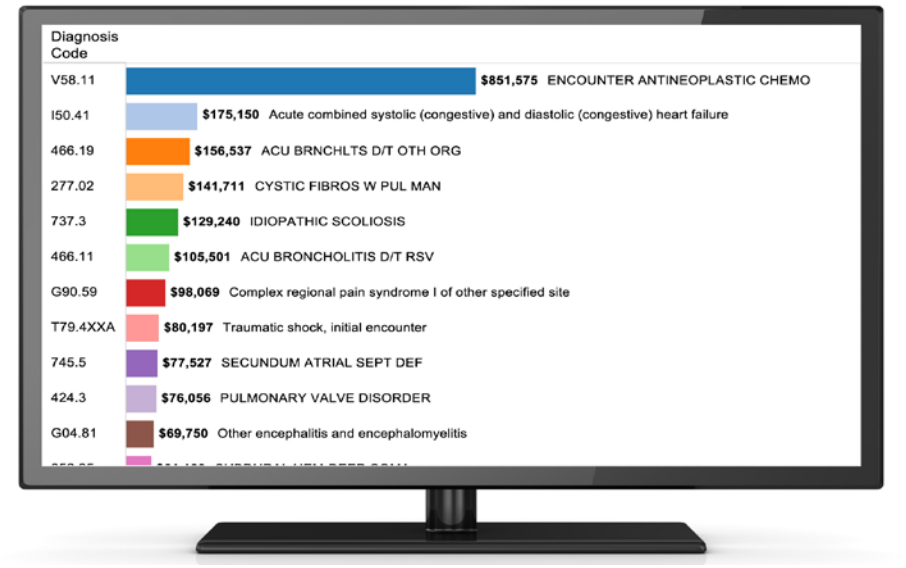
In addition to standard reporting, the BI department receives requests for ad hoc reports used to answer tactical clinical or operational questions. These reports may inform or validate operational or policy decisions, contract negotiations, and care model development. Our integrated data systems and experienced staff provide analytic information to support real-time business decisions. We will continue to provide ad hoc reporting and evaluation capabilities to the Department to better understand the dynamics of the RAEs.

As a data-driven transformation leader, our talented and diverse staff are able to take the data and information generated through these processes and use it internally and externally to help achieve the goals of the RAE. These activities include providing ongoing support smaller PCMP practices trying to better understand their populations and make informed clinical and administrative decisions. Our internal review and validation of KPIs and other metrics have identified areas where the administrative data may not be reflective of the clinical care being delivered, and we can proactively work with providers and billing teams to ensure that the data accurately reflects the care provided. The RAE Regional Governance Council and Regional Advisory Council will provide additional opportunities for comprehensive data review and analysis at the regional level. Most participants are used to looking at data through their own specific lens; as the RAE, we will enhance this by helping providers understand their data in the broader context of the health neighborhood and region.

Analysis and Reporting

Our data and analytics processes meet all requirements of federal and state regulations and support informed data-driven business decisions through descriptive, prescriptive, and predictive analytics. The BI team supports analytics conducted across the enterprise, from BI analysts conducting standard and ad hoc claims analyses, to epidemiologists refining population stratification models, medical directors conducting disease-specific investigations, or evaluators assessing outcomes related to pilot initiatives. Many of our standard reports are descriptive analyses designed as a starting point for further analysis to identify root causes of trends. Figure 21-1 on the next page is an example of a descriptive analysis: total cost of care by diagnosis. Please see Offeror's Response 23—Quality Improvement Program for more information on a wide variety of standard descriptive reports we regularly produce.

FIGURE 21-1 TOTAL ANNUAL COST OF CARE BY RANKED DIAGNOSES*



*Graphic illustration of data as seen in Tableau

Data and Analysis Lead to Insight and Action

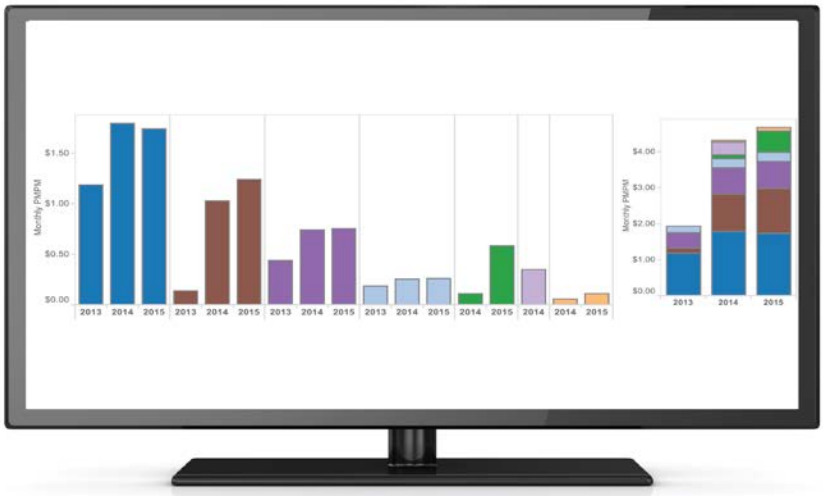
We have a unique and comprehensive understanding of key cost drivers within and across our current service regions because of experience as a Behavioral Health organization (BHO), Regional Care Collaborative Organization (RCCO), Single Entry Point (SEP), and Child Health Plan *Plus* (CHP+) contractor. This generates a relatively comprehensive understanding of member populations across physical and behavioral health components as well as disability-related factors and complements our status as the first (and currently only) RCCO in the state to establish data sharing arrangements to obtain vital statistics and other external social determinants data.

We have standard analytic reports that **characterize key cost drivers**. A variety of data sources are included in cost analyses, with claims data (across multiple programs) as a primary data source, supplemented by other internal and external member, provider and systems data. Using validated statistical methods, cost and utilization metrics are compared to historical patterns to identify trends that are outside of standard and customary variance, leading to targeted analytics on key drivers. Once identified, key metrics associated with unexpected costs are further analyzed to identify the root causes driving the variance. Control charts graphically display data trends over time and are a tool we use to differentiate special cause variation from sources of common, or chance variance. Using validated statistical methods, a variety of cost and utilization metrics can be trended over time, and those metrics that require further research can be quickly identified based on sound statistical principles applied through the control chart method. Figure 21-2 below is an example of a cost driver analysis. It compares both total costs and relative differences in trends over time to identify potential service locations to target for cost containment strategies with high potential for impact. The cost driver report normalizes for change in membership by measuring cost drivers on a per-member-per-month (PMPM) basis. The

first example below shows cost drivers by service location; however, our tools allow multiple variable views (by member, provider, category of service, diagnosis, etc.) to identify the root cause of a cost driver.

FIGURE 21-2: COST DRIVER ANALYSIS: WHERE IS THE INCREASE IN HEALTH CARE COSTS OCCURRING?*

This figure illustrates an example of trend analyses we complete to look at PMPM health care costs across different types of providers.



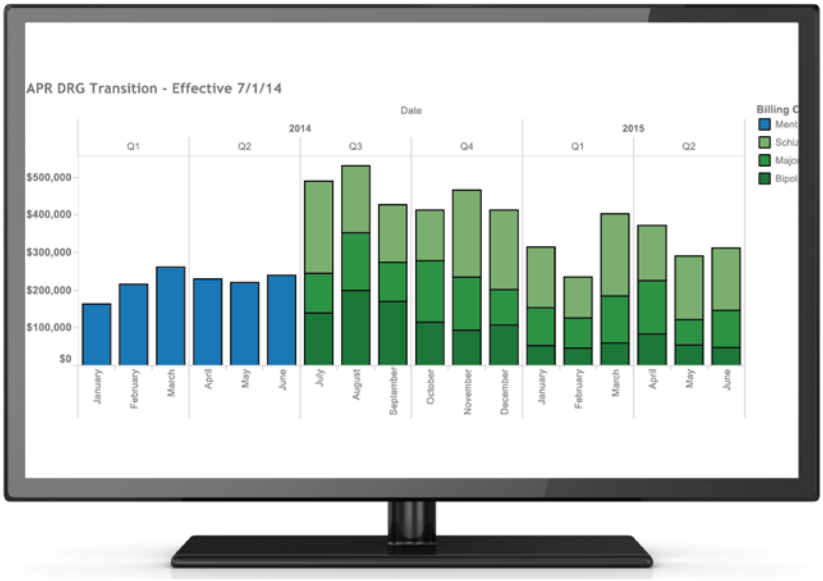
*Graphic illustration of data as seen in Tableau

Top Three Cost Drivers by Service Location and Gross PMPM Change

Federally Qualified Health Center (FQHC)	• $(1.10) PMPM
Inpatient Hospital	• $(.61) PMPM
Independent Clinic	• $(.58) PMPM

The second cost driver analysis example uses diagnostic trend data merged with cost data. This analysis was conducted to understand the effects of a 2014 BHO reimbursement change for inpatient behavioral health services to an All Patients Refined Diagnosis Related Groups (APR-DRG) model: members were stratified by severity of illness, and providers received higher reimbursement for higher severity members. Using this analysis we were able to detect consistency in relative proportions of diagnoses, but significant increases in overall inpatient costs following the transition from a standard behavioral health payment to the stratified, APR-DRG model, as most members were in the more severe groups.

FIGURE 21-3 COST DRIVER ANALYSIS: HOW DOES APR-DRG PAYMENT MODEL DRIVE INPATIENT BEHAVIORAL HEALTH COSTS?*



*Graphic illustration of data as seen in Tableau

Prior DRG—Expired 7/1/2014 One Reimbursement Rate	APR-DRG—Effective 7/1/2014 Severity Level and Reimbursement Rate		
Mental Illness—430	**Schizophrenia—750**	**Major Depression—751**	**Bipolar—753**
$7,387.87	1- $9,858.04	1- $9,858.04	1- $9,858.04
	2- $11,704.05	2- $11,704.05	2- $11,701.05
	3- $16,091.35	3- $16,091.35	3- $16,091.35
	4- $31,637.97	4- $21,170.19	4- $18,782.73

Multidisciplinary teams including cross-organizational departments (and, as appropriate, partner organizations), meet regularly to evaluate cost trends and develop context and understanding, adding an important qualitative component to cost driver-analysis. This critical qualitative component factors in deep knowledge of the regional environment and the practical impacts of national policies, state initiatives, and local values/culture. Uniting this local knowledge, historical context, and cross-program understanding ensures that quantitative analyses results are interpreted in an informed manner that best supports whole person care, and ensures that locally-driven, targeted interventions are used to address unnecessary cost/cost variance. For example, key to interpreting Figure 21-2 above is an understanding of changes from a fee-for-service to an encounter rate model that were implemented with federally qualified health centers (FQHCs)/regional health centers (RHCs) during the time period of the analysis. Key to interpreting and creating actionable steps based on the APR-DRG analysis (shown in Figure 21-3) is a clear understanding of the goal of the payment change (i.e. improving access for members

with severe behavioral health conditions by encouraging providers to serve more members through higher reimbursement) and a nuanced understanding of the practice patterns of local hospital providers.

Our years of experience as a Colorado managed care company has provided years of quantitative data to inform a forecasting model that takes into account historical and seasonal trends. The combination of quantitative historical data and qualitative local knowledge helps us to interpret date trends and effectively manage medical expenses in both stable and volatile environments. We anticipate and monitor seasonal surges in utilization of services and manage budgets accordingly. For example, youth tend to access more behavioral health services during the school year than in the summer.

In addition to regular review of claims data, we use the following internal processes to study cost drivers and identify unexplained and/or unwarranted variation in claim costs:

- Monitoring of KPIs and other quality measures.
- Disease-specific registries to identify targeted populations that may be at risk of high utilization, accessing low-value services, or gaps in care.
- Regular review of eligibility and enrollment to identify trends in members transitioning in and out of programs.
- Inclusion of Colorado Department of Public Health and Environment data sets, such as vital statistics records and BRFSS surveys, into our EDW.
- Analysis of associations between social and clinical cost drivers within specific populations; assessing cost change in response to interventions.
- Analysis of care coordination data to include member encounters, referral trends, care coordinator productivity, and caseload management.

Having gained direct experience with the strengths and challenges of using cross-program data to analyze trends, we are uniquely prepared to calculate risk-adjusted utilization expectations based on comprehensive data sets and implement strategies to address higher-than-expected utilization patterns within a systematic approach that aligns with regional priorities. Our risk stratification model (described in Offeror's Response 15—Population Health) is designed to build upon shared state resources and analytics and promote a common language and alignment across regional and provider level population stratification efforts. The design drives resources toward the most effective interventions with flexibility for PCMP practices and regional initiatives to operate concurrently and in a coordinated fashion. This stratification model will be incorporated into the Department's model once available.

Low value service utilization: We have developed a sophisticated approach to identify and address low value service utilization using geographically specific, disease specific or other specific targeted interventions. In some instances, a region-wide strategy might be indicated, such as helping providers adopt evidence-based guidelines. An important goal of the RAE will be to provide the right level of service at the right place and time to our members. Data analysis will inform both systematic and practice level interventions, which are both important to reduce overutilization of low-value service options. For example, through trend analysis, we identified that the subset of members with comorbid depression and diabetes had high rates of emergency department (ED) use as compared to other members. ED services are typically low value for this subpopulation;

most can be more effectively treated in outpatient primary care settings and by addressing their social determinants of health. We now utilize a depression/diabetes registry and have developed a model to target low-to-medium risk (for ED use) registry members for additional care coordination and other interventions.

Risk adjusted utilization expectations: A critical function of our population health management strategy is to assess and address member risk for negative health outcomes and high care costs. We utilize a **service risk variable,** a continuous variable that compares the use of high cost health care services against the use of primary and outpatient care. This variable is important in accurately adjusting utilization expectations based on individual risk. Using the depression/diabetes registry above as an example, we know that members on this registry are expected to have higher than average utilization and costs based on their multiple diagnoses. However, by analyzing the use of intensive, potentially avoidable services versus engagement in preventative services, we can identify which members are truly at risk for negative outcomes and potentially avoidable health care costs. If we used total costs, it would be impossible to reliably distinguish high from low risk members, as appropriate and potentially avoidable service costs are aggregated in that metric. This service risk variable will be used in a variety of ways to track utilization and plan interventions. At the individual member level, it informs individualized care coordination interventions. We will provide PCMPs with comparative practice-level data for their attributed members versus assigned members; these data may drive targeted practice transformation interventions. The population-based view of this metric will allow for a new view into the success of the stratification model and a better understanding of how to use similar metrics to identify and target specific subpopulations of interest.

Accessing and Interpreting Analytics and Reports

At COA, we use data to create meaningful actionable information, and create opportunities to interpret this information with nuanced supplementary data for the Department and/or providers. These reports incorporate KPI trend data (accessed through Truven's BIDM), nationally recognized quality and utilization measures, cost data, and member data (care coordination, utilization, demographics, geographic information, diagnosis, place of service, category of service, etc.) and provider level data, such as Truven's calculated vendor data (risk scores, total cost, population segment).

KPIs were historically developed using proprietary formulations and did not lend themselves well to national comparison. Further, there were limited relevant trend comparisons for accountable care organizations, a relatively new concept. Therefore, early in the ACC program, we created regional benchmarks appropriate to this new model. Informing this work was our deep experience in risk-based and other health plan formats, such as CHP+, Medicare, and others, making use of national benchmarks, cross-program comparisons, and national rating systems to evaluate absolute and relative performance in process and outcome measures. Evolving the use of defined KPI metrics and increasingly incorporating other validated benchmarks and related metrics is well within our expertise, and we are excited to leverage that experience as we move into the second phase of the ACC.

Currently, we use scorecards, dashboards, and control charts to provide high-level feedback to the Department, regional provider groups, and individual practices. These query-based reports are supplemented with drill-down options to provide more detailed information and supplementary related data on trends and potential drivers that require additional attention and follow-up (e.g. a particularly low and unexpected KPI performance).

Key Components: The Department, the RAE, Providers, and Truven's BIDM

Colorado Access was formed as an organization with the specific intent to partner with the State to improve care for Coloradans, and we now have a long-standing trust-based relationship built on our history of collaboration and transparency. We have shared important findings with the State and proactively collaborated to develop solutions. Examples include: errors in new file transmission formats or enrollment files, stratified cost impacts of changing payment structures or values (e.g. Figure 21-3 above), and information gained by leveraging outside vendors for analytics and member outreach. As a RAE, we will continue to work as complementary partners with the Department in support of a shared mission.

Collaboration with our network providers towards shared goals is critical to regional accountability and population health management. As the RAE, Colorado Access will continue to support providers in data infrastructure development, reporting, analysis, interpretation, and related clinical and operational revisions. For example, we have deep expertise in accessing and using Medicaid claim data and are prepared to support provider access to Truven's BIDM portal through a variety of ways suited to practice need. We currently support several network PCMPs in monitoring their outcomes by sending aggregated raw claims data for their practice to merge with the SDAC data (and with Truven's BIDM data when it is available). Some practices would not have the resources to access this information or interpret it on their own. However, as the RAE, we will provide this type of data support efficiently across the region and deliver provider-specific standard and custom reports to help practices understand KPI drivers and other factors. We will also support providers by providing and interpreting practice and regional trends. By working as partners, leveraging technology and data from the Department, and supporting providers, Colorado Access as the RAE will support an efficient and data-driven system that is powered to achieve the aims of the ACC.

Commitment to Ethical and Compliant Data Management

We are fully committed to ethical and compliant practices in all aspects of data management and data sharing. We have a robust privacy program to ensure that individually identifiable information is not improperly shared. Our data sharing protocols are customized based on the issues, scalable, repeatable, and compliant with state and federal privacy rules including HIPAA and 42CFR Part 2. Our data governance policy, as part of our privacy program, addresses data sharing practices, including under what circumstances we will share data with other entities, including providers and community organizations. We will submit and update our data governance policy to the Department as per contract. Some examples of our current, fully compliant processes include:

- Our care coordination tool uses role-based access that allows PCMPs to view information on their attributed members only.
- We generate and upload a variety of reports and data files to our secure file transfer protocol (sFTP) drive, both aggregate and member-level, for PCMPs and other HIPAA-covered entities.
- We limit information protected by 42 CFR Part 2 (substance use information) to only those individuals authorized by the member to see it.
- We comply with HIPAA and 42 CFR Part 2 and obtain authorizations to disclose information when required.

- We have the capacity to manage multiple authorizations for non-provider community organizations that are not covered entities under HIPAA.

Data Management and Claims Processing System

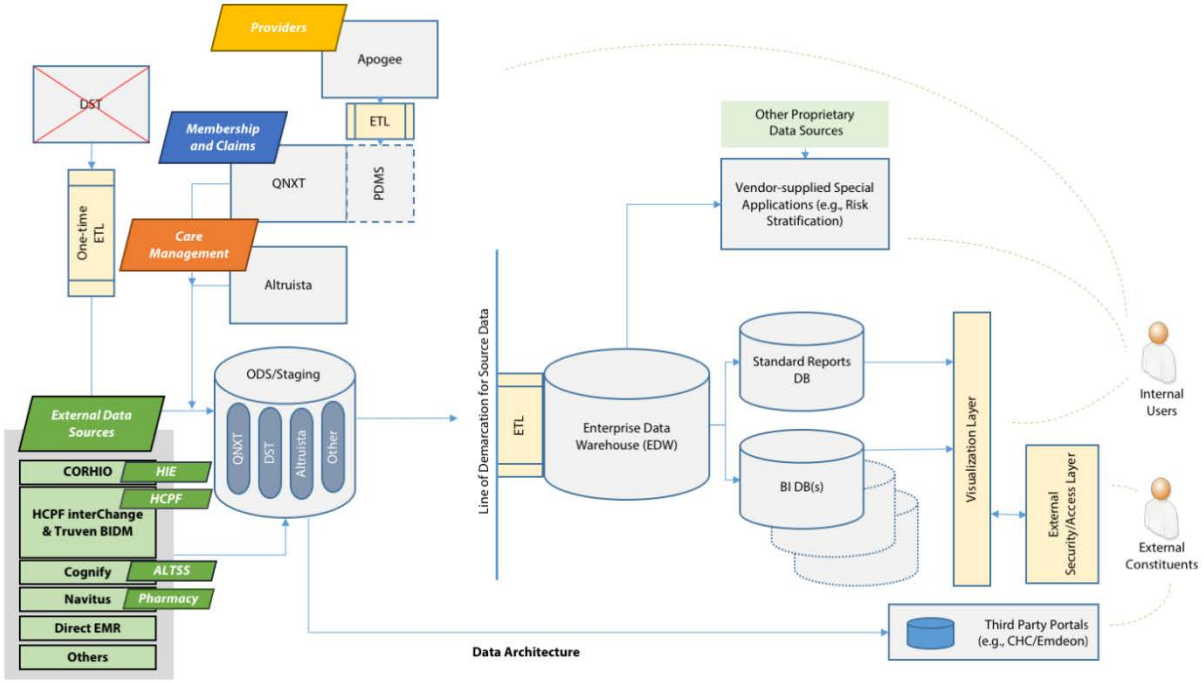
OFFEROR'S RESPONSE 22

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.

DATA MANAGEMENT SYSTEM STRUCTURE AND ARCHITECTURE

With a 22-year history successfully implementing multiple Colorado Medicaid programs, we have a unique understanding of the data management structure needed to operate behavioral health at-risk programs and physical health accountable care programs concurrently and in an integrated fashion. We are prepared to simultaneously support a variety of payment formats, such as alternative payment models in which the Regional Accountable Entity (RAE) distributes incentive or value-based payments while the Department of Health Care Policy and Financing (the Department) retains responsibility for claims payment and risk. Our robust system structure includes a multitude of data sources including claims data, enrollment and attribution data, care coordination data, provider data, external and community data, and performance data such as Truven's BIDM (previously SDAC) data. Our architecture is built upon structured query language (SQL) which ensures ease of integration with any other data source and the security required for protected health information (PHI).

FIGURE 22.1 COLORADO ACCESS DATA ARCHITECTURE



Our data management structure is continually evolving based on our conviction that health care transformation is not just for providers but is a shared venture. As a partner of both the State and providers, we must continually advance our data and analytics to reflect the ongoing evolution of the Department in order to efficiently process

claims, export data to the Department and providers, and integrate with ever-improving systems such as the MMIS (interChange) and SDAC (BIDM). Ongoing improvements include increasingly centralized data through an internal electronic data warehouse (EDW), centralized analytics tools, code library, data definitions, and increasingly automated queries and reporting to build upon, but not replicate, Department data and analytics. We are also continually assessing and evaluating the value potential of other tools such as provider portals or other practice-facing engagement functions and member-facing tools that enhance direct engagement in care. As the Department's data and analytics capabilities become more sophisticated through the interChange and BIDM systems, our data and analytics will be ready to meet, match and leverage these capabilities to deliver more value to our members, providers and ultimately the State.

CORE TRANSACTION SYSTEM: CLAIMS PROCESSING

We have licensed QNXT from the TriZetto Group as our core transaction system. QNXT stores and processes member eligibility, provider contracts, benefits, claims, adjustments, and payments. This best-in-class system is the choice of more than 50 health plans nationally and has been optimized to administer Medicaid programs using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. The powerful claims processing engines within the QNXT system allow for very accurate claims handling practices, including tracking of third party liability (TPL) status. We commit to sharing this information with the Department and/or the Centers for Medicare and Medicaid Services (CMS) as required.

With TriZetto, we have implemented significant measures to ensure that data are maintained and tracked accurately. In addition, TriZetto has an Uninterruptible Power Supply (UPS) to prevent data losses during temporary public utility power outages and an auxiliary generator in the event of long-term power outages.

For data integrity, TriZetto uses journalizing to maintain data availability. Journals are electronic logs that track all changes, including who made the change, to the production data files. All changes are logged and backed up nightly. Journals and the weekly backup insure a complete system restoration, if needed.

We currently process and adjudicate both paper and electronic claims. TriZetto processes approximately 1.4 million health plan claims transactions annually for Colorado Access, with more than 90% of those received electronically. We have a robust internal claim quality/audit process intended to ensure timely and accurate payments to our providers. We maintain a claims payment accuracy rate of 99% or greater. We routinely participate in State Medicaid audits with consistently positive findings. We are fully compliant with the Department's behavioral health coding manual and diligently monitor for any changes required by state or federal law.

ALTRUISTA GUIDINGCARE™ CLINICAL MANAGEMENT TOOL

We use an electronic care coordination tool that supports communication and coordination among members of the provider network and health neighborhood. Central to these tools is the GuidingCare system from Altruista Health. We use GuidingCare for internal functions and make it available to providers and care coordinators. To support population health management and person-centered care models, we use innovative clinical management tools. GuidingCare supports a patient-centered model of care by integrating all activities and functions required for optimal care coordination, including clinical and predictive analytics, care transitions, gaps

in care, disease registries, chronic disease management, behavioral health, social service coordination, and long-term services and supports.

Altruista's GuidingCare platform is designed to easily give a 360-degree view of the member's care coordination needs and interventions across programs and providers. The architecture of the platform is designed to ensure ease of viewing, accessing, and documenting items in any of the modules with the ability to easily view the whole member profile. Our strong partnership with Altruista has led to the development of many custom elements within the GuidingCare tool to optimize its effectiveness within the State's Medicaid and Child Health Plan *Plus* (CHP+) programs.

GuidingCare is designed to support the entire health neighborhood, including non-traditional/non-medical services, and is recognized as a leading software solution for long-term services and supports (LTSS), creating the opportunity to enhance care coordination for members who are served by both RAE and LTSS programs. GuidingCare provides both a team care plan and a member service plan to differentiate between types of services and interventions. Service interventions can be driven by an assessment within the system or manually entered by the care coordinator, and can drive authorizations in the linked utilization management module. Depending on the access granted to the user, the authorization can be generated as well as approved directly in the service plan. Claim and utilization data, either from the Department's monthly extracts or from the paid behavioral health claims paid internally, are loaded into the GuidingCare tool so that gaps in care and utilization histories are up to date and readily available. The care coordinators or others with appropriate role-based access to the system can augment those gaps with information from the medical record or other sources to provide the most accurate representation of the member's care. We have utilized the GuidingCare tool to track the Medicare Medicaid Program (MMP) Service Coordination Plan or SCP. We are prepared to load the Health Needs Survey data that we will receive from the Department and the Nurse Advice Line data into Altruista, as well as any other member-specific data that would contribute to the member's comprehensive record and care plans.

The tool meets Department requirements, including the need to: work on mobile devices, support HIPAA compliant data-sharing, provide role-based access to providers and care coordinators, collect and aggregate name, Medicaid ID, age, gender, race/ethnicity, name of entities providing care coordination, lead care coordinator, stratification level, capture care plan (e.g. clinical history, medications, social supports, community resources, member goals). GuidingCare has a mobile application for clinicians that enables care coordinators, providers, and other users to review member records, perform assessments, and capture notes and other information using an iOS, Android or Windows mobile-compatible device. In addition, the mobile application is designed for use in an offline/disconnected mode, allowing users to work with members and capture information even when an Internet connection is not available. The web-based platform also works on any mobile device. GuidingCare processes a full suite of HIPAA-compliant transactions, including:

- HIPAA EDI x12, including 837 Claims (Institutional, Professional and Dental), Member Eligibility (834), Authorization Request and Response set (278)
- HL7v2 or v3 messages including Admission/discharge (ADT), Document management (MDM), Master file notification (MFN) as well as Pharmacy and Treatment messages,
- CDA/C-CDA, CCD, CCR documents
- Custom XML extracts

To ensure that every user has access to only the members and data for which they are authorized, GuidingCare has a robust role-based authorization system that allows for the granular assignment of roles and permissions. These roles not only drive what a user can do or see in the system but also help to drive workflows and dashboard views. Business rules and configured activities and business requirements can then automate tasks/activities for different roles or users. These permissions are governed within Colorado Access (COA) and will be determined based on specific requirements for each role. These policies and procedures will be created for all appropriate members of the medical neighborhood and regularly reviewed and audited to ensure that the access is compliant with data sharing regulations and other requirements.

The system integrates all critical activities and functions required for optimal population health management and care coordination, including clinical analytics, preventive services, discharge and transitions management, disease registries, complex care coordination, disease management, behavioral health management, utilization management, appeals and grievances management, social support service coordination and long-term services and supports. GuidingCare integrates all relevant data and functions into a seamless electronic care record that supports a member-centered, team-based model of care while ensuring ease of use and quick navigation by a wide range of users.

Within the GuidingCare member record, users have the ability to view all current and past eligibility, primary care provider, primary behavioral health provider, and primary medical home information from the care team and programs screens that are part of the member record. GuidingCare users also have the ability to view benefit plan details such as covered services. Altruista has the ability to accept accumulator files to accrue for a member as well. Benefit and accumulator detail files are stored directly in the member record documents section, where users can then open the attachment and see all benefits available for that member.

In addition to comprehensive enrollment and eligibility data, the GuidingCare member record enables care coordinators to enter and/or view current and historical clinical health, behavioral health, pharmacy and social health data, including:

- Member medical information
- Visits
- Diagnoses
- Medications
- Health indicators
- Appointments

The GuidingCare member record also consolidates all care planning data. Care plan opportunities (gaps), goals and interventions are configurable and can be prioritized to align with member preferences. Individualized care plans can be generated automatically from assessment responses. Algorithmic, intelligent decision support tools within assessments identify potential gaps and build a customized care plan to address them. Predictive risk modeling identifies and stratifies high-risk members within a population to ensure appropriate targeting and prioritization of interventions.

As a shared care coordination system, care plans and related activities can be updated by any authorized user (provider or health plan) using a GuidingCare application. Other authorized users, to include health

neighborhood partners as appropriate, have immediate access to these changes with appropriate alerts on updates. Furthermore, the care record provides ongoing tracking of all notes and care plan updates for all members of the care team. We will continue to work with Altruista on the GuidingCare tool to enhance its effectiveness for the Colorado Medicaid program.

DATA MANAGEMENT AND EXPORT: ENTERPRISE DATA WAREHOUSE (EDW) VIA – ADMINISTRATIVE AND OPERATIONAL ANALYTIC TOOLS

The Colorado Access EDW is our internal enterprise database, using robust database systems including Microsoft SQL Server, which includes member eligibility, provider contracts, authorization data, and physical, behavioral health and pharmacy claims. We also receive and load HIE data directly from CORHIO as well as other direct admit, discharge and transfer (ADT) feeds from facilities that are not connected through CORHIO. These data can be studied in the context of each other to form powerful, actionable information that may be used for decision making. Business Objects is a fully integrated query, reporting and data analysis tool that accesses the EDW. Business Objects is used primarily for operational and financial reporting and analysis. The EDW is updated nightly with any changes made to our transaction system for that day. A scheduler allows us to generate standardized reports at predetermined dates and times. Business Objects includes a set of pre-defined tables, and its flexibility allows us to create customized tables and fields. With nightly updates, near real-time reporting is available on claim status, eligibility and financial information. This timely source of data provides information to management on the production levels of various departments and the means to monitor business and system changes and their impact.

Tableau and Power BI are dashboard creation and data visualization tools which also integrate with the EDW. Power BI is used for clinical and care coordination dashboard development and advanced analytics for population health through the use of the R statistical environment. Tableau is employed for interactive dashboards on costs and utilization and facility reporting. ArcGIS, a geographic information system, is used to support network adequacy reporting and develop advanced insights into member, provider, and community-based resources based on geographic distributions and spatial modeling and analysis.

We also utilize Extract/Transform/Load (ETL) tools to create custom extracts from the EDW so that data can be shared and loaded into other systems, such as disease registries or electronic health records. This type of data exchange will allow providers to have actionable member-level information from across the medical neighborhood to better manage each member's care. We expect to expand our EDW over the scope of the RAE contract to include more HIE data, including inpatient and outpatient services, selected data elements from electronic health records, other available data sources from the region such as survey or census data and other elements as they are available. As the key performance indicators are defined and performance targets set, these metrics will be created within our EDW and inform ongoing activities by our business intelligence (BI), population health, quality improvement, and clinical teams to support achievement of the goals of the Accountable Care Collaborative (ACC). The construction of the EDW was designed to offer maximum flexibility and easy incorporation of new data elements without disrupting the base data model. Our team of BI, EDW and IT experts stay current with new and emerging trends in data warehousing and analytics and regularly identify areas in which we should expand our capabilities to better meet the needs of members and providers.

BEHAVIORAL HEALTH ENCOUNTER DATA

We have extensive electronic data interchange (EDI) experience using ANSI ASC X12N 837 formatted encounter data, 834 HIPAA compliant transactions for reporting eligibility, processing paper and electronic claims/encounters and reporting encounters to the State. We have also submitted encounters in the required flat file format during 20+ years as a BHO contractor. Colorado Access was approved by the Department in June 2008 for 837 file submissions and has accepted 834 HIPAA-compliant transactions sets for reporting eligibility since 2010. We are actively sending and receiving 834 files with the State and other key trading partners, such as our pharmacy benefit management (PBM) and dental benefit management vendors, as well with Connect for Health Colorado, the health insurance marketplace. In addition, we are fully compliant with the ACA Section 1104 Mandatory Operating Rules for eligibility and claims status transactions that went into effect January 2013. We are already compliant with the claims remittance/payment and electronic funds transfer (EFT) Mandated Operating rules.

We have had systems in place to accurately report institutional and professional claim encounter data in the ANSI ASC X12N 837 5010 file format since the required compliance date of January 2012. Encounter claims data represent paid and denied services provided by facilities, behavioral health group practices, clinics, physicians, federally qualified health centers (FQHCs), and all other credentialed providers in both the 837 I (Institutional) and 837 P (Professional) file formats. Our encounter submissions meet the Department's requirements for which services are to be included and follow the applicable Volume VIII rules and EDI HIPAA transaction guides, as well as all relevant federal and state guidelines and timelines. We will submit raw encounter data, excluding data protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD). We currently successfully submit data to the APCD for multiple programs and are familiar with those processes. We meet the data certification requirements for accuracy and completeness. Extensive quality review processes are in place to analyze and verify the appropriateness of the encounter data prior to submitting files to the Department. Additionally, trending analysis is routinely conducted to assist in understanding data trends and suitability of encounter data. We will continue to validate the accuracy of the 837 formats (file syntax) through an external 3rd-party vendor determined by the Department prior to submission of the files to the interChange. If, once the encounters are accepted into the interChange system, we are notified that an encounter claim has an error resulting from a federal or state mandate or request that requires the review of the completeness or accuracy of the encounter data, we will correct the error in a timely fashion through resubmission of the encounter. We take all necessary measures to ensure the:

- Accuracy of all required fields
- Completeness of encounter claims data submitted
- Presence of medical record documentation
- Submission of data including paid and denied claims
- Submitted data exclude interim, serial, duplicate and late billings or claims in appeal status
- Submitted data include the most current version of adjusted claims.

We will continue to review compliance with these criteria annually by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department. We further understand that the

Department has the right to change format and/or data value requirements at any time, following consultation with the RAE contractors, and we understand the Department has the final decision.

We will use enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. These data transmissions and enrollment reports will meet all contractual requirements to include roster and reconciliation reports.

HEDIS Reporting

We contract with an NCQA-certified Healthcare Effectiveness and Data Information Systems (HEDIS) software vendor, Verisk, to produce HEDIS measures. Encounter/claims data are supplemented with registry, lab, RHIO and medical record data obtained by review from our nurse abstractors. We also contract with a HEDIS audit firm, HRA, who reviews all our HEDIS processes and ensures that rates are calculated accurately and can be fairly compared to those of other plans. We are interested in partnering with the Department in collecting and comparing formal, audited HEDIS measures across RAEs and supporting the Department in reporting of Adult and Child Quality Measures (CHIPRA) to CMS.

SUPPORT FOR HEALTH INFORMATION EXCHANGE

We strongly support health information exchange, not only with the Department, but also among providers and, as appropriate, social services entities. We have just completed an extensive survey of the HIE connections and capabilities of our current primary care medical provider (PCMP) and behavioral health networks to collect information about the type of EHR used, the available functionality, the practice's use of available tools, their meaningful use certification, their planned upgrades and their ability to modify their system. These data are being analyzed to develop a regional HIE/HIT strategy to guide our work in expanding the HIE connections and leveraging those connections to provide the right care at the right time in the right setting. We regularly reevaluate our health information exchange capabilities in light of new enhancements at provider sites and regional area. We are committed to promoting the development and adoption of these technologies through Colorado Regional Health Information Organization (CORHIO) and to adopting practices within our own systems to allow for additional information exchange. We were the first health plan to develop and execute a direct connection to CORHIO and develop our own tools to extract actionable information from the voluminous data available and transmit that information directly to our care coordinators and clinical teams as well as pushing to PCMPs who are providing care coordination at the point of care. The Department has subsequently arranged for CORHIO to provide that data feed directly to all current Regional Care Collaborative Organizations (RCCOs), and we have adapted our delivery mechanisms to incorporate that new data feed. As mentioned below, our clinical care coordination and utilization management platform Altruista GuidingCare supports our data sharing agreement with the CORHIO and allows us to support network providers with information about their members' hospital admissions and ED visits. We continue to collaborate with our clinical leadership and tap the deep expertise of local partners such as UCHealth, Children's Hospital Colorado, and CORHIO to take full advantage of the available and emerging HIE data.

360 – DEGREE PROVIDER VIEW

As a RCCO contractor, we have been asked to collect various data elements about primary care practices that are not typical managed care data feeds. These include information about the practices' participation in various state programs such as SIM or CPC+, the practice's integrated care score, whether the practice has been qualified as an enhanced PCMP (ePCMP), ADA compliance status, special expertise and services, etc. These diverse data elements are combined with traditional managed care data such as billing ID, physician board certification status, practice locations and with the recently collected practice HIE and EHR data to provide a robust view of the practice and the practitioners at each site that does not exist anywhere else in the state. This database allows us to query for and target specific types of practices or providers, set up customized evaluation cohorts, develop learning collaboratives and identify opportunities for additional support or engagement with practices. This type of information is frequently requested by the Department and other stakeholders to support national and statewide efforts. Our ability as the RAE to understand the provider network within the region with the depth and breadth of this data will allow us to be a powerful partner in the health system transformation within Medicaid as well as in collaboration with the other payers locally and nationally.

ABILITY TO INTERFACE WITH DEPARTMENT RESOURCES

Colorado interChange

At Colorado Access, we possess flexible resources and capabilities designed to build upon existing data systems – creating new systems and tools only as needed to fill critical gaps. Across our long Colorado managed care history, we have maintained an interface to retrieve eligibility, enrollment and attribution information by HIPAA standard transaction to include 834 and other file formats. In partnership with the Department, we have successfully transitioned from the Medicaid Management Information System (MMIS) to the new Colorado interChange system. Our BI department and other key personnel worked to ensure that the transition was as seamless as possible for members and providers. Having experienced prior state system transitions, we had contingency plans in place to prepare for any potential disruptions in day-to-day operations and programs and to ensure accurate verification of eligibility. In addition, for months prior to the transition, we worked collaboratively with the Department and as a leader among health plans to share our contingency plans, support implementation of contingency plans, and ensure that all involved could benefit from historical lessons learned from previous platform transitions. We applaud the Department's evolution to the interChange, which supports a more efficient processing of claims and provides access to improved data and analytics tools for measuring health outcomes, assessing value, and minimizing fraud, waste and abuse.

Business Intelligence and Data Management (BIDM) System

Having historically accessed Medicaid claims and encounter data for physical and behavioral health, care coordination information related to physical, behavioral, and long-term care, pharmacy data, and even clinic-level electronic health record (EHR) data from multiple sources, we are strongly appreciative of the state-level transformation to BIDM, a platform that efficiently aggregates these diverse data sets within a powerful analytics tool. While the experience in retrieving and analyzing these disparate data sources ourselves will only enhance our in-depth understanding of and our ability to use raw and calculated metrics in an informed manner, we anticipate major efficiencies arising from statewide analytics and the shared vocabulary, definitions, and

benchmarks that characterize a centralized system. Having regularly accessed KPI and other metrics from SDAC, we have years of experience interfacing successfully with Department platforms and look forward to the enhanced metrics to be available through BIDM.

Outcomes, Quality Assessment and Performance Improvement Program

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.

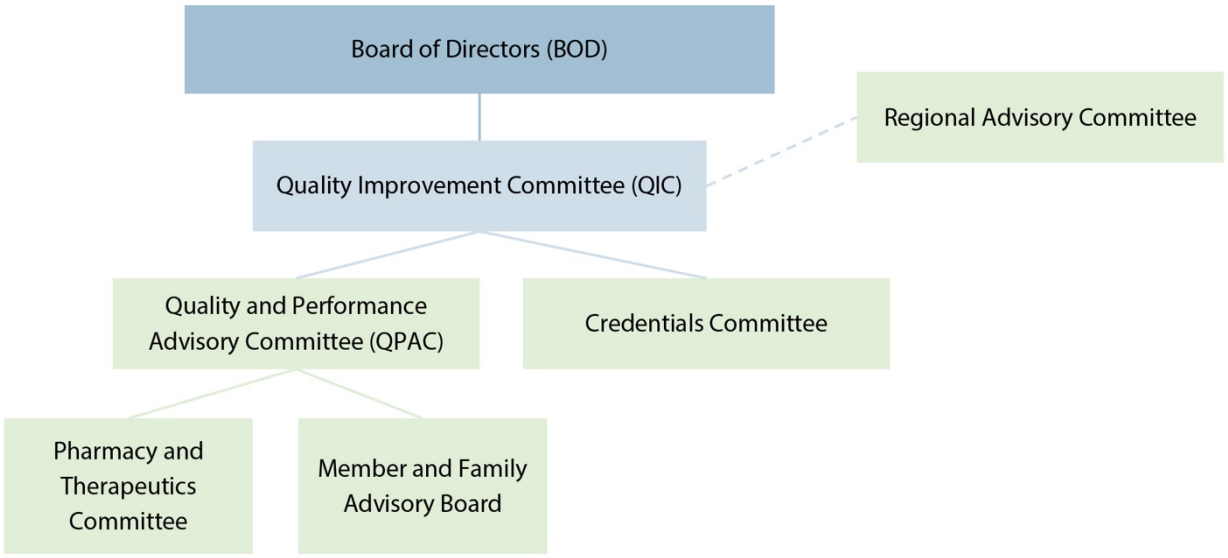
CONTINUOUS QUALITY IMPROVEMENT

Quality Improvement is foundational to the Colorado Access Regional Accountable Entity (RAE) Model (described in Offeror's Response 7—Integrated Administration), which uses a data-driven approach to improve service quality and performance outcomes. Our Quality Improvement (QI) Program will be implemented in accordance with the Department of Health Care Policy and Financing (the Department) requirements and the Health Resources and Services Administration (HRSA)'s four key principles: focus on the use of data; focus on patients; being part of the team; QI work as systems and processes. The QI Program will be integral to the work of the Regional Governance Council and Regional Advisory Council; they will ensure that the QI infrastructure is monitoring, measuring and supporting the region's common agenda and the Department. We bring deep experience and robust, established practices in QI for managed care programs, both state and federal, and will continue to evolve to meet the transformational needs of a regionally driven, accountable care system that ties payment to quality, not just volume. Below we describe how we will implement and maintain our Quality Improvement Program and address quality throughout the RAE administration.

Confidence in our future success is ample in our successful history. Our comprehensive and robust QI program has operated as an independent, cross-contract department for the past 16 of the 22 years that we have been in operation. During this time, QI has been responsible for a variety of quality improvement and management related activities for the company, including monitoring the quality and effectiveness of care and services, guiding the integration of care coordination between physical and behavioral health, and measuring program efficacy. The program has maintained full compliance with 42 C.F.R. 438.310-370, and pursued efforts that meet or exceed the Centers for Medicare and Medicaid and Services (CMS) definition of quality.

Since we enrolled the first member in 1996, our QI department's primary responsibilities have focused on using evidence-based and promising practices, integrated, whole-person care, and building and maintaining systems that align with the Department. While the QI team currently provides the Department with contract-specific Behavioral Health Organization (BHO) and Regional Care Collaborative Organization (RCCO) quality reports, QI's positioning as an independent, cross-contract team with experience across the full spectrum of physical and behavioral health metrics provides the experience and expertise to support the RAE contract deliverables. The committees detailed in Diagram 23-1 on the next page (with the exception of the Pharmacy & Therapeutics committee) are program agnostic and encompass both physical and behavioral health matters. As the RAE, our QI team will continue to maintain a single, unified Quality Improvement Program that meets federal requirements for both the Primary Care Case Management (PCCM) Entity and Public Health Improvement Plan (PIHP).

DIAGRAM 23-1 QI PROGRAM GOVERNANCE STRUCTURE



The structure enables the QI program to:

- Identify the most important quality assessment and performance improvement issues
- Obtain comprehensive feedback from a variety of stakeholders about the effectiveness of interventions
- Use the results of quality assessment, performance improvement, and program evaluation activities to conceptualize and carry out efforts to enhance administrative services and clinical care

Our QI team uses a population-based and member-centered approach to identify, design, implement, track, and evaluate Colorado Access (COA) activities and programs. While we have more than 22 years of experience as a health plan, we recognize that much of our success is tied to the knowledge and experience we have gained from having strong partnerships with our community. Through these partnerships with local public health, human service agencies, food banks, community centers, schools, churches, and many other entities, we are able to build a comprehensive support network to address the social determinants of health, in addition to physical and behavioral health. Over the years, QI has worked to strengthen these partnerships, incorporate and align strategies between ourselves, our community partners, and the Department, and to position COA to be a leader in population health and care coordination as the future RAE.

Relationships with members, providers and community agencies are critical to our QI program structure, which is supported by a variety of collaborations and advisory committees. The QI program structure (illustrated above) is comprised of core committees with interface and support from a number of collaborating committees and key staff members. Some committees include community stakeholders, members, family members, and practitioners from various disciplines. Committees with providers include representation of the types of practitioners that most frequently provide services to the member population in the region. We use a

collaborative approach that combines local and federal expertise, provider and member input, and the integration of physical, behavioral, and pharmaceutical expertise to guide our QI activities.

Committee Name	Chairperson/Member(s)	Committee Responsibilities
Board of Directors	**Chairperson:** Mitzi Moran, Colorado Community Managed Care Network The **membership** of the board of directors consists of representatives of the organization's corporate members, including: • Children's Hospital Colorado • University of Colorado Health • University Physicians, Inc. • The Colorado Community Managed Care Network (CCMCN) • A representative from Federally Qualified Health Centers (FQHCs) • A representative with expertise in behavioral health for the underserved • Three (3) at large community-based members • The president and chief executive officer (CEO) of COA is an *ex officio*, non-voting member of the board of directors	The board of directors maintains ultimate responsibility and accountability for the QI program. The board of directors delegates the authority and responsibility for daily operational activities of the QI program to the Quality Improvement Committee (QIC) with oversight of the program by COA executive leadership. • On an annual basis, review and approve the QAPI program description • Review summary report(s) on quality management and performance improvement activities as needed • Provide feedback regarding quality activities based on the review of summary reports presented by executive leadership • Review of feedback from the regional advisory committee on a regular basis
Quality Improvement Committee (QIC)	**Chairperson: COA** Director of Quality Management **Committee membership** includes the following COA staff members: • President & Chief Executive Officer • Senior VP health care systems & clinical operations, chief medical officer • Chief operations officer • Senior VP health care systems & accountable care • Senior VP & chief financial officer	The board of directors delegates authority and responsibility for daily operational activities of the QI Program to the QIC, with oversight by executive leadership. The QIC charter details rules and procedures. • Align corporate priorities for quality and performance improvement activities • Appoint task forces as needed to perform additional quality improvement activities • Provide guidance to staff on quality management and improvement priorities and projects (such as HEDIS)

Committee Name	Chairperson/Member(s)	Committee Responsibilities
	• VP strategic services and community • VP integrated care • VP legal services • VP program services • VP & chief compliance officer • VP accountable care • VP & chief information officer	• Provide oversight and input into quality improvement projects • Monitor progress in meeting quality improvement goals • Review activities and reporting from the Credentials Committee and Quality and Performance Advisory Committee
Regional Advisory Council	**Chairperson: Elected representative from the membership**	This committee will serve as the official Performance Improvement Advisory Committee (PIAC) in this region. The PIAC will delegate certain clinical functions such as the review and adoption of practice guidelines, clinical intervention programs and other activities that require the input of licensed practitioners to the QPAC. The PIAC (or regional advisory committee) will meet regularly in an open forum, review data and Key Performance Indicator outcomes from the region and recommend programmatic directions to the COA executive staff, the QPAC and potentially the Board of Directors.
Credentials Committee	**Chairperson:** COA medical director **Committee membership** includes at least one of the following positions/occupations: • Behavioral health specialist • Pediatrics provider • Internal medicine provider • Certified nurse • Surgeon • Family medicine provider • *Ex officio* non-voting membership shall include a COA medical director and credentialing program manager and/or coordinator	A peer review body that considers the applications of providers and organizational providers who have applied for initial or ongoing participation in the network. The Credentials Committee is accountable and reports to QIC. • Consider the applications of practitioners who have applied for initial or ongoing participation in the COA provider network • Determine provider participation status. If an adverse recommendation is made upon re-credentialing, the provider will be offered a hearing or appeal process that is addressed through COA policy • Perform a pre-contractual credentialing and re-credentialing at least every three

Committee Name	Chairperson/Member(s)	Committee Responsibilities
		years for organizations and providers and determine network participation • Review and approve credentialing criteria used to designate committee review classification, quality elements incorporated into the re-credentialing process, the process for ongoing monitoring of sanctions, and the hearing and appeals process • Annually review and approve the policies and procedures guiding the credentialing and organizational assessment process • Review and accept a list of delegate approved providers • Conduct peer review activities • Provide periodic summary reports to the QIC as needed
Quality Performance Advisory Committee (QPAC)	**Chairperson:** COA senior vice president of health care systems and clinical operations/chief medical officer **Committee membership** includes at least the following: • Members • Members' families • Advocacy groups/organizations • Network provider representatives (primary care, behavioral health, and other Medicaid providers) • Nursing facility/assisted living facility representatives • Community charitable/faith-based/service organization representatives • Representatives from other state agencies and local counties as necessary	The QPAC is an external quality improvement and clinical advisory committee to QIC and is primarily responsible for recommending strategies to monitor and improve the quality of health care delivered to members. QPAC meets quarterly and is chaired by the COA senior vice president of health care systems and clinical operations/ chief medical officer. The QPAC charter details the committee's rules and procedures. • Guide and oversee the clinical components of the program including disease and care management, utilization management and health promotions • May design and implement additional quality improvement/education programs • Review and approve utilization management criteria and clinical practice guidelines • Recommend the selection and prioritization of clinical QAPI projects and

Committee Name	Chairperson/Member(s)	Committee Responsibilities
	Regular attendees include: • *Colorado Cross Disability Coalition* • *Colorado Community Health Network* • *Colorado Health Care Association* • *Inner City Health Center* • *The Center for African American Health* • *Colorado Coalition for the Homeless* • *Arapahoe House* • *Denver Health* • *MCPN* • *Children's Hospital Colorado* • *St. Joseph's Hospital* • *Denver Department of Human Services*	measurement indicators, in addition to analyzing study results, identifying and proposing actions to improve care delivery and outcomes, and aiding in communication of QAPI activities and results to other providers and members. • Maintain communication with the Consumer and Family Member Advisory Boards
Pharmacy and Therapeutics Committee (P&T Committee)	**Chairperson:** COA senior medical director **Committee membership** is comprised of qualified practicing physician and pharmacists representing various clinical specialties. Ex officio, non-voting members include a medical director and director of pharmacy services. This group is a subgroup that reports to, and helps inform larger QPAC initiatives.	The P&T Committee is responsible for oversight of formulary and drug utilization management for COA. • Recommending which drugs shall be included in the COA clinical formulary and prescribing guidelines • Recommending clinical appropriateness of drugs • Advising on programs to improve care, including but not limited to drug utilization programs, prior authorization criteria, therapeutic conversion programs, and drug profiling initiatives
Member and Family Advisory Board	**Membership** is open to all members. The board is staffed by the Office of Member and Family Affairs (OMFA) and attended by the other departments as needed. This group is a subgroup that reports to, and helps inform larger QPAC initiatives.	A representative of the QI department presents a variety of topics of interest to members and, through an open-forum, seeks input and recommendations for improvement.

To ensure member voice is represented in these QI efforts, we actively support meaningful member and family participation in our advisory board. Support strategies include compensating members for travel, addressing child or elder care needs, providing meals/snacks, having translation headsets available, and choosing conveniently located and accessible venues.

QUALITY IMPROVEMENT PROGRAM

Our QI team is prepared to assume any and all quality assessment and performance improvement tasks required by CMS, the Department, and the Division of Insurance (DOI) to implement the RAE program. As a long-standing partner to the Department, we are familiar with reporting requirements, processes, and standards and have existing structures in place that fully support and are in compliance with the Department's quality strategy. Our existing and robust quality improvement program (QAPI) is aligned with the Department's quality strategy (see Table 23-2 *QI Goals Alignment* below) and is based on our population health department's data-based health objectives and clinical measures of care quality.

TABLE 23-2 QI GOAL ALIGNMENT

Goal 1: Create/maintain a system for collecting and monitoring quality and effectiveness of care and services			
Objective	**Colorado Access Success Factors**	**Department Alignment**	**Department Goal/Objective Description**
Goal 1: Create/maintain a system for collecting and monitoring quality and effectiveness of care and services.	• As a long-standing partner, we have an in-depth understanding of the Department expectations and are confident in our ability to carry out this work in alignment with the Department.	✓	• Collection and submission of performance measurement data, including member experience of care • Mechanisms to detect both underutilization and overutilization of services and communicate these findings with PCMPs • Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs as defined by the Department

Objective 1a: *Utilize current, evidence-based, scientifically proven practice guidelines, indicators, and benchmarks*	• As an established health care company with experience across behavioral, physical, and integrated health care, we are familiar with industry standards, best practices, quality metrics, and benchmarks for both RCCO and BHO related work.	✓	• Collection and submission of performance measurement data, including member experience of care • Mechanisms to detect underutilization and overutilization of services • Mechanisms to assess quality and appropriateness of care furnished to members with special health care needs as defined by the Department
Objective 1b: *Prioritize measures and study topics according to epidemiological characteristics of the membership, prior performance, and/or Colorado Access strategic direction*	• As a locally based, system-level entity, we understand the unique needs of members and system-level strategies that are most effective in reaching critical sub-populations. • The Regional Advisory Council will provide an additional layer of confirmation to data driven recommendations	✓	• Performance improvement projects
Objective 1c: *Demonstrate and sustain improvements in care and services*	• We have consistently delivered on cost and quality outcomes to the State. • Achieve commitment from Regional Advisory Council members to support prioritized key performance indicators (KPIs) or performance metrics as a region and within their own organizations	✓	• Collection and submission of performance measurement data, including member experience of care
Objective 1d: *Measure the*	• QAPI conducts ongoing evaluations of our	✓	• Performance improvement projects

effectiveness of interventions	programs and has an established feedback loop that includes the Regional Advisory Council to incorporate feedback regarding trends in program outcomes into our programming. Evaluation reports are submitted to the Department and are publicly available.		• Collection and submission of performance measurement data, including member experience of care
Goal 2: Incorporate input from key providers and stakeholders, systematically collect, review, and analyze valid data and select targeted actions and interventions designed for maximum impact			
Colorado Access Success Factors		**Department Alignment**	**Department Goal/Objective description**
• As a local partner, we leverage existing and positive relationships with members and providers via the Regional Advisory Council. The development of this new regional group as the PIAC allows us to review outcomes and identify targeted interventions most likely to impact shared goals that leverage the strengths and needs of members' clinics.		✓	• Regional Advisory Council and statewide learning collaboratives • Innovative payment models • Performance measures/KPI goals
Goal 3: Lead members to optimal health, satisfaction, and functional status through health education, active collaboration, and community integration			
Colorado Access Success Factors		**Department Alignment**	**Department Goal/Objective description**
• We know that in order to have the best outcomes possible, we must meet members where they are and provide comprehensive care by partnering with local providers and resources in the community. Our member education efforts are informed by a variety of member feedback results and partner provider input.		✓	• Collection and submission of performance measurement data, including the member experience of care • Mechanisms to assess the quality and appropriateness of care furnished to members who have special health care needs as defined by the Department
Goal 4: Integrate coordination between behavioral and physical health care into all aspects of program			

Colorado Access Success Factors	Department Alignment	Department Goal/Objective Description
• Understanding that true health outcomes necessitate whole-person care across the lifespan, we have systematically pursued the full complement of state contracts needed to coordinate behavioral and physical health as well as long term care. We are strategically positioned to integrate and coordinate behavioral and physical health care – and have successfully supported huge integration advances since RCCO inception.	✓	• External quality review • Stakeholder transparency and feedback
Goal 5: Comply with local, state, federal, and accrediting requirements for quality improvement with special attention to measures and performance levels established by the Department and CMS		
Colorado Access Success Factors	**Department Alignment**	**Department Goal/Objective Description**
• As an existing and long standing full service health plan, we have systems put in place to ensure that we are in compliance with all federal and Colorado state regulations and requirements.	✓	• Collection and submission of performance measurement data, including member experience of care • Mechanisms to detect overutilization and underutilization of services • Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs as defined by the Department • Quality of care concerns • External quality review • Advisory committees and learning collaboratives

The specific activities that our RAE Quality Improvement Program will conduct include, but are not limited to: (1) performance improvement projects, (2) collection and submission of performance measurement data (including member experience of care), (3) mechanisms to detect both underutilization and overutilization of services, (4) mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs (as defined by the Department), (5) quality of care concerns, (6) external quality review, and (7) participation in advisory committees and learning collaboratives. We will utilize several measures and monitoring activities as seen in Table 23-3 *Quality Performance Measurements and Highlights* below. We currently

collect quality measures across multiple Health First Colorado (Colorado's Medicaid Program), hereto referred to as Medicaid, contracts, enabling us to identify places to apply quality improvement successes from one contract to additional settings.

TABLE 23-3 QUALITY PERFORMANCE MEASUREMENTS AND HIGHLIGHTS

Measurement Activity/Tool	Highlight
Experience of Care and Health Outcomes (ECHO) Survey	Ratings were particularly high for how well members felt helped, and how well clinicians communicate (**≥85%** in both categories)
Health Care Effectiveness Data Information Set (HEDIS)	Members have **high rates of primary/preventative care utilization** (>80% for youth and >70 for adults) and **Clients on Persistent Medications Receiving Annual Monitoring** (>83%). CHP+ data found that providers **met or exceeded the 2015 state average in three of the five performance domains**: immunizations, well-child visits, access to a primary care provider.

Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey	We had particularly high ratings from RCCO members in:
	How Well Doctors Communicate: 98%
	Getting Care Quickly: 92%
	Customer Service: 82%
	Shared Decision Making: 80%
	Over the past 2 years, CHP+ CAHPS scores have improved as well.
	• 3 domains scored in the Medicaid 90th percentile:
	  ○ How well Doctors Communicate (3% improvement since 2014)
	  ○ Rating of all Health Care (25% improvement since 2014)
	  ○ Rating of Personal Doctor (17% improvement since 2014)
	• 2 domains in the Medicaid 75th percentile
	  ○ Rating of Specialist seen most often (4% improvement since 2014)
	  ○ Getting Care Quickly (6% improvement since 2015)
	• Other improvements:
	  ○ Getting Needed Care (6% improvement since 2014)
	  ○ Coordination of Care (10% improvement since 2014)

Member Grievance Monitoring	**Grievances decreased 60%** since 2013; down to 1.4% in 2016
Clinical Denials and Appeals	**Appeals have decreased each year at a rate of 0.04** in 2016. These represented 1% of denials.
Penetration Rates	Prior to FY16, we saw an increase over the past 4 years in which we exceeded the benchmark with a **16.5% penetration rate**
Secret Shopper and After-Hours Survey Results	Secret shopper results found that clinic sites **exceeded the goal of 90% compliance for all types of appointments** (i.e. routine, non-urgent, and urgent) during FY15. Non-urgent and routine appointments were the highest at approximately 100%.
Telephone Abandonment and Speed of Answer Monitoring	**Over 80% of calls answered within 30 seconds** and less than 5% abandonment rate despite increasing call volume over the past 4 years

Measurement Activity/Tool	Highlight
Provider Appointment Availability	**Over 99% of members** were able to get a routine appointment within 7 days, urgent care within 24 hours, and emergent care within 1 hour with a provider of their choice
Network Adequacy Analysis (geographical and cultural/linguistic)	**17.9% provider network growth** in 2016 to 3,464 behavioral health providers, **100% of members have access to a provider within 30 miles** **100% of RCCO patients have access to a PCMP accepting new patients in the region** **16 languages** offered within the RAE *(Russian, Chinese, Italian, Romanian, Afrikaans, German, Japanese, Spanish, Arabic, Hindi, Polish, Tagalog, Burmese, Portuguese, American Sign Language)*

We look forward to building upon a successful track record of collaborating with the Department to submit and implement quality improvement plans and reports for the RAE. We will continue to evaluate the impact and effectiveness of the QI program and QI activities on an annual basis, or per a revised Department schedule. The COA evaluation plan currently includes: performance on various measures, the results of each improvement activity or project, and detailed findings of the program's effectiveness.

Performance metrics are and will continue to be regularly monitored and included in annual reports to the Department. Our most recent report shows quality metrics (e.g. penetration rate, utilization monitoring, follow-up, readmission, and access to services) improving over time or holding steady at rates that meet or exceed benchmarks.

TABLE 23-4 ACCESSIBILITY AND AVAILABILITY OF SERVICES

Measure		Goal	Improvement since 2013	FY15
Penetration Rate (overall)		> 14.0%	39%	16.46%
Access to Services	*Routine care within 7 calendar days*	100%	--	99.5%
	Urgent care within 24 hours	100%	--	100%
	% of members within 30 miles of provider	100%	--	100%
Appeals	*Resolution timeliness*	100%	--	100%
	Appeal rates	< 2.0	71%	.04%
UM Decision Timeliness		97%	--	97.9%
Quality of Care Concern Rate		< 2.0	88%	0.03

Monitoring Appropriateness and Quality of Care

We currently utilize a variety of activities and mechanisms to monitor the appropriateness of care received by members, including members with special health care needs, including, but not limited to: physical and developmental disabilities, chronic conditions, substance use disorders, severe mental illness, and traumatic brain injuries. The mechanisms we use most frequently include:

- Assessments of member satisfaction (survey, grievance, and appeal data)
- Medication utilization monitoring: using a variety of data sources, the pharmacy director analyzes drug utilization patterns to identify and assess trends in overall and provider-specific prescribing and cost patterns and provide information to providers regarding appropriate medication use
- Quality of care concern investigations

Quality outcomes studies are designed to objectively and systematically monitor and evaluate the appropriateness of care and service provided to members and compare results to established goals. We choose topics for routine monitoring and for special studies based on relevant demographic and epidemiological characteristics of the plan membership, high risk and/or high volume services, input from providers, members, state, and federal agencies, as well as results from other monitoring activities. Population-based assessment is utilized whenever appropriate and may be supplemented by focused medical record review and/or surveys. We use HEDIS measures, BHO performance measures, and RCCO key performance indicators (KPIs) as the primary measurement of health outcomes.

As seen in the next table, we have adopted health guidelines related to key initiatives/sub-populations for which data is collected, reviewed, analyzed for trends, and compared to national benchmarks and established performance goals. Barriers to care and service are identified and opportunities to enhance patient safety, improve care and or outcomes, and manage and coordinate care are identified. These behavioral health guidelines are related to:

Behavioral Health Guidelines	Physical Health Practice Guidelines	Preventive Health Practice Guidelines
• Adolescent alcohol and substance use screening, brief intervention and referral to treatment (using the CRAFFT tool) • Adult alcohol and substance use screening, brief intervention and referral to treatment (SBIRT) • Attention Deficit Hyperactivity Disorder • Bipolar disorder (child) • Bipolar disorder (adult) • Major depressive disorder	• Appropriate antibiotic use-adults • Appropriate antibiotic use-children • Asthma • Diabetes care • Gastroesophageal reflux disease • Obesity –adult • Obesity prevention – child • Obesity treatment – child	• Adult health maintenance • Adult immunizations • Pediatric health maintenance • Pediatric immunizations • Influenza vaccination

Behavioral Health Guidelines	Physical Health Practice Guidelines	Preventive Health Practice Guidelines
• Substance use disorders • Monitoring of adults prescribed antipsychotics	• Smoking cessation	

Finally, we monitor the quality of the services performed internally. Providing managed care functions in a timely and effective manner allows members to access the needed services in a more efficient manner. The internal services we monitor include, but are not limited to:

Internal Services
• Grievances and quality of care concerns • Claims processing accuracy and timeliness • Credentialing and re-credentialing turnaround times • Utilization management decision turnaround times • Inter-rater reliability analysis for utilization management decisions

Quality Improvement Plan and Annual Progress Report

We will develop and submit a Quality Improvement Plan to the Department and/or its designee that outlines how we plan to implement our RAE Quality Improvement Program during the contract period. We will make reasonable changes to our plan, upon request by the Department. This Quality Improvement Plan will be implemented following plan approval by the Department, and reviewed and updated at least once annually.

Currently, we have a standard process and reporting procedure to collect and analyze RCCO and BHO data and compile the data in required reports. We have successfully submitted four reports to the Department for every year that we have had integrated contracts. Our annual reports include a summary of program activities and accomplishments by fiscal year, a description of the techniques the contractor used to improve performance, qualitative and quantitative data detailing the impact the techniques had on quality, and identification of opportunities for improvement. In addition to submitting the annual report to the Department, we also publicly post all annual quality reports to our website along with minutes from meetings relevant to state, community, and member stakeholders. Table 23-4 above, *Accessibility and Availability of Services*, is an example of metrics included as part of our annual report. Please see coaccess.com/annual-quality-reports for complete reports.

An annual quality progress report will be submitted to the Department and/or designee. The report will include at minimum: (1) a description of the techniques we used to improve our performance, (2) description of the qualitative and quantitative impact the techniques had on quality, (3) the status and results of each performance improve project conducted during the reporting period, and (4) opportunities for improvement. This report will be made available to the public.

PERFORMANCE IMPROVEMENT PROJECTS

We have more than 15 years of experience in identifying and conducting performance improvement projects (PIP). Topics for Medicaid (RCCO and BHO) and Child Health Plan *Plus* (CHP+) populations are designed in collaboration with the Department and the External Quality Review Organization. Criteria used to guide in the

selection and prioritization of quality improvement projects result in activities designed to support the overall quality management strategy approved by clinical leadership, generate a measurable impact, and provide improvement on member health outcomes or internal work processes.

PIPS are completed and evaluated on an ongoing basis, and at least once per year. Data are collected, compared, analyzed, addressed, and re-measured according to program goals and objectives.

Potential projects for the RAE will be reviewed by the Quality Improvement Committee (QIC), the Regional Advisory Council, the Quality and Performance Advisory Committee (QPAC), and various other task groups along with input from internal staff and external community stakeholders, including members. We will select projects based on a number of criteria including: patient safety, risk factors such as co-morbidities or chronic conditions, number of members served, potential impact on individual and population-level health outcomes, project scale, ease of implementation, financial considerations, available resources, and likelihood of success. Projects will be designed to have a positive impact on member care outcomes, health and functional status, and member satisfaction. We will work with the Department to select at least two PIPs to complete during the contract period.

Historically, we have chosen projects that have involved the integration and coordination of care and data between RCCO and BHO contracts and that leverage our existing relationships with both types of providers. For example, during fiscal year 2016 (FY16), our Access Behavioral Care (ABC) Denver program conducted a PIP that addressed the depression screening and transition of care to a behavioral health provider. Specifically, the project identified the number of shared BHO and RCCO members between the ages of 12-17 whose medical provider screened the members for depression. The members who coded positive (V40.9 with 99420 CPT code) on the depression screening were monitored to determine if they attended a follow-up visit with a behavioral health provider. This topic lacks historic rates for reference, which was the impetus for examining these particular rates of transition of care within the target population. The goal of this study was to encourage members to be screened for depression and to transition to a behavioral health provider with the support of medical providers who can facilitate this transition (as clinically appropriate).

In addition to the two projects selected in collaboration with the Department, we have the capacity to conduct up to two additional PIPs upon request from CMS. Additional projects will include performance measurement using quality indicators, implementation of system interventions to achieve improvement in quality, an evaluation of the efficacy of the interventions, planning and imitation of sustaining and/or increasing improvement, and participation in Department learning collaboratives.

Whenever possible, performance will be evaluated not only for the network as a whole or by program or product line, but also by provider. We will collaborate with network providers both to receive performance data from providers (e.g., Access to Care performance) and to distribute performance data to providers (e.g., KPIs, performance measures, medical record reviews, encounter data validation, etc.). Our PIPs will include the measurement of performance indicators using objective, widely used indicators of member satisfaction, efficacy, and quality and ongoing plans for sustainability. These projects will meet or exceed the requirements set forth in 42 C.F.R.

The results of each of our PIPs will be summarized and included in the Annual Quality Report and/or upon request by the Department.

PERFORMANCE MEASUREMENT

We will participate in the measurement and reporting of performance measures per the Department requirements, and will ensure performance reports are publicly available. Current performance reports highlight the successful partnership we've had with the Department to produce and report on performance measures using both state and COA metrics. Behind this promise is not just a 22-year history of meeting or exceeding all Department performance requirements, but a history of partnering with the Department to identify areas to improve the quality, utility and efficiency of data and reporting, as well as measurement criteria, reporting frequency, and other performance components.

In March of 2017, the Department went live with a new payment and eligibility system, interChange. The transition to this new system represented significant changes to the business processes of all of the Department's managed care organizations (MCOs), and its successful launch was predicated on many months of preparation, organization, planning, and testing. As a long-standing partner to the Department, and a historical contractor across multiple entitlement programs, we had an unparalleled depth and breadth of experience with which to support project success. Having held both risk, and not-at-risk contracts, we have technological expertise with 834 files (enrollment and eligibility) 820 files (payment and capitation) and 837 files (encounters and claims) - as well as both the old (proprietary MMIS file) and the new (Department standard interChange) formats. Similarly, we have existing MCO relationships developed across multiple behavioral and physical health programs and years. Leveraging this unique blend, we were able to provide consultation to the Department regarding the potential technical and business impacts of the transition upon the MCOs, and assume a leadership role in soliciting MCO feedback. We also provided statewide support and training. We were able to help set up and test the new file layouts, anticipate file transition issues, and establish mitigation processes to help ensure the Department had a successful launch of this product. Having experienced prior file format transitions, we had existing business process processes created and documented. We shared these with our fellow MCOs statewide - regardless of any current or future competitive positioning - because our primary concern is, and has always been, for the member experience, and not competitive boundaries.

We look forward to building on this ongoing relationship and continuing, as a RAE, to participate in opportunities that forward our mission of improving access to quality care for all through shared expertise and collaboration rather than making proprietary or profit-based decisions.

Using Multiple Sources of Data to Enhance Provider Performance

Through our provider engagement and strategy team, we are prepared to build upon the existing and trusting relationships we hold with network providers. As described in Offeror's Response 17—Provider Support and Practice Transformation, a key component of our provider engagement strategy is delivering the appropriate level of support to our network providers. This allows us to adjust our strategy based on the provider's specific needs for support in collecting and reporting on performance measures. We have found these needs vary across our network depending on the provider's size, administrative capacity, clinic based care management abilities, and other factors. Many of our larger practices have the administrative and technological capacity to meet all performance measurement requirements themselves. For smaller practices and others without this capability, we build systematic efficiencies that support their needs by leveraging our own internal capacities for multi-practice solutions.

For all types of practices, we will use our extraordinary access to multiple sources of data and expertise in merging these data sources to provide more comprehensive views of practices' patient populations. Sources we will use include: behavioral health through our BHO history; physical health through our RCCO history; disability through our Single Entry Point (SEP) history; member experience through our Medicare CAHPS administration and analysis experience; and 5) population-level data such as birth statistics through our unique data sharing agreement with the Colorado Department of Health and Environment. This strategy ensures that performance reporting efforts do not just meet Department requirements, but actually improve the ability of providers to increase the quality of their care using complementary data sources. We will also work collaboratively with providers to appoint a member or members of the Regional Advisory Council to ensure that stakeholders in the region understand the data and analytics available and can provide feedback on how to continuously improve performance. We will continue to track performance on a monthly basis using Truven's BIDM and other data sources to identify systematic opportunities for performance improvement. We welcome the opportunity to continue to partner with the Department to ensure that calculation methods optimize the ability of both individual providers and the system, to make meaningful interpretations regarding healthcare utilization and cost trends. We will continue to meet or exceed Department and CMS requirements for existing and future performance measurement and reporting requirements.

Pay for Performance and Key Performance Indicators

We are pleased to offer our unique expertise to the ACC 2.0 pay for performance structure. We support the direction of the State in leveraging new and innovative funding mechanisms to increase accountability for cost and member experience while improving care quality. As the RAE, we will offer experience in administering KPIs, flexible funding pools, public reporting of multi-data source measures that cross behavioral and physical health benefits. Rather than just receiving member experience data, we will continue to collect, analyze and follow up on CAHPS data. As we have done with other CHP+ and RCCO plans across the state, we will offer a source of support to other RAEs that are participating in the full Colorado Medicaid program for the first time. We have successfully leveraged the flexibility of the Per-Member-Per-Month (PMPM) payment throughout ACC 1.0 with a focus on increasing member access to integrated care in the primary care setting.

We have the breadth and depth of experience needed to improve performance as measured by the eight KPIs identified by the Department (and the additional contractor-selected indicator). We applaud the Department's direction in identifying KPIs that measure potentially avoidable expenses and high-intensity service utilization. We also support the intent to measure new collaborations and health neighborhood activities that, while not directly under the control of Medicaid providers or accountability entities, have a known and critical impact on health outcomes. These adjacent possibilities have a high potential to forward the quadruple aim through an enhanced quality of life for the communities in our region. We will echo this thoughtful approach in the selection of our RAE-specific indicator. Utilizing our Regional Advisory Council and Regional Governance Council, building on the connections we have to cutting edge research and an up-to-date understanding of the peer-reviewed literature, we will select an indicator that has an evidence base for being responsive to intervention, is of concern/interest to regional providers, and aligns with existing initiatives (e.g., SIM, MACRA, CPC+) – in order to maximize measurement quality and minimize additional administrative burden and initiative fatigue for providers.

Table 23-5 *KPI Successes* includes highlights related to some of the proposed KPIs that best demonstrate our historical success and our capability to flexibly develop new metrics and measurement processes based on the needs of the member population, the Department, and the CMS direction.

TABLE 23-5 KPI SUCCESSES

Key Performance Indicator	Example of Colorado Access Success
Total Cost of Care	We partnered with Next Health Technologies to implement an emergency department (ED) utilization reduction program where we made IVR calls to members with historically high rates of ED utilization. The calls were to educate and encourage members to access care at PCMP/urgent/more appropriate levels of care. **As a result, we saw a reduction of 9.4% in the trial population versus the control group.**
Emergency Department Visits (Ambulatory)	In our RCCO Region 3, we had **better than average performance in ED visits**, as compared to the State, with 701.88 visits per thousand.
Wellness Visits	We currently track Well-Child Checks (WCC) for children ages 3-9. **RCCO Regions 2 & 3 increased their WCC rates** between July 2015 and June 2016. In an effort to prepare for the proposed RAE wellness visit KPI, QI has created a Well Visit Performance Improvement team with members from QI, strategy, provider engagement, CHP+, population health, care management, and RCCO operations to support wellness initiatives and coordinate efforts across the provider network.
Behavioral Health Engagement	The QI team has created a Performance Improvement team to evaluate the barriers to optimal performance on this measure. Opportunities have been identified and we are working with several network providers to implement meaningful, targeted interventions designed to achieve substantial improvement in early FY18.
Prenatal Care	We partnered with the Bruner Family Clinic and **successfully secured Rose Foundation funding to implement a perinatal virtual integrated care initiative.** This initiative will leverage our televideo services for enhanced care management and supported referral for perinatal members and telepsychiatry consultation to their Ob-Gyn providers In addition, our population health and care management units are working on a digital engagement campaign that will run from July through December 2017. This program targets pregnant women. **Members will receive text messages related to their individual stage of pregnancy** and reminders to engage in prenatal and post-partum care.
Dental Visit	Our CHP+ program has **partnered with Delta Dental and the Colorado Health Institute to collect and evaluate dental visit data**. This can serve as a foundation for future work on a RAE dental visit KPI.

Key Performance Indicator	Example of Colorado Access Success
Obesity	**We currently receive BMI, height, weight, and other obesity related metrics through CORHIO data** imports. Our population health department is working on a risk stratification model to combine obesity and other non-clinical data points with claims to enhance our predictive analytic capabilities.
Health Neighborhood	We are ready to adopt the Department's hybrid measure of utilization of the Colorado Medical Society's Primary Care-Specialty Care Compact and number of electronic consultations made in a 12-month period. We are actively researching ways to track consultations in collaboration with our provider partners. As a system-level entity, we have existing formal contracts and teaming agreements with a variety of human services organizations i.e. local public health, food banks, vocational services, educational institutions, health alliances, and the full complement of public service eligibility determination agencies.

Incentive Payments

We are well prepared to offer differing incentive payments based on individual practice performance. Our experience participating in the ePCMP program will contribute towards this success, as we already have RCCO processes in place for certifying primary care medical providers (PCMPs) for enhanced PMPM payments based on their ability to meet five out of nine designated criteria. Our certification process extends from monitoring PCMP status on enhanced offerings such as extended hours and advice line access, through ensuring receipt of the enhanced PMPM.

We appreciate the new opportunities within the RAE model to incent local and regional innovation to improve care quality and efficiencies. Supporting and encouraging providers in using their on-the-ground expertise to identify opportunities to improve care allows local, informed innovation to flourish. This increases a sense of authentic collaboration between network providers and their RAE – as we have experienced as a RCCO and BHO. This also allows the RAE to best leverage its system-level role by providing data support and education to providers as they identify their own areas for improvement and innovation – and expanding and supporting effective innovation to the system level following positive results. As a locally based, nonprofit organization, we reinvest funding incentives back into the provider network and the community to enhance the system of care and the member experience.

Within ACC 1.0, we have used some of this flexible funding to enable innovative initiatives such as:

- System-level, on-demand specialty care telehealth (care management, behavioral health and psychiatry) through AccessCare Services (our telehealth subsidiary)
- Cross-agency, cross-systems initiative to increase prenatal visits in Northeastern Colorado

- Medical-legal partnership to help members address health-harming legal needs related to insurance, public benefits, housing, education, employment, legal status, and safety – to improve health and well-being, and reduce health care utilization in Region 3.
- Cross-agency, cross system initiatives to increase access to affordable, permanent housing for a variety of high-risk sub-populations-including criminal justice and homeless members in Regions 3 and 5. Funding includes leveraging private investments through social impact bonds, and at least one housing model includes integrated medical, dental, and vision services provided on-site below the housing units.

Notable Efforts to Measure, Align and Report Public Health and System-Level Measures

We are prepared to continue with our long history of publicly reporting the core health and cost measures that demonstrate improving network performance. In addition, we participate in SIM across all of its workgroups to ensure that we are not just appraised of, but are working in alignment with SIM, CPC+, and other statewide initiatives. We have a dedicated team focused on the Colorado Opportunity Framework, and have been selected to be a Practice Transformation Organization for SIM. Through this work, we will continue to create efficiencies and alignment for members and providers in the provision of improved metrics that are available publicly. Our population health department is a particular strength in forwarding the measurement and reporting of aligned public health and system level measures. With existing relationships and data-sharing templates we have been, and will continue to break new ground in comprehensive reporting.

For example, the population health department is utilizing birth certificate data to better understand current membership, members' use of prenatal care, gaps in access and/or utilization of services, and the impact of public health data on predictive analytics and program development when combined with SDAC. The table below illustrates some of the important findings from this analysis.

TABLE 23-6 ODDS OF USING PRENATAL CARE IN FIRST TRIMESTER

	Odds Ratio	*P* - Value
African American	0.7	<0.001
Asian Pacific Islander	0.7	0.02
Hispanic	0.9	0.4
Native American	0.4	0.002
Other/Unknown	0.7	0.01
4-year College Degree	1.0	0.8
Some College	1.2	0.01
Masters or more	1.5	0.10
Less than High School	0.8	<0.001

This analysis suggests that:

- Women of racial minority had lower odds of starting care in the first trimester than non-Hispanic white women.

- Mothers with a less than high school education had lower odds of starting prenatal care in the first trimester.
- Health conditions such as pre-pregnancy hypertension were not predictive of using care in the first trimester.

To our knowledge, this project represents the first time in Colorado history that birth certificate data was merged with Medicaid data. Integration of multiple types and sources of data such as birth certificate data, daily electronic health record data (such as the admission/discharge/transfer data from the Colorado Regional Health Information Organization), and other public health data sources will vastly improve our comprehensive understanding of members and the impact of current efforts, and will guide our future work.

We also have a notable strength in monitoring and reporting on member experience using an enhanced approach to the CAHPS (Consumer Assessment of Healthcare Providers and Services) survey. Historical records will show that we have consistently met the Department needs in reporting and utilizing our regions' CAHPS data as collected by the State. However, we have additional expertise gained through our Medicare contracts. As a Medicare administrator, we have historically not just received, but have been responsible for collecting CAHPS data from providers, enabling our quality team to implement rapid cycle analysis and reporting and identify opportunities for qualitative follow up for particular items, or with particular practice or areas (i.e. particularly low or high rates of member satisfaction). This in-depth experience gained through our Medicare contract enhances our ability to support the Department in current and future goals related to the collection, analysis, augmentation, and reporting of CAHPs data for the RAE population. Based on this historical experience and our ongoing provider relationships, we will able to ensure that data reports do not simply meet a RAE requirement, but authentically improve the ability of system and direct-care level entities to understand populations and sub-populations and to make informed care transformation decisions.

Skills to Support Value-Based Payment Models and the Behavioral Health Incentive Program

We have invaluable expertise in the full complement of technical, analytic and reporting, and value-based payment skills needed to forward this component of system transformation. Our existing expertise includes:

- Making capitated behavioral health payments
- Measuring and reporting on a provider and regional level across the full continuum of quality of care metrics from base to enhanced standards
- Assessing providers and certifying for enhanced rate criteria
- Concurrently and flexibly implementing a variety of capitated, and PMPM payment models, including value-based initiatives.

We anticipate being fully eligible to participate in the behavioral health incentive program and look forward to the potential for enhanced flexibility to encourage local innovation.

We are uniquely positioned to administer the behavioral health benefit and are confident in our ability to perform optimally across the standards and metrics that will drive the full capitation payment within our well-known regional population. We understand that in ACC 2.0 payments will be influenced by performance and will remain within CMS federal managed care regulations.

Metric	COA Success Example
Hospital Readmissions (7,30, 90 days)	Surpassed goals by of less than: 5, 13, and 20% respectively, and further reduced rates from prior year
Penetration Rates	Have surpassed goal of >14% for three consecutive years
Inpatient Utilization	Surpassed goal of less than 6% and further reduced rate from prior year
ED Utilization for MH	2016 ED Utilization lower than in two prior years
Follow up after ED: MH or SUD	Improved 7 and 30-day follow up rates in FY 12-15; sustained rates in 2016

In addition to demonstrating positive outcomes on these behavioral health metrics, we have a historically high rate of accuracy in submitted encounter data that meets or exceeds the 90% criteria. In 2016, our overall rating of compliance was 99.4% as compared to the statewide BHO average of 76%.

We have ongoing initiatives designed to meet or exceed performance criteria related to both behavioral health and substance use treatment. During FY16, the Colorado Access subsidiary, AccessCare, developed new programs and services to increase access to behavioral health care for members through telemedicine technology. AccessCare is a leader in Colorado in the telehealth field. COA and AccessCare have implemented an integrated care consultation model to increase the professional capacity of primary care providers to deliver behavioral health care themselves, enhancing capacities for both members and providers. Seventy of our network PCMPs have onsite behavioral health services through telehealth and in-person solutions. Goals for 2017 are focused on expanded access to SUD education for providers and services for members.

As ACC 2.0 begins, we are prepared to maximize the available behavioral health incentive payment to, in turn, maximize the quality of behavioral health benefit provided to members. As noted above, we are committed to collaborating with the Department to identify and begin to monitor aspirational performance measures. This flexibility provides another opportunity for provider influence, and thus enhanced buy-in, alignment across multiple initiatives and synergistic progress across health and community entities with shared visions for improved population health and life quality.

MEMBER EXPERIENCE OF CARE

We plan to continue to assess member satisfaction with quality of care and services using a combination of approaches, including: the CAHPS and ECHO (Experience of Care and Health Outcomes) surveys, analysis of disenrollment data, and member grievance data. The CAHPS and ECHO surveys are designed to evaluate member perception of services received from the health plan and to evaluate performance of network physicians and providers in the delivery of care. The CAHPS survey is currently conducted annually by the Department for CHP+ and RCCO members, while the Department conducts the ECHO survey annually for ABC members. We will use this survey data for continuous quality improvement by establishing benchmarks and/or performance goals and assessing overall levels of satisfaction as an indication of whether the plan is meeting member expectations. Member satisfaction highlights from previous survey for adults include **surpassing 80% satisfaction** for: how well clinicians communicate, getting information on how to manage conditions and about

patient rights, feeling empowered to accept or refuse treatment, privacy, and feeling that service helped members' symptoms/conditions. Previous member satisfaction highlights for children include **surpassing 80% satisfaction** for: how well clinicians communicate, length of office waits, being informed about medication side effects, getting information on patient rights, feeling empowered to accept or refuse treatment, privacy, and social connectedness.

Quarterly member grievance and appeal data provides additional valuable information regarding potential member dissatisfaction with both the care delivery system and service operations. These measures are not mutually exclusive. Data are analyzed for trends across measures, opportunities for improvement identified and prioritized, and interventions for improvement implemented. **We have maintained low rates of grievances (0.01 per 1,000 members in 2016) despite increasing membership - which is another indicator of positive member experiences of care.** As the RAE, we will continue to analyze and use grievance and appeal data as an important source of member satisfaction information.

MECHANISMS TO DETECT OVERUTILIZATION AND UNDERUTILIZATION OF SERVICES

We strive to prevent the over- and under-utilization of services by using medically necessary and appropriate levels of care in the least restrictive environments, and by actively monitoring utilization for services that we don't authorize or pay claims for. We have demonstrated that we meet high utilization management (UM) quality standards by assessing coordinated clinical services/UM staff members using the McKesson InterQual® (IQ) Behavioral Health Criteria (Adult) Interrater Reliability Tools, and exceeding our goal of 90% with a measured **92% inter-rater reliability between both intake and clinical staff in each area of area of pediatric and adult services.** This testing is completed annually to ensure ongoing compliance.

As the RAE, we are prepared to support the Client Over-Utilization Program (COUP), which is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. The program uses paid claims to review member utilization profiles and identify patterns of potentially excessive utilization. We will actively participate with the Department to identify PCMPs and pharmacies that are willing to serve as designated COUP providers and work with the members, providers and the Department to review and continually improve the program. We will perform additional analyses of members identified by the Department for the COUP, including assessing for: primary care medical home (PCMH) attribution, PCMH visits, ED visits, ED risk factors, previous quarter high-risk medication count, and diagnoses. We will systematically track the outcomes of members in the COUP using a registry to measure the effectiveness of the interventions for this population and identify opportunities for refining its approach.

Outside of the formal COUPs, we currently work across multiple systems to foster partnerships and programming aimed at identifying members who are utilizing health care services inappropriately and supporting their transition to the effective use of resources. These efforts vary, from sponsoring educational opportunities for health care providers to convening and participating in community-wide partnerships and program implementation. We play a central role in connecting health care and human service providers to disparate agencies that have the means and expertise to support member-focused programming—helping to mitigate the issues caused by inappropriate utilization of services. Some Region 3 examples include:

Salud Family Health Centers Integrated Clinical Pharmacy Program – Since 2015, we have partnered with Salud Family Health Centers (Salud) to integrate clinical pharmacists into certain primary care clinics. As part of Salud's integrated team, these pharmacists work directly with high utilizing members to support their knowledge about and proper use of prescribed drugs, leading to a decrease in inappropriate utilization and notable improvements to health outcomes in areas such as diabetes management and hypertension.

North Suburban Medical Center– In late 2015, providers at this large Thornton hospital reported a large spike in women in active labor presenting in their ED with no history of prior obstetrical care. Many of these patients were non-English speaking. Upon investigation, they determined that many of these women had actually been receiving prenatal care from Clinica Family Health, but those records were not shared with the hospital. Our population health department reviewed claims data to validate their concerns, and representatives from Tri-County Health Department, North Suburban Hospital, Clinica, and COA met to review the findings. The inter-agency group traced the root of the problem to the closing of St. Anthony's Hospital, where Clinica patients had traditionally gone for delivery. When St. Anthony's Hospital closed, no new system had been created to support records-transfer for delivery elsewhere. The assembled group was able to execute the needed agreements to share data and patient records so that Clinica's prenatal patients arrive at North Suburban Hospital along with their records. Hospital providers now have access to complete pregnancy records and have made efforts to match patients with a provider who speaks their language. The existing trust and collaboration between COA and partner agencies, and the ability to take a cross-provider, systems level approach, has reduced unnecessary use of ED resources and improved care quality and outcomes, which will continue to benefit perinatal patients into the future.

South Metro Fire Department/Westminster Fire Department: When South Metro receives a 911 call that is determined to be low acuity, they send out a medical provider instead of the full ambulance/emergency response. This service is called Advanced Medical Response and is delivered through a partnership with Dispatch Health. After resolving the immediate issue, if the provider determines that the patient is a COA member, they contact a care manager to refer for further treatment. The care manager can arrange for a scheduled medical appointment (often the same day) instead of an emergency room visit. This program with South Metro has resulted in major cost savings, and has been replicated by the Westminster Fire Department. We have developed a relationship with the Department whereby we send them a list of members we want to connect with if they call 911. We have supplied them with a list of resources and connections to four practices that they can refer these members for same-day assistance: Rocky Mountain Youth, Clinica, Partners in Health, and Next Care Urgent Care. Again, the focus is to reduce ED use by facilitating referrals to primary care when members call 911.

Connecting Partners Across Region 3 – We have been a consistent catalyst in driving connections that align the resources and programmatic goals of varied agencies and providers across Adams, Arapahoe and Douglas counties. As the RAE, we will extend this focus to include Elbert County. Many of these connections focus on delivering needed, appropriate services to individuals who fall into special population categories, such as SUD, foster care, or at-risk youth. For example, we have been instrumental in connecting Signal Behavioral Health, the region's managed service organization, to providers dealing directly with the impacts of over-utilizing individuals who suffer from substance use disorder. In addition, we helped found and have provided continuous support for the Douglas County Health Alliance. One of the priority issues for this alliance is reducing over-utilization of emergency department services.

QUALITY OF CARE CONCERNS

Our current quality of care (QOC) process identifies, investigates, and addresses potential quality of care concerns, including those involving physician providers. We intend to maintain and enhance this process as we move forward as the RAE. Under this process, QOCs can be raised by members, providers, or our staff members. They encompass all potential problems, concerns, or complaints concerning access to urgent or emergent care, delay or denial of care or services, after-hours services, professional conduct or competence, coordination of care, medication issues, diagnosis issues, service plan or delivery issues, or concerns with legal or member rights. Member complaints regarding quality of care will be handled through our member grievance and appeals process, regardless of content. QOCs are also triggered by care resulting in unexpected death, suicide attempts requiring medical attention, medication errors or adverse medication effects requiring medical attention, preventable complications requiring medical attention, assault or accident related injuries requiring medical attention, or an at-risk client missing from a 24-hour facility.

Potential QOCs are forwarded to the QI program for initial investigation and are then submitted to a COA medical director for review and a determination. Findings are kept confidential as required by peer review statutes. There were seven QOCs reported for ABC during FY16. **This represents a rate of 0.03 per 1,000 member months, well below the identified goal.**

EXTERNAL QUALITY REVIEW

As the RCCO and BHO, we have complied with the Department's requirements for external quality reviews and confirm our willingness to continue to actively participate in these reviews as the RAE. In addition to reporting QI activities and results to the QAPI Governance Structure (e.g., board of directors, QIC, QPAC, members), QI has also participated in an annual external independent review and performance measure validation. The addition of the Regional Advisory Council will provide another opportunity to share the findings and recommendations of the External Quality Review Organization with the regional stakeholders and engage them in participating in the ongoing improvement of the RAE program.

ADVISORY COMMITTEES AND LEARNING COLLABORATIVES

We are dedicated to participating in ongoing multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the program and guiding the improvement of program performance. Our Regional Advisory Council and the Regional Governance Council will provide fertile ground for representatives and content to be brought to the statewide committees. As the RAE, we will participate in ongoing efforts to engage stakeholders and provide guidance on how to improve health, access, cost and satisfaction of providers and members in the program through regional and statewide PIACs. Our PIAC responsibilities are divided between our Regional Advisory Council, which will be the formal PIAC and address all data and quality activities, and the Quality and Performance Advisory Committee (QPAC) which will deal with the more clinical aspects of the quality program given its clinical membership.

The Regional Advisory Council will meet at least quarterly and will be open to the public. The time and location of the meetings will be sensitive to the varying needs and schedules of its members. We will accommodate individuals with disabilities through accessible locations, hearing support, and other adaptive strategies. The

agendas, minutes and other materials will be posted on the COA website within thirty days. The meetings will be chaired by the regional program officer and staffed by the QI and community engagement teams. To support systematic improvements in the provision of whole-person care, as the RAE we will integrate both physical, behavioral, and public health stakeholders to create a comprehensive PIAC through the Regional Advisory Council. We will encourage active participation from local stakeholders such as:

- Medicaid providers including primary care, behavioral health, and specialty services
- Advocacy groups and organizations
- Nursing facilities/assisted living providers
- Charitable, faith-based, or service organizations within the community
- Members and family member representatives
- Other state and local agencies
- State and local policymakers

The evolving PIAC and QPAC charter documents will be created to detail the shared acceptance of mutual management of the ACC program across providers in the region, the shared responsibility for partner agencies, and regional success, as well as established regulations for membership and voting responsibilities.

The PIAC responsibilities via the Regional Advisory Council will include:

- Review COA's deliverables and program policy changes and provide feedback
- Designate two representatives to serve as members of the statewide PIAC
- Review regional and program performance data
- Review member materials and provide feedback
- Discuss and address operational and quality issues related to RAE implementation across the region and supply information to the Regional Governance Council
- Conduct duties on behalf of the Regional Governance Council, such as reviewing KPIs performance data, and outcome data, develop priorities for community investments (e.g. incentive dollars or new funds)
- Conduct in-depth review of regional data and make recommendations for new or enhanced programming
- Actively collaborate with population health teams to review and digest analyses and suggest areas of focus
- Develop a mechanism for collection and evaluation of member and community feedback
- Coordinate with and learn from other entities that have conducted community or regional needs assessments including the state and local public health departments, nonprofit hospitals, and other agencies
- Vet potential infrastructure or external vendor investments (intended to support the region)
- Coordinate common elements of policy priorities and shared lobbying/engagement efforts among partners

- Delegate specific clinical functions to the QPAC committee

The QPAC committee will meet at least quarterly. Responsibilities include:

- Review and approve utilization management criteria and clinical practice guidelines
- Provide input into clinical quality or performance improvement activities
- Offer clinical input into the design of provider incentive programs
- Maintain communication with the Member and Family Advisory Board

Some of these functions will be supported by two subcommittees that report to QPAC: Pharmacy and Therapeutics and the Member and Family Advisory Board. These committees are described earlier in this Response. Members and family members will be actively invited and encouraged to attend both QPAC and regional advisory committees as consistent or ad hoc members. These subcommittees will be particularly active in reviewing clinical practice guidelines and reviewing member materials, respectively, and support a stable forum for sharing system-level information, providing education about clinical and policy issues, and retain regional engagement.

We look forward to participating in the Department's Operational Learning Collaborative that will support the collaborative development and improvement of program activities. This venue offers a great opportunity to share lessons learned across RAEs, share new local and national findings, and improve experiences for members and providers.

Compliance

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

At Colorado Access, our mission of partnering with communities and empowering people through access to quality, affordable care, speaks to our commitment to members and community partners to conduct ethical business. We have more than 22 years of experience as a health plan in Colorado, which uniquely positions us with the knowledge to comply with the laws and regulations that govern the delivery of our business. We are able to leverage the extensive expertise and skillsets of our compliance, finance, credentialing, and legal departments, in addition to our board of directors, to ensure full compliance with the laws and regulations required in the Regional Accountable Entity (RAE) Contract.

We maintain an enterprise-wide corporate compliance program designed to prevent, detect, and deter fraud, waste, and abuse. Our program meets the requirements set by the federal government and by the Department of Health Care Policy and Financing (the Department) in the RFP. We also adhere to revised rules for Medicaid Managed Care Organizations and Primary Care Case Management entities. Our corporate compliance program is outlined in a formal compliance plan that is approved by our chief executive officer, chief compliance officer, and the board of directors. We submit this plan to the Department annually, and whenever it is revised.

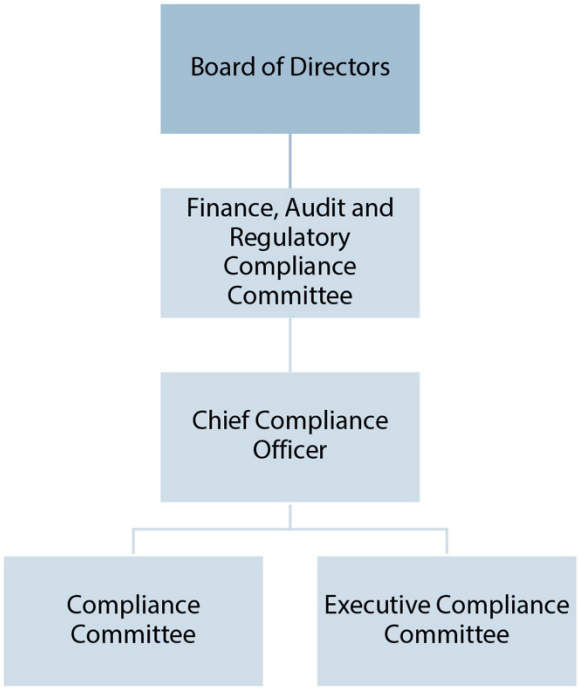
FRAUD, WASTE, AND ABUSE

Described below, our compliance program includes mechanisms for identifying, investigating, and addressing known or suspected fraud, waste, and abuse. The seven elements of the compliance program are summarized below:

1. Designation of a chief compliance officer who oversees our compliance program and reports to the chief executive officer and board of directors.
2. Written policies, procedures, and standards to ensure compliance.
3. Regular training and education for all employees about our compliance program and applicable federal and state rules.
4. Effective lines of communication, including a toll-free hotline to receive complaints or reports of compliance-related issues.
5. A system for responding to allegations of improper conduct or activities including well-publicized disciplinary guidelines.
6. Procedures for routine monitoring and auditing to detect inappropriate conduct.
7. Procedures for ensuring prompt responses to detected offenses and development of corrective action plans when necessary.

Designation of Compliance Personnel

Our board of directors maintains ultimate responsibility and accountability for the compliance program through the Finance, Audit, and Compliance Committee (FACC), a subcommittee of the board of directors. The board of directors has delegated the authority and responsibility for daily operations of the compliance program to the chief compliance officer (CCO), who oversees the organization's commitment to ethical, honest, and lawful conduct. The CCO is responsible for proposing and developing policies and for advising other departments and functions on the development and implementation of their own policies, procedures, and practices designed to ensure compliance with the applicable regulatory requirements of our business. The CCO reports to the FACC quarterly.



Written Policies and Procedures

We have written standards of compliance that provide guidance on the conduct expected of all staff members. This includes our code of conduct and written policies and procedures. Our code of conduct serves as a guideline for ethical business practices for anyone acting on behalf of our company. We develop and enforce corporate policies and procedures that address identified compliance risks and activities, where risk of regulatory violation makes establishing clear standards prudent for our business. We regularly review and update all written standards, which are always available to staff members on our internal website. Additionally, our code of conduct and policies and procedures on fraud, waste, and abuse are posted on our website, accessible to members, contractors, and the general public.

Compliance Training

Upon hire, and regularly thereafter, Colorado Access staff members, including the CCO and key personnel, receive education and training in applicable regulations, the compliance program, the code of conduct, and policies and procedures. As additional compliance needs are identified, we develop and deliver appropriate

training related to these needs. The CCO develops and updates the training, based on issues identified by the compliance program, changes in contract requirements or applicable rules and regulations. Training may be in the form of webinars, in-person meetings, or topic-specific memos and bulletins. Training is tracked either electronically or with sign-in sheets. Training shall be updated periodically, by our CCO, to address the changing regulatory environment and new laws and rules that apply to Colorado Access and members.

Effective Lines of Communication

We are committed to the timely identification, investigation, prevention, and prompt resolution of all issues that may adversely affect our employees, members, or the organization. We have several avenues of communication and information available to employees and agents to raise such concerns. We expect management to promote and support an open, receptive, and non-retaliatory environment. To support this commitment, we have established a variety of communication channels to report concerns and suspected problems, including an independent and confidential telephone hotline.

Staff members are free to access whatever avenues they prefer to report any concerns. Questions and concerns regarding the code of conduct, the compliance program, or any policy and procedure can be addressed to the supervisor, any member of the management team, our human resources department, or the compliance officer, in person, by phone, letter, or email. The compliance officer will be notified of any compliance-related concerns and will respond and/or investigate. We have established a problem resolution process and a strict non-retaliation policy to protect individuals from retaliation who report problems and concerns in good faith.

Well Publicized Disciplinary Guidelines

We have listed corporate compliance responsibility as a requirement in all employee job descriptions. Each employee electronically acknowledges that violation of the compliance program may result in disciplinary action. Violations of the code of conduct, compliance program, policies and procedures, or laws and regulations governing Colorado Access shall be addressed according to the nature of the violation. Management, in consultation with our human resources department, will take disciplinary action that is appropriate, proportionate, and consistent, based upon the seriousness of the violation committed, up to and including termination. Violations of law will be reported to the appropriate level of legal authority as required.

Routine Monitoring and Auditing

We conduct internal and external reviews to monitor, assess, and evaluate our own operations, as well as those of our provider network. The CCO conducts these reviews or facilitates other departments as they conduct their own reviews. The CCO also provides periodic updates on auditing and monitoring activities to the CEO, the FACC, and the compliance committee, or the department or function lead, as applicable.

We use a number of tools to conduct routine monitoring and auditing, and participate in audits and investigations as requested by the Department. These tools and processes help us identify patterns of inappropriate usage, as well as potential improper billing and overpayments. Described below, these tools and processes include:

- Provider medical record reviews
- Annual BHO encounter data quality review

- Ad hoc or targeted provider audits
- Member-identified issues
- Use of claims/encounter processing audits and edits
- Use of third party contractors

Provider medical record reviews: Our quality management department routinely audits provider records to validate that they are meeting our standards for medical necessity, quality, and appropriate documentation of services billed. We select participating network providers, or provider groups, through various criteria, including (but not limited to): provider type, documentation issues, and/or targeted service categories.

Annual BHO encounter data quality review: Each year, we conduct a BHO encounter data quality review that compares medical records against claims and encounters for accuracy of coding and billing for delivered services. Our auditors are highly trained and experienced medical record review auditors. We use the results of these reviews to determine if corrective action, training, or additional auditing of specific providers, types of services, or types of providers, is required to prevent fraud, waste, and abuse.

Ad hoc and targeted provider audits: We will conduct ad hoc or targeted audits to determine if there are any potential billing issues with a provider and/or a service. These reviews and audits may be initiated as a result of provider reports of overpayments, results of previous audits, billing patterns, complaints, or information provided by regulatory agencies, such as the Department. We require providers to return overpayments, and beginning July 1, 2017, will require return of overpayments within 60 days of identification. We will review the overpayments to determine patterns, and will further investigate and report to the Department, as required.

Member-identified issues: We utilize information provided by members to help us identify fraud, waste, and abuse, or other compliance issues. For example, trends in member complaints related to improper member billing are brought to our compliance department, who will then rectify the issue with the provider. We determine if follow-up with the provider is necessary or if there should be an audit of the provider. Additionally, beginning July 1, 2017, we will sample members to verify they received the services for which a provider billed Colorado Access.

Claims/Encounter processing audits and edits: We use several mechanisms to verify that provider billing and payment accurately reflect delivered services. Our claims system is configured to validate member eligibility, covered diagnosis, covered services, and also identifies duplicate payments and overpayments.

We utilize the TriZetto QNXT claims/encounter processing system. Within this system, paper and electronic claims and encounters are electronically matched to the appropriate member and provider. Once a member and provider are established, the system runs through a series of automated adjudication rules that are administered within each member's eligibility and benefit package. The benefit package contains covered services and codes, benefit limitations, authorization rules, and member responsibility (i.e., copayments), if applicable. Then, we calculate the provider reimbursement amount from the fee schedule attached to that provider, under appropriate contract and line of business, and then the claim is ready for payment.

In addition to payment rules within the provider and benefit setup, we also apply system-generated adjudication edits. These include validations of the service and diagnosis codes, as well as ensuring the claim was submitted within the timely filing requirements. The system also uses logic to check for duplicate claims

submission to ensure that duplicate payments are not made. We routinely audit system setup and reimbursement accuracy to ensure these payment rules are working correctly. We also utilize two McKesson tools: ClaimCheck and Policy Administration Module (PAM), which are integrated with the TriZetto QNXT transaction system. These tools are configured to edit claims against the requirements of the Uniform Services Coding Standards Manual by reviewing for coding utilization limits, invalid code combinations, correct modifiers, and place of service edits.

With TriZetto, we have systems in place to flag and monitor outliers and unusual claim submissions for audit. A number of automated tools support this function. For example, controls are in place to identify high cost claims for review prior to payment. Colorado Access and Trizetto each employ operations/claims auditors who are specifically trained and experienced with reviewing claims/encounters against payment and processing policies and procedures. These claims auditors randomly audit at least 3% of claims processed daily. They audit for payment and processing accuracy for claims that were auto-adjudicated (i.e., without manual intervention), as well as claims we processed manually.

We contract with external audit vendors to perform various post-payment audits, and these contractors are trained in recognizing potential fraud, waste, and abuse issues:

- SCIO – reviews facility claims for coding accuracy, up-coding, high-dollar claim reviews, and specialty audits, such as infusion/DME audits.
- Optum – conducts reviews at hospitals to identify credit balances and overpayment.
- First Recovery Group (FRG) – reviews claims paid for potential subrogation recovery opportunities.

If audits raise concerns about suspected fraud, we notify the Department, as required by contract, and continue to work with the Department to either conduct additional reviews or turn the information over to the Medicaid Fraud Control Unit. We will work with the Department to address any potential fraud, waste, and abuse related to the program.

INVESTIGATING AND REPORTING POTENTIAL FRAUD, WASTE, AND ABUSE

Investigating and Reporting Potential Fraud, Waste, and Abuse

The chief compliance officer tracks the progress of inquiries and investigations and documents resolutions relative to reported compliance incidents. The CCO, or designee, promptly initiates a preliminary review of the concern or incident and will either respond directly or refer the issue to the appropriate management person or legal counsel for investigation and response or action. The CCO will involve various members of management, staff, external consultants, legal, and/or the privacy official, and/or security official, when appropriate, to resolve issues.

The CCO is responsible for ensuring that the following objectives are accomplished:

- Identify the cause of the problem, desired outcome, affected parties, applicable guidelines, possible regulatory or financial impact;

- Investigate, or direct the referring party to investigate, the facts of the reported issue;
- Determine any corrective action measures needed (e.g., policy changes, operational changes, system changes, personnel changes, training/education, monetary reconciliation, disciplinary action, and reporting requirements);
- Document the investigation, all findings, recommendations, and resolution;
- Notify external parties/agencies as appropriate, in accordance with statutory, regulatory and contractual requirements;
- Notify internal parties, as appropriate

We have the processes, skills, and technology to identify questionable claims and to identify any suspect claims, or other forms of potential fraud, waste, and abuse. In the event that potential fraudulent activity is detected, the CCO will communicate with the appropriate state agencies, including the Department and the state's Medicaid Fraud and Control Unit (MFCU).

PRIVACY PROGRAM

We have a privacy program to address the privacy, security, and integrity of member health information. The chief compliance officer, who is also the privacy officer for the organization, oversees the privacy program. We maintain policies and procedures on the proper use and disclosure, storage, and transmission of member information, and all employees receive training on the requirements of applicable state and federal privacy regulations. Colorado Access is not only a HIPAA-covered entity, as well as a business associate to the Department, but we are also a "program" as defined by federal substance use program confidentiality rules (42 C.F.R Part 2). We follow Colorado regulations regarding privacy of health information, and, for example, when we are asked to share BHO claims data, we ensure that any claim identifying a substance use disorder (SUD) diagnosis, and/or SUD specific HCPC codes, is excluded from the extraction.

We also maintain an active program for promptly investigating any potential improper disclosures, as well as responding to questions about if, how, and when information may be disclosed. Employees (e.g., care managers), who regularly encounter protected health information, receive additional training about handling and reporting breaches, including requirements of 42 C.F.R. Part 2. Our care managers follow all compliance and regulatory requirements related to 42 C.F.R. Part 2, and when disclosure is necessary to meet a member's needs, they utilize the Authorization to Disclose Protected Health Information form for the member.

RECORDS RETENTION

We maintain a policy and procedure that includes processes and controls to ensure the record retention and record destruction procedures meet applicable contractual, federal, and state statutory requirements. These guidelines apply to general administrative, compliance, corporate, electronic, legal, financial, personnel, and provider contract records that pertain to our operation, programs, projects, and the delivery of services under the program.

We maintain a complete file of all records, documents, communications, and other materials sufficient to fully disclose the nature and extent of services and goods provided to each member. These records are maintained according to statutory or general accounting principles, and are easily distinguishable from other records. Our files properly reflect all direct and indirect costs of labor, materials, equipment, supplies and services, and other various costs for which a contract payment was made, and include:

- All medical records, service reports, and orders prescribing treatment plans; records of goods, including items like drugs, medical equipment and supplies, and copies of original invoices;
- Records of all payments made or received for the provision of such services or goods;
- Records of action decisions and appeals;
- Records of oral and written grievances, records of oral and written grievances received by our providers, records of the transfer or referral of provider-received grievances to us, and records documenting the investigation and resolution of grievances;
- Records of financial claims transactions, including payment to providers, reconciliations with providers, and recoupments from providers.

We maintain all such records, documents, communications, and other materials for at least 10 years from the date of any monthly payment under our contract(s) with the Department.

PROHIBITIONS AND SCREENING OF EMPLOYEES AND CONTRACTORS

Sanctions Screening

We have implemented a process for initial and ongoing screening of employees, providers, and other individuals/entities establishing a relationship with Colorado Access, in order to determine if the relationship is prohibited. We will not employ, contract with, or have a relationship with any individual or entity that is prohibited from participation in federal health care programs due to sanction, debarment, exclusion or suspension. We will not contract with providers whose license to practice has been sanctioned.

We utilize the following databases and sources of information to determine if someone has been excluded from participation:

- Office of Inspector General List of Excluded Individuals and Entities (LEIE)
- System for Award Management (SAM)
- State licensure boards

REPORTING

We have more than two decades of experience working with the Department, and this longstanding relationship demonstrates our ability to build trusting relationships with the Department, across a myriad of compliance requirements, including reporting. We maintain clear policies and procedures for monitoring licensure and credentialing for all of our providers. Our policy ensures that all actions by Colorado Access

adversely affecting a network provider's relationship with COA are based on a process of fairness, uniformity, consistency, and protection of members' rights. We established a dispute resolution process for all network providers who have had their participation status adversely affected by an imposed action relating to quality of care, professional competency, conduct, or for administrative actions. If we find that we must conduct a professional review of a provider, we will comply with 45 C.F.R. Subtitle A, Part 60, Subpart B, and report such action to the National Practitioner Data Bank and the appropriate state regulatory board. Additionally, when we receive information about a change in a provider's circumstances that may affect their eligibility to participate in the managed care program, or in the Colorado Medicaid program, including a change in their licensing, elimination of a provider from the network, or the conviction of a crime related to the provider's involvement in any program under Medicare, Medicaid, or the Title XX services program of the Social Security Act, we will notify the Department immediately. Finally, if we decide to terminate any existing network provider, we will notify the Department of our decision within 60 calendar days prior to the services terminating. However, if the basis for termination is for quality performance issues, we agree to notify the Department within two business days of our decision to terminate the network provider. Along with notification of our termination of a network provider, we will provide a narrative describing how we intend to secure the provider's services after termination.

Financial Reporting

As the contractor for two Behavioral Health Organizations (BHOs) and three Regional Care Collaborative Organizations (RCCOs), as well as a risk-bearing Health Maintenance Organization (HMO), we maintain a robust and comprehensive financial budgeting, accounting, and reporting program. Since our inception in 1994, we have met all of the financial reporting requirements set by the State's Commissioner of Insurance, the State's Division of Insurance (DOI), and the National Association of Insurance Commissioners (NAIC). We meet these requirements by providing annual and quarterly financial reports and any other supplemental reports requested by the Department. These formal reports, which are carefully reviewed by the regulatory bodies, are unique to the insurance industry and require specialized skill sets to complete. Additionally, we file annual financial statements, including an opinion by both an independent CPA and actuary, confirming the accuracy of our reserves for future claims payments. We also comply with regular and non-routine requests from the State's DOI for Financial Examinations and other audits and examinations. In addition to this regulatory reporting, as the current RCCO for Regions 2, 3, and 5, we currently complete quarterly reports required by the Department. The regulatory reporting requirements of the Commissioner, DOI, and NAIC are different from those of the Department, and we have consistently met all of these requirements, for more than two decades.

We maintain a Finance, Audit, and Compliance Committee (FACC) through our board of directors. Our FACC is chaired by the treasurer of the board and includes at least three of the nine board members. All board members are welcome to join the committee or attend the committee meetings on an ad hoc basis. The FACC chooses an independent CPA firm, and each month, we present all information regarding our finances, audits, and compliance to our FACC. Included in these presentations are monthly, quarterly, and annual financial statements, ratification of investment activity, and reports by the independent CPA firms (at least twice per year). The FACC chairperson provides a financial, audit, and compliance update at every full board meeting. Additionally, minutes of the FACC board meetings, where compliance reports are given, are reviewed at full board meetings.

Our staffing model in our accounting department is built and organized to meet all financial reporting requirements. Our staff members are highly competent, experienced and continuously trained. Our chief

financial officer (CFO) has 21 years of experience as a state employee, including seven years as the controller of the Department, time in the Office of the State Auditor, and the Office of the State Controller. Our CFO has been with Colorado Access since 2005. Additionally, our controller has spent his entire career in the insurance industry in both Colorado and Illinois.

MAINTENANCE OF RECORDS

For every contract we finalize with a subcontractor or provider, we include language explaining our policies for record retention. If a contract with a subcontractor or provider is terminated, we include a reminder of this section in the termination letter. This requirement extends beyond the termination date of the agreement.

SOLVENCY

At Colorado Access, we solely do business in Medicaid, Medicare, and the Child Health Insurance Program, as an HMO. Therefore, we must comply with C.R.S. 10-16-411(1.5) for the determination of solvency, and must identify any concerns about the solvency of our company. Under this statute, the State's DOI oversees and evaluates our company.

There are two measures within the statute that we calculate each month - capital and surplus statutory minimum, and the Insolvency Clams Reserve (ICR).

We regularly report on these measures, to the DOI, each quarter, and know that if there are concerns or troubling trends we need to report them to the Department immediately. If there is a mid-month negative economic event, which is significant enough to possibly compromise our company's solvency, our controller and CFO would immediately identify and assess that event and its impact.

ACTIONS INVOLVING LICENSES, CERTIFICATIONS, APPROVALS, AND PERMITS

Upon any action taken by the Commissioner of Insurance, the State's Division of Insurance, or any other regulatory body, we would notify the Department within two business days, as required in the contract. This notification includes any actions regarding:

- Noncompliance with the requirements of Title 10, Article 16, C.R.S.
- Any action suspending, revoking, or denying renewal of its certificate of authority
- Any revocation, withdrawal or non-renewal of necessary licenses, certification, approval, permits, etc., required for COA to properly perform the contract as the RAE

Our compliance program is structured to meet the laws and regulations outlined in the RFP because we have the expertise and the experience more than two decades as a health plan in Colorado, to adhere to the requirements set by the multitude of agencies governing our work. It has been carefully considered, adopted, and amended as industry regulations continue to evolve. Our compliance program defines and guides our business activities and is more than a set of policies that we must follow. Rather, our program is a foundation for our business that enables us to perform our mission and meet the regulatory demands that allow us to continue providing access to quality care.

Accountable Care Collaborative: Medicare-Medicaid Program

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.

We affirm that we are willing and able to perform the work described in requirements 6.2.1-6.2.4 of the RFP, which reference the proposed Accountable Care Collaborative Medicare-Medicaid Program for full-benefit Medicare-Medicaid members. We agree to administer this program in accordance with the Department of Health Care Policy and Financing's (the Department's) Memorandum of Understanding and Final Demonstration Agreement with the Centers for Medicare and Medicaid Services (CMS). Provided the existence of appropriate funding, we will negotiate with the Department in good faith to execute the scope of work outlined in this agreement.

In 2005, we became the first Medicaid health plan certified by CMS as a Medicare Advantage Special Needs Plan through our Access Advantage program. This program was developed in response to the need for a health plan capable of serving the unique and challenging population of members who are dually eligible for Medicare and Medicaid benefits. Through this program we developed strong relationships with providers skilled in treating complex members and successfully participated in the Department's Medicare-Medicaid Dual Demonstration Program. With this experience, we are well prepared to partner with the Department to serve this population in the evolution of Accountable Care in Colorado.

Wraparound Program Administration

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.

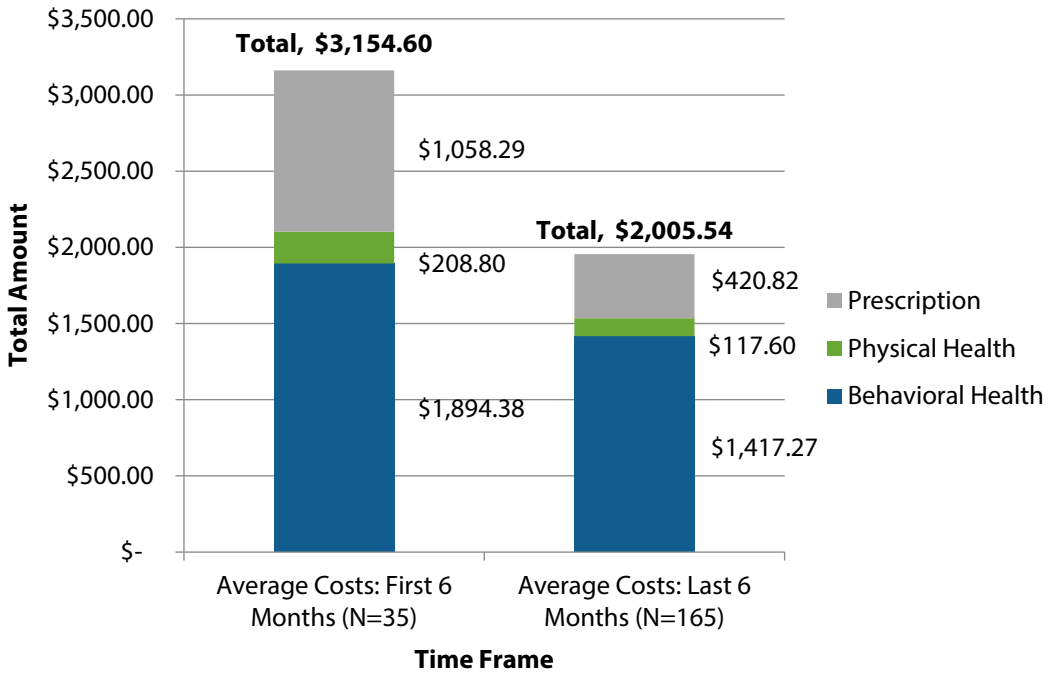
We are fully in support of the Wraparound model and successfully administered a two-year Wraparound program from 2013 to 2015. As a Regional Accountable Entity (RAE) applicant, we are uniquely positioned to attest to our willingness and confirmed ability to perform the scope of work described in the proposed Wraparound program.

With Centers for Medicare and Medicaid Services Health Quality Improvement (CHIPRA) grant funding, the Wyoming Department of Health (WDH) participated in a multistate quality collaborative grant to *"Improve the health and social outcomes for children with serious behavioral health needs by implementing and/or expanding a Care Management Entity (CME) provider model to improve the quality - and better control the cost - of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program."* Colorado Access was selected as the WDH contractor through a competitive procurement process. Major program accomplishments include substantial workforce development, youth recruitment and enrollment, and positive outcomes including decreased health care costs, improved clinical outcomes, and high levels of youth and family satisfaction.

As the Wyoming CME, we actively promoted community awareness and client participation in the Wraparound program. During the two-year pilot program, we recruited and screened 361 applicants, reviewed eligibility, and successfully enrolled 165 youth. One of our initial tasks as the CME was to build a network of High Fidelity Wraparound (HFWA) vendors who were invested in working collaboratively to serve Wyoming's high-needs youth. We partnered with community-based agencies to develop a diverse network of vendors: entities specifically dedicated to wraparound services, counseling centers, family support agencies, community mental health centers, and nonprofit organizations dedicated to youth and family advocacy, referral, and support. The result of this workforce development was a broad and sufficient network of 17 contracted vendors to provide HFWA services to youth and families across the seven-county pilot region, including both family care coordination and family support partner services. A key component of the workforce development effort was expanding HFWA training and coaching. While the grant funding initially covered HFWA trainings, we found it necessary to allocate additional resources to ongoing training and coaching to ensure the growth and sustenance of a HFWA trained workforce. Figure x. below demonstrates the positive impact of HFWA services on health care costs for high-needs youth in Wyoming.

FIGURE 26-1 CHANGE IN MEDICAID HEALTHCARE EXPENDITURES FOR HFWA MEMBERS

AVERAGE MONTHLY PMPM COSTS—FIRST VERSUS LAST SIX PROJECT MONTHS



The first six months include Medicaid costs from August 2013 to January 2014, and the last six months include costs from October 2014 to March 2015. Monthly averages reflect costs from all youth enrolled by each month's end, including youth newly or recently enrolled who may have yet to realize any health-related benefits.

We are committed to a data-driven approach, collaborating with both the Department of Health Care Policy and Financing (the Department) and our community partners, to ensure transparency and to support continuous program monitoring and improvements. As the CME in Wyoming, we worked collaboratively with the WDH to develop and implement appropriate reporting mechanisms and procedures that capture the HFWA program processes and aims and are also compatible with Medicaid requirements. We are prepared and committed to provide standard and custom reports regarding Wraparound program referrals, disposition, utilization, and clinical and cost outcomes.

Our success as a CME was dependent upon our ability to partner effectively with a variety of community agencies, including child welfare, probation officers, schools, etc. in urban, rural, and frontier areas. Our current participation in regional interagency groups (IOGs) and other forums means that we are well prepared to

leverage ongoing partnerships to effectively administer the CME model. Our success in an extremely rural state also means that we understand the regional flexibility needed, and unique challenges to, administering the program in rural areas of Region 3.

In addition to the experience in another state, we are familiar with the System of Care program in Colorado and the CME pilot programs in the eight original and now 16 communities of excellence. We have reviewed the 2014 evaluation report of El Paso County's pilot program site, and we are well prepared to implement a Wraparound program in collaboration with the Department, building on the System of Care program and lessons learned from the pilot program sites across Colorado. In Region 2, we partner with Youth and Family Connections, which serves as the IOG and the Juvenile Assessment Center for Weld County; a current system of care pilot program site. We will continue to partner and leverage their existing Wraparound program and our system-level view and broad region-wide understanding and links to services to support a sustainable model for Weld, and leverage this experience as we expand Wraparound services for all RAE communities.

Pre-Admission Screening and Resident Review (PASRR)

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.

We are committed to performing all of the work described in the proposed Colorado Pre-Admission Screen and Resident Review (PASRR) scope of work including reviewing all Pre-Admission Screen (PAS) Level I Assessments, conducting PAS Level II Assessments, coordinating care planning, ensuring continuity of care, ensuring resident reviews for status changes, and overseeing quality and compliance. As the Regional Accountable Entity (RAE) we will manage the Colorado PASRR in accordance with federal statues for individuals who are suspected of having a mental illness or intellectual and/or developmental disability. We currently function as the Single Entry Point (SEP) for Adams, Arapahoe, Denver, Douglas and Elbert counties and have demonstrated competencies to achieve the three goals of PASRR: identifying individuals with mental illnesses or intellectual and/or developmental disabilities, or both; ensure individuals are placed appropriately, whether in the community or in a nursing facility; and ensure that individuals receive the services required for their diagnosis in whatever setting they reside.

As the current Behavioral Health Organization (BHO) for two regions in the state, we have robust experience in assessing for the presence of a behavioral health and/or a developmental disability, assisting with the determination of the most appropriate living situation, and recommending any other services needed. Our care coordinators serve as the single point of contact for long-term care facilities and are in regular contact with all facilities at least monthly to ensure that all needed services are being provided to the residents of their facility. All residents with a Level II PASRR are assigned a Colorado Access care coordinator.

Our policies and procedures fully ensure that PASRR Level II requirements and PASRR identified behavioral health services are being provided. We ensure that all admission processes and procedures are followed and that long-term care clients with a covered behavioral health diagnosis who do not meet Level II requirements receive all medically-necessary services related to their diagnosis. We will provide care coordination and support for accessing non-covered health services for any non-covered health issues. We will ensure that appropriately trained designated staff members provide coordination, collaboration, and service delivery within each facility. At intake, we will ensure that clients who exceed Level I PASSR criteria will be screened for Level II PASSR by designated licensed staff members at each facility. All client needs will be monitored by facility staff members on an ongoing basis. Clients who experience major improvements or declines that are unlikely to resolve without intervention will have a status change review following state guidelines and may undergo an initial or follow up Level II PASSR screen. For members who currently or newly meet PASSR Level II criteria, we will ensure individualized, recovery-oriented, holistic services are delivered according to client needs and state guidelines and that a Pre-Admission Care Plan is developed and followed to ensure continuity of care and appropriate communication between all parties. Services may include a range of options, from peer support and care coordination to intensive individual therapy and medication.

We are experienced in monitoring quality and compliance with the current SEP, Regional Care Collaborative Organization (RCCO) and BHO contracts and will meet all of the quality and compliance standards set forth by

the Department of Health Care Policy and Financing (the Department) for the PASRR program. Upon direction from the Department, we will further define the scope of work and will negotiate program and contract details.

Brokering of Case Management Activities

OFFEROR'S RESPONSE 28

Provide a positive 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.

We will utilize our experience and position as a pilot site for the No Wrong Door initiative and as the Single Entry Point (SEP) for Adams, Arapahoe, Denver, Douglas and Elbert counties to ensure person-centered options for case management and assistance in finding the appropriate Case Management Agency (CMA). Our participation in the No Wrong Door initiative and the Colorado Choice Transitions (CCT) Program uniquely position us to work closely with Community Centered Boards (CCBs), transition service agencies, Area Agencies on Aging, Disability Resource Centers, SEPs, and independent living centers, all of which may be part of a network of case management agencies. We will use all of our resources to align case management brokering activities with the Department of Health Care Policy and Financing (the Department) programs and initiatives.

We are aware of the need for conflict-free case management and will work to ensure that members are not receiving Home and Community-Based Services (HCBS) direct services and case management from the same agency. We will maintain a list of CMAs in the region, which will specify their expertise and other services provided which may be in conflict with unbiased case management for a particular member.

Upon direction from the Department, we will further define the scope of work and will negotiate program and contract details.

Health Information Exchange Connectivity Assessment

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.

We are willing and able to conduct a health information exchange (HIE) connectivity assessment and report findings to the Department of Health Care Policy and Financing (the Department) annually. We offer the advantage of experience in this process; having worked collaboratively with the Department and CORHIO to complete the Regional Care Collaborative Organization (RCCO) network's first such assessment during the spring of 2017. This prepares us with both a clear understanding of the resources needed to complete such an assessment and knowledge of what the network looks like today. We will continue to build on network strengths and look for systematic and provider-specific ways to address network gaps and needs throughout the last year of our RCCO contract, and forward this important work upon successful Regional Accountable Entity (RAE) award.

Of 253 practice sites that provided electronic health record (EHR) information, about a third are using some form of Epic, and less than 5% are still using paper charts with no electronic health record. Of sites with EHR, 233 have an EHR system that is certified by the Office of the National Coordinator for Health Information Technology (ONC); meaning the system offers the necessary technological capability, functionality, and security to meet the meaningful use criteria. Having this and other HIE/HIT data helps us make well-informed network decisions and efficiently promote system transformation and improved health outcomes for members.

EHR Vendor Name	Count	%
Epic	84	33.2
eClinical Works	28	11.1
Cerner Ambulatory	23	9.1
NextGen	23	9.1
Practice Fusion	13	5.1
No EHR, Paper Charts	12	4.7
Greenway	11	4.3
Amazing Charts	10	4.0
GE Centricity	9	3.6
Other	40	15.8
Total	**253**	**100**

Attachment A

Colorado Access W-9

Region 3 #2017000265

Colorado ACCESS
Caring for you and your health

Substitute Form
W-9

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER (TIN) VERIFICATION

State of Colorado
Do NOT send to IRS
RETURN TO ADDRESS BELOW

PRINT OR TYPE

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SOCIAL SECURITY ADMINISTRATION RECORDS)
DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPIETORSHIP ON THIS LINE - See Reverse for Important Information

Colorado Access

Trade Name -- complete only if doing business as (D/B/A)

Remit Address

11100 East Bethany Drive Aurora, Co 80014

Purchase Order Address -- Optional

PART II See Part II Instructions on Back of Form

Check legal entity type and enter 9 digit Taxpayer Identification Number (TIN) below:
(SSN = Social Security Number EIN = Employer Identification Number)

Do Not enter an SSN or EIN that was not assigned to the legal name entered above

☐ Individual (Individual's SSN) ___-__-____
NOTE: If no name is circled on a Joint Account when there is more that one name, the number will be considered to be that of the first name listed.

☐ Sole Proprietorship (Owner's SSN or Business EIN) SSN ___-__-____
Note: Enter both the owner's SSN and the business EIN (if you are required to have one) EIN __-_______

☐ Partnership ☐ General ☐ Limited (Partnership'S EIN) ___-_______

☐ Estate/Trust (Legal Entity's EIN) ___-_______
NOTE: Do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title. List and circle the name of the legal trust, estate, or pension trust.

☐ Other > (Entity's EIN) ___-_______
Limited Liability Company, Joint Venture, Club, etc.

☒ Corporation Do you provide medical services? ☐ Yes ☒ (No) (Corp's EIN) 84-1297547
Includes corporations providing medical billing services

☐ Government (or Government Operated) Entity (Entity's EIN) ___-_______

☐ Organization Exempt from Tax under Section 501(a) (Org's EIN) ___-_______
Do you provide medical services? ☐ Yes ☐ No

☐ Check Here if you do not have a SSN or EIN, but have applied for one. See reverse for information on *How to Obtain A TIN*
Licensed Real Estate Broker? ☐ Yes ☐ No

Under Penalties of Perjury, I certify that:

(1) The number listed 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 (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secure property, contribution to an individual retirement arrangement (IRA), and payment other than interest and dividends).

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 of under reporting interest or dividends on your tax return. (See Signing the Certification on the reverse of this form.)

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

NAME (Print or Type) Philip J Reed TITLE (Print or Type) C.F.O.
AUTHORIZED SIGNATURE [signature] DATE 7-3-17 PHONE (720) 744-5485
DO NOT WRITE BELOW THIS LINE RETURN BOTH COPIES TO ADDRESS ABOVE

AGENCY USE ONLY

Agency _ _ _ Approved by _ Date _
1099: Yes _ No _ Action Completed by _ Date _
VENDOR: Addition _ Change _

615-82-50-7093 (R 4/97)

Attachment B

Division of Insurance Certificate and Information

Region 3 #2017000265

Colorado ACCESS

Caring for you and your health

A-3083

STATE OF COLORADO

Division of Insurance

DEPARTMENT OF REGULATORY AGENCIES

CERTIFICATE OF AUTHORITY

This is to Certify that the Colorado Access, organized under the laws of Colorado, subject to its fundamental organizational documents and in consideration of its compliance with the laws of Colorado, is hereby licensed to transact business as a Health Maintenance Organization, so long as it continues to conform to the authority granted by its Certificate and its organizational documents, or its Certificate is otherwise revoked, cancelled or suspended.

In Witness Whereof, I have hereunto set my hand and caused the official seal of my office to be affixed at the City and County of Denver, this 31st day of October, A.D., 1995.

COMMISSIONER OF INSURANCE

COLORADO
Department of Regulatory Agencies
Division of Insurance

Health Maintenance Organizations (HMO)
HMO Annual Fee Form
Due March 1

Date: 1/6/17
NAIC Number: 95733
Amount Paid: $ 4,650.00
Check Number: 64619

Company Name: Colorado Access
Mailing Address: 11100 E. Bethany Drive
Aurora, CO 80014

Contact Person: Kathy Nyberg
E-mail Address: legal@coaccess.com
Phone Number: 720-744-5471
Fax Number: 303-649-8918f

Fee Schedule:
Fees paid by HMO's (§§10-3-207(1)(b) 24-31-104.5, C.R.S.):

2015 Direct Written Premiums	Annual Fee	Fraud Fee	Total Amount Due
$1,000,000 or less:	$670	$305	$975
$1,000,001 to $10,000,000:	$2,010	$1,305	$3,315
$10,000,001 and over:	$3,345	$1,305	$4,650

Make check payable to **Colorado Division of Insurance** and mail along with this form to the following address:

Colorado Division of Insurance
Attn: Cash Management
1560 Broadway, Suite 850
Denver, Colorado 80202

Email inquiries to: DORA_INS_CORPORATEAFFAIRS@STATE.CO.US

8/2016

64619

CO Division of Insurance

January 6, 20...

Document No.	Document Date	Amount	Discount	Net Amount
ANNUAL HMO LIC FEE	01/05/17	4,650.00	0.00	4,650.00

Total **4,650.00**

CO Division of Insurance

January 6, 2017

64619

Document No.	Document Date	Amount	Discount	Net Amount
ANNUAL HMO LIC FEE	01/05/17	4,650.00		4,650.00

Total **4,650.00**

CO BUSINESS BANK
821 17TH STREET
Denver, CO 80202-3040
303-383-1255
23-320/1020

64619

COLORADO ACCESS
11100 E BETHANY DR
AURORA, CO 80014

January 6, 2017 $********4,650.00

PAY ****FOUR THOUSAND SIX HUNDRED FIFTY AND 0/100 DOLLARS

TO ORDER OF: CO Division of Insurance
Attn: Cash Management
1560 Broadway Room 850
Denver, CO 80202

⑈064619⑈ ⑆102003206⑆3400794⑈

Attachment C

Personnel Resumes

Region 3 #2017000265

Colorado ACCESS
Caring for you and your health

PATRICK GILLIES, MPA

PROGRAM OFFICER

EXPERIENCE

Colorado Access — **Vice President, Accountable Care** — **2015-Present**

- Lead executive for three of the seven Regional Care Collaborative Organizations (RCCOs) set up through the Colorado Department of Health Care Policy and Financing's Accountable Care Collaborative (ACC). Lead a team of professionals to connect ACC Medicaid members to primary care medical providers.
- Serve as Executive Director for the RCCO program. Managing over $40 million in a combination of internally and community care managed services. Providers supportive services for over 300 providers. Provide members services and supports of over 440,000 members. Lead initiatives to increase data sharing with provider organizations. Led directly to increased awards of incentive payments to providers and the RCCO in every quarter since taking leadership.
- Serve as executive lead for Adams, Arapaho and Douglas counties. Lead corporate and community efforts to increase access and effectiveness for the health care system in the counties and the diverse communities contained within them. Developed a regional governance model to increase authority of provider organizations in the clinical design of the RCCO program.

Health Resources and Services Administration (HRSA), US Department of Health and Human Services (HHS) — **Supervisory Public Health Analyst (Regional Administrator)** — **2011-2015**

- HRSA provides funding to support health equity through access to quality services, a skilled health workforce, and innovative programs. The Denver office supports activities in six states and territories including Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming, coordinating Agency activities for 362 grants to state, local, and community entities for a total of $284 million in 2011.
- Promoted national health initiatives. Plan and lead organizational mission, goals, priorities, and initiatives in regions, states, and territories. Support recruitment and retention of primary health care providers. Demonstrate sound strategy and decision-making in all financial matters. Utilize strategic planning to help meet long-term organizational goals. Assure effective internal controls to safeguard program integrity. Leverage human capital to recruit, and retain a diverse, high-quality workforce.

Department of State Health Services (DSHS), State of Texas — **Director III** — **2009-2011**; **Director II** — **2005-2009**

- Oversaw compliance on 1,200 annual contracts to ensure delivery of critical services statewide.
- Recruited, directed, and retained staff of 96.
- Oversaw departmental interactions with Title X, Title XX, and community health management.
- Advocated health care policies that increased access and affordability.
- Facilitated development of strategic and operational plans.
- Delivered successful process improvements in operations, technology, communications, management, and administration
- Created and developed internship program for mental health and substance abuse programs.

Texas Department of State Health Services — **Director, NorthSTAR** — **2000-2005**

- Led the vision and full implementation of NorthSTAR, an integrated system of managed mental health care and chemical dependency services, covering 1.2 million individuals with $110 million dollars' annual capitation.
- Managed staff of 22: clinicians, fiscal analysts, providers, enrollee relations, IT staff, and quality and contract management.
- Developed innovative delivery system for telemedicine integration, which resulted in 17,000 active behavioral health clients, mostly underserved/at-risk groups.
- Increased funding by over $15 million from federal and local sources, Medicaid, and counties.

EDUCATION

Texas Tech University	Bachelor of Arts, Political Science
Texas Tech University	Master of Public Administration, Health Policy and Administration
Texas Tech University	Addiction Counseling Certificate
LBJ School of Public Affairs, University of Texas at Austin	Senior Management Program
LBJ School of Public Affairs, University of Texas at Austin	Project Management Program
LBJ School of Public Affairs, University of Texas at Austin	Contracts Management Program

SCOTT LLOYD

CHIEF FINANCIAL OFFICER

EXPERIENCE

Colorado Access **Senior Financial Analyst** **2017-Present**

- Responsible for the external financial reporting activities for Colorado Access, including the preparation of regulatory financial statements and audit reports.
- Preparation of ad-hoc financial reporting as requested by the CFO and/or Controller.
- Responsible for Treasury activities such as bank account management, cash flow/cash adequacy analysis, investment activity and research, monitoring functions and management of banking relationships.
- Monitoring capitation activity, including preparation of capitation payments to providers, monthly reconciliations and preparation of monthly financial statement activity/statements for certain lines of business.
- Assists with the preparation of monthly journal entries and periodic audit information requests.

Colorado Division of Insurance **Chief of Financial Affairs** **1992-2016**

- Responsible for managing a staff of analysts who performed a detailed financial review of all domestic insurance company financial statements and other filings.
- Oversaw all reviews and conducted a supervisory review of the analyses performed by subordinates.
    - The supervisory review included verifying that the analysts followed the National Association of Insurance Commissioners Financial Analysis Handbook and/or the Colorado Financial Analysis Procedures Manual, had properly documented his/her findings adequately, used sound judgment and prepared an appropriate conclusion.
- Required a thorough understanding of GAAP and SAP accounting, financial auditing procedures, and of insurance industry regulatory requirements and operations.
- Provided assistance to the industry on interpreting the many laws and regulations.
- Responsible for ensuring the State's compliance with NAIC regulatory requirements, including drafting and adopting model laws, regulations, and financial regulation procedures.

EDUCATION & LICENSES

Washington and Jefferson College — Bachelor of Arts, Accounting
Certified Financial Examiner
Certified Public Accountant (CO#15964)

SORINA RODGERS, MD

CHIEF CLINICAL OFFICER

PROFESSIONAL SUMMARY

Experienced physician leader with broad experience in Medicaid behavioral health programs, psychiatry, geriatric psychiatry, and health systems leadership. Clinical expertise in full spectrum: crisis/emergency, inpatient, stepdown/alternative, outpatient, and recovery models, including substance use disorders and integrated care

PROFESSIONAL, CLINICAL, AND ACADEMIC APPOINTMENTS

Colorado Access	Medical Director	2016-present
The Medical Center of Aurora	Geriatric Psychiatry Service	2007-present
Highlands Behavioral Health System	Chief Medical Officer	2014-2016
The Medical Center of Aurora	Adult Psychiatry	2012-present
Porter Adventist Hospital	Psychiatry	2012-present
Arapahoe Douglas Mental Health-Bridge House ATU	Psychiatry	2010-2013
Haven Senior Behavior Heath (Thornton, CO)	Medical Director	2006-2010
STEP Program for Girls IOP (Aurora, CO)	Medical Director	2008-2010
Aspire Behavior Health (hospital closed)	Psychiatry	2008-2009
Private Practice	Psychiatry	2004-2006
Magic Valley Regional Medical Center/Canyon View Hospital	Independent Contractor Psychiatry	2004-2006
Private Practice (Danville, VA)	Psychiatry	2003-2004
Paradigm Health (Danville, VA)	Independent Contractor (Psychiatry)	2003-2004

EDUCATION, LICENSE, AND CERTIFICATION

Colorado Medical Board	Active Medical License	*Present*

COMMITTEES AND HEALTH SERVICES ACTIVITIES

Long Island Jewish Medical Center-Hillside Hospital	Psychiatry Resident-PGY4	1998-1999
Long Island Jewish Medical Center-Hillside Hospital	Geriatric Psychiatry Fellow (not completed due to visa issues)	1999-1999
University of Virginia, Psychiatry Department	Psychiatry Resident-PGY1 to PGY3	1995-1998
Brasov County Hospital	Family Medicine Resident	1987-1990

TYLER WATLINGTON, MD, MSPH

CHIEF CLINICAL OFFICER

PROFESSIONAL SUMMARY

Dedicated and attentive physician, medical director and assistant professor committed to healthcare quality improvement. Proven expertise in quality outcomes; clinical systems; health evaluations; preventive medicine; pediatrics; public health; decision support and clinical leadership. Scholarly accomplishments include 1 publication and 5 presentations. Active member in 2 professional leadership committees and health services activities.

PROFESSIONAL, CLINICAL, AND ACADEMIC APPOINTMENTS

Colorado Access	Medical Director	2016-present
Children's Hospital Colorado	Physician Liaison	2012-present
Children's Hospital Colorado	Attending Physician	2008-present
Children's Hospital Colorado	Physician Analyst	2006-2012
Southeast Denver Pediatrics	Locum Tenens Physician	2003-2004
Colorado Personalized Education for Physicians	Physician Consultant	2002-2004
CEO of Parks/Watlington family	CEO	1996-2003
Westside Family Health Center	Contract Physician	1996
The Children's Hospital Community Based Program	Locum Tenens Physician	1995
Denver Health Care Group	Staff Physician	1994
The Children's Hospital	Attending Physician	1993

EDUCATION, LICENSE, AND CERTIFICATION

Colorado Medical Board	Active Medical License	Present
University of Colorado Health Sciences Center	Masters of Science in Public Health	2006
Medical College of Virginia	Doctor of Medicine	1989
Virginia Commonwealth University	Pre-Med	1984
Dartmouth College	Bachelors of Arts in French/Economics	1982
University of Colorado Health Sciences Center	Residency in Preventive Medicine	2004-2006
University of Colorado Health Sciences Center	Chief Residency in Pediatrics	1992-1993
University of Colorado Health Sciences Center	Residency in Pediatrics	1990-1992
University of Colorado Health Sciences Center	Internship in Pediatrics	1989-1990
American Board	Preventive Medicine Certification	2007-2017
American Board	Pediatrics Certification	2015

COMMITTEES AND HEALTH SERVICES ACTIVITIES

Children's Hospital Colorado	HIM Committee (Chairman)	2007-present
Children's Hospital Colorado	Credentials committee (Chairman)	2013-present
American Academy of Pediatrics	Alpha Omega Alpha	

LINDSAY COWEE, LPC, CACII, CPHQ

QUALITY IMPROVEMENT DIRECTOR

EXPERIENCE

Colorado Access — **Director of Quality Management** — **2015-Present**
Clinical Quality Manager — **2015**

- Direct the quality improvement projects for 3 product types (and over 1 million members throughout the entire state of Colorado), including, Medicaid, Child Health Plan Plus, and Long Term Services and Supports.
- Experience in full-spectrum of HEDIS process, including file extracts and measure production, managing software and medical record review vendors, and designing and implementing interventions to drive performance improvement.
- Implement numerous process/performance improvement initiatives to improve staff productivity, cost savings, and clinical outcome performance (e.g., member engagement, inpatient follow up rates, well-child visits, post-partum visits).

Behavioral Healthcare, Inc. — **Manager of Quality Improvement** — **2013-2015**
Quality Improvement Project Manager — **2012-2013**

- Directed organization in becoming the only NCQA-accredited Managed Behavioral Health Organization with a 99.15% compliance score.
- Piloted a clinical documentation training to increase provider billing and documentation compliance – implemented and trained over 400 providers in the first 18 months, increasing provider satisfaction with training by 70%, and driving overall provider satisfaction by 50%.
- Audited 25% of network providers, representing $59 million of total expenditures; identified $1 million of questionable charges
- Achieved 99% agreement with Health Services Advisory Group over-read of encounter data validation.
- Collaborated with utilization management and other departments for process improvement, including improving authorization turnaround times, grievances and appeals, and monitoring follow-up after inpatient discharge.

Arapahoe Douglas Mental Health Network — **Behavioral Health Treatment Provider** — **2009-2012**

- Developed the ARCHES program (in collaboration with Arapahoe County Residential Center) to provide behavioral health treatment to women transitioning to the community after incarceration.
- $1 million reduction in recidivism costs in the first year of operation.

Alternative Behaviors Counseling — **Domestic Violence and Substance Abuse Treatment Provider** — **2006-2009**

- Created an intensive domestic violence treatment program for repeat offenders (including a 12-week Victim Empathy program), the first of its kind in the state of Colorado.
- Effectively managed a caseload of 160+ clients from the criminal justice system, including collaborating with multiple referral sources, including the Department of Corrections, various community corrections facilities, and probation departments in Jefferson, Arapahoe, and Douglas counties.

Other Professional Experience — **Prior to 2006**

- Arapahoe House – STIRRT Program: Facilitated therapy in a two-week intensive residential treatment program for male offenders.
- Courtroom Performance, Inc.: Analyzed and presented data from focus groups, mock trials, and jury research.
- Booneville Correctional Center: Conducted interviews and investigations in the administrative segregation unit, presented reports to administration.
- VSA Missouri: Instructed creative writing class for adults with disabilities.

EDUCATION

University of Missouri	Bachelor of Arts, Psychology
University of Missouri	Bachelor of Arts, Sociology
University of Denver	Master of Arts, Psychology
	Licensed Professional Counselor (LPC)
	Certified Addictions Counselor, Level II (CACII)
	Certified Professional in Healthcare Quality (CPHQ)

DAVID NAPOLI

HEALTH INFORMATION TECHNOLOGY AND DATA DIRECTOR

EXPERIENCE

Colorado Access — **Director of Business Intelligence** — **2016-Present**

- Serves as the Champion of data management, data quality, and analytics, through the establishment and facilitation of the Data Governance Committee (DGC) and the Business Intelligence Competency Center (BICC)
- Collaborates with, and provides essential guidance to, the Information Technology team around data warehousing, tools, processes, reporting, and dashboards to maximize efficacy and efficiency of data analytics
- Promotes a data information-driven culture in the organization utilizing the BIDM data received and data quality, methods.

Nurse-Family Partnership — **Director, Planning & Analytics** — **2015-2016**

Managed department staff, and implemented a plan to ensure staffing was sufficient to meet the organization's needs

- Oversaw report quality control and integrity, including the process of periodically reassessing what data should be gathered about NFP implementation for continuous improvement
- Produced business intelligence products that helped NFP implement agencies and monitor for improvements.

Colorado HealthOP — **Director, Performance Improvement & Strategic Analytics** — **2013-2015**

- Established an analytics business plan aligned on an in-house developed data warehouse, an enterprise analytics suite, and implemented organization-wide business intelligence/reporting tools
- Formed a Center of Excellence based analytics department comprised of staff with competencies in clinical, claims, and quality.
- Integrated data from multiple sources, including claims and enrollment files from the CO-OP's TPA, all- payer claims database, pharmacy claims, enrollee reported data, and provider EHRs

Rocky Mountain Health Plans — **Director, Corporate Analysis & Health Care Economics** — **2011-2012**

- Responsible for oversight of the Corporate Analysis and Health Care Economics Department in offices statewide
- Partnered with Senior Leadership Group regarding best practices, through unit and total medical cost trend management, Care Management and QI initiatives, Health Care Reform requirements, and predictive modeling
- Served as corporate-wide resource for guidance and development of complex quantitative analyses and data models.

Various Organizations — **Statistical, Actuarial, and Senior Healthcare Industry Consultant** — **2008-2013**

- Developed analytic approach to monitor appraise Care Transition program instituted throughout multiple levels of patient care.
- Statistical modeling of metrics and outcomes of CMS' Reporting Hospital Quality Data Annual Payment Update Program.
- Established provider financial incentive components associated with Accountable Care models.

Physician Health Partners

Research Manager — **2007-2008**
Statistician and Actuarial Specialist — **2006-2007**
Finance and Analysis Supervisor — **2005-2006**

- Led staff of Research Analysts, and performed duties of Led Actuary and Statistician
- Developed approaches of quantitatively evaluating Care Management, Quality Initiatives and Disease Registry Outcomes
- Created and presented statistical studies on Registry Outcomes, NCQA Quality Standards and Disease Management initiatives.
- Developed Provider Performance Scorecard and Dashboard reports for monitoring metrics and identifying quality leaders.
- Collaborated with Executive staff in selection and implementation of Business Intelligence tool for analytical capabilities.
- Developed predictive models for identifying conditions correlated with specific utilization patterns

McKesson Health Solutions — **Risk Assessment Manager** — **2005**

- Performed data management, and reconciliations for multiple State Medicaid disease and medical management programs
- Lead research by directing SAS programmers and actuarial support in reconciliations methodologies and evaluation approaches

Colorado Access

Decision Support and Financial Planning Lead — **2004-2005**
Decision Support and Financial Planning Analyst — **2000-2004**

- Performed Rate Setting analyses to support generation of fiscal year premium rates
- Designed the IBNR, Key Indicator, Summary of Healthcare Activity reporting, and analyzed of cost and utilization statistics
- Improved Key Indicator reporting by identifying vital statistics for clinical care management and patient outreach

EDUCATION

Rensselaer Polytechnic Institute	Bachelor of Science, Aeronautical Engineering
Rensselaer Polytechnic Institute	Master of Science, Aeronautical Engineering
University of Colorado	PhD Candidate, Health Services Research/Biostatistics

CHASE GRAY, RN

UTILIZATION MANAGEMENT DIRECTOR

EXPERIENCE

Colorado Access **Program Director, Care Management Services** **2016-present**

- Formulates care management strategy and provides leadership for CM programs (RCCO, BHO and Long-term care services).
- Collaborates with executives, medical leadership and departments to align care management services and evaluate outcomes.
- Responsible for the development and success of care management strategic and financial goals.
- Design and oversight of the implementation of care management services for members and HCPF contract deliverables.
- Ensures quality, effectiveness and operational efficiency across care management programs.
- Directs, guides, and evaluates the care management workforce.
- Develops and maintains community partnerships where care management processes occur for RCCO, BHO and LTSS.
- Utilizes complex data sets (claims data, clinical data, risk stratification) to design care management interventions.
- Ensures quality documentation and reporting processes across multiple electronic systems.

Magellan Behavioral Care **Consultant** **2014-2015**

- Advised Magellan program staff on the State of Iowa, Medicaid Integrated Health Home (IHH) program design, implementation, and evaluation for the 30 participating sites across the state of Iowa.
- Advised Magellan clinical staff on change management, organizational development, communication strategies, and the implementation of new polies and processes that make cross departmental work more effective.
- Conducted various didactic trainings for the IHH program via webinar and in person learning sessions.
- Developed tools and processes for the program staff to deliver content more effectively to participating IHH sites.
- Mentored program staff (coaches) who work directly with IHH centers in the implementation of the IHH model concepts (integrated care, population management, risk stratification, care coordination, disease management etc…).

HealthTeamWorks **Regional Director** **2010-2017**

- Provided executive level consulting pre-contract and post-contract signature to ensure clients received contracted services needed to meet their Triple Aim goals.
- Lead healthcare transformation initiatives and staff in the Pacific and Central time zones in the USA (5-10 active initiatives).
- Provided expertise via webinar and live presentations in care coordination, care management, team based care, healthcare leadership, behavioral health integration, evidence based guideline implementation, optimizing health information technology, expanding access, care transitions, managing high risk patients and building medical neighborhoods/systems of care.
- Facilitated teams and multi-stakeholder groups to meet their desired goals and objectives.
- Developed curriculum to meet client needs of increased quality of care, decreasing costs and increasing satisfaction for patients.
- Provided budget oversight and management for all programs.
- Provided direction, collaboration, professional development and oversight of program managers and coaches.
- Created learning networks/collaborative in communities for best practice. Served as faculty at HealthTeamWorks University.
- Managed and provided feedback to program consultants, and provided program progress to leadership and national clients.

AllCare Home Health **Quality Improvement Consultant** **2009-2010**

Allergy and Clinical Research Center **International Research Liaison** **2008-2009**

- Initiated and maintained relationships with pharmaceutical industry to ensure ongoing projects and funding.
- Worked with medical director to implement vision of international network. Negotiated budgets and contracts for clinical trials.
- Managed research department financial database. Negotiated Memorandum of Understandings with sub-investigators.
- Developed new SOPs that followed Good Clinical Practice guidelines and FDA regulations.

American International Health **Contractor** **2004-2005**

EDUCATION & LICENSES

Johns Hopkins University, School of Nursing	Bachelor of Science, Nursing
University of Colorado	Bachelor of Arts, Russian Language & Culture and International Affairs
Colorado Medical Board	Active RN License

Attachment D

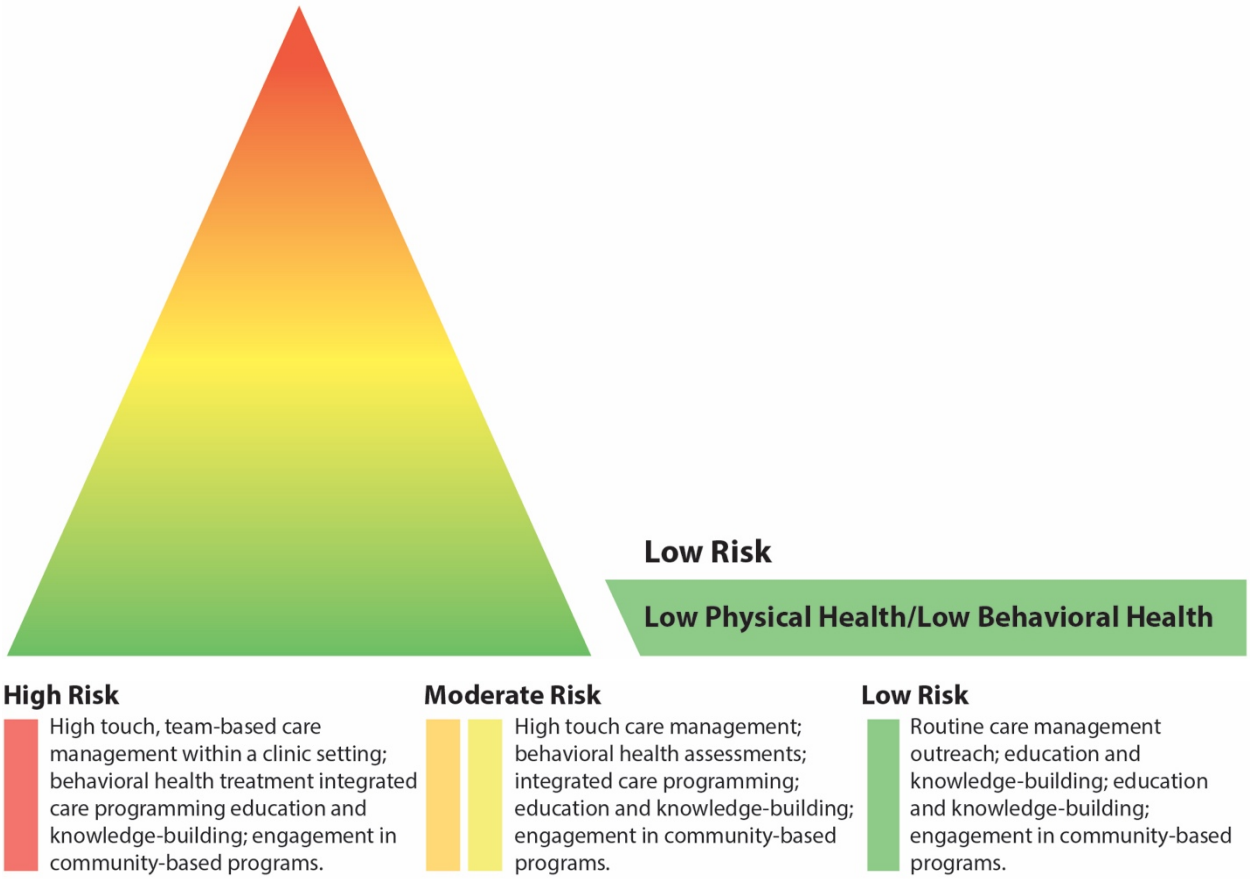
Appendix I

Region 3 #2017000265

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Adult Wellness Program

Description:



Adult Wellness Program

Our Adult Wellness Program adopts the United States Preventive Services Task Force (USPSTF) A and B preventive screening guidelines and aligns these with evidence-based interventions that are proven to increase screening rates. Health topic areas include, but are not limited to, cancer screening, sexually transmitted infection (STI) screening and counseling, depression screening, and obesity screening and counseling. Evidence-based interventions include member reminder/recall systems, reduction of barriers, member incentives, and provider assessment and feedback loops. Interventions are focused on both increasing screening rates as well as increasing member engagement with their provider about their health needs. We use administrative claims and pharmacy data to translate USPSTF recommendations into clinical registries that are used to identify target populations in need of screening. The registries are also used to prioritize practices that may benefit from Colorado Access support to increase screening rates amongst their Health First Colorado (Colorado's Medicaid Program) members. Clinical registries are often stratified at the practice level and made available to providers to

help prioritize where they should spend their time and effort. Interventions are evaluated every six months for both member engagement and screening rates, and outcomes are used to refine future approaches.

Please check one of the following three options:

X Evidence Based

Promising Practice

Other

How the frequency of intervention will be determined:

Interventions for USPSTF A & B recommendations included in the Adult Wellness Program are run **at least monthly, with many interventions spanning 3 months or longer** due to tiered efforts (such as a direct mailing campaign followed by an IVR call). Target populations enrolled into the interventions are identified through clinical registries and are determined to be out of screening compliance.

How the method of delivering the intervention will be determined:

Interventions within the Adult Wellness Program are delivered through multi-channel efforts (e.g. direct mail, phone, text messages, etc.) based on the member-defined preferences and evidence-based research. The delivery of interventions occurs within the clinic system and through the RAE, creating a wrap-around approach for populations who need screening. Member communication channels include IVR, direct mail, text messages, and email. All channels proactively transfer the member to a care manager in order to provide immediate support.

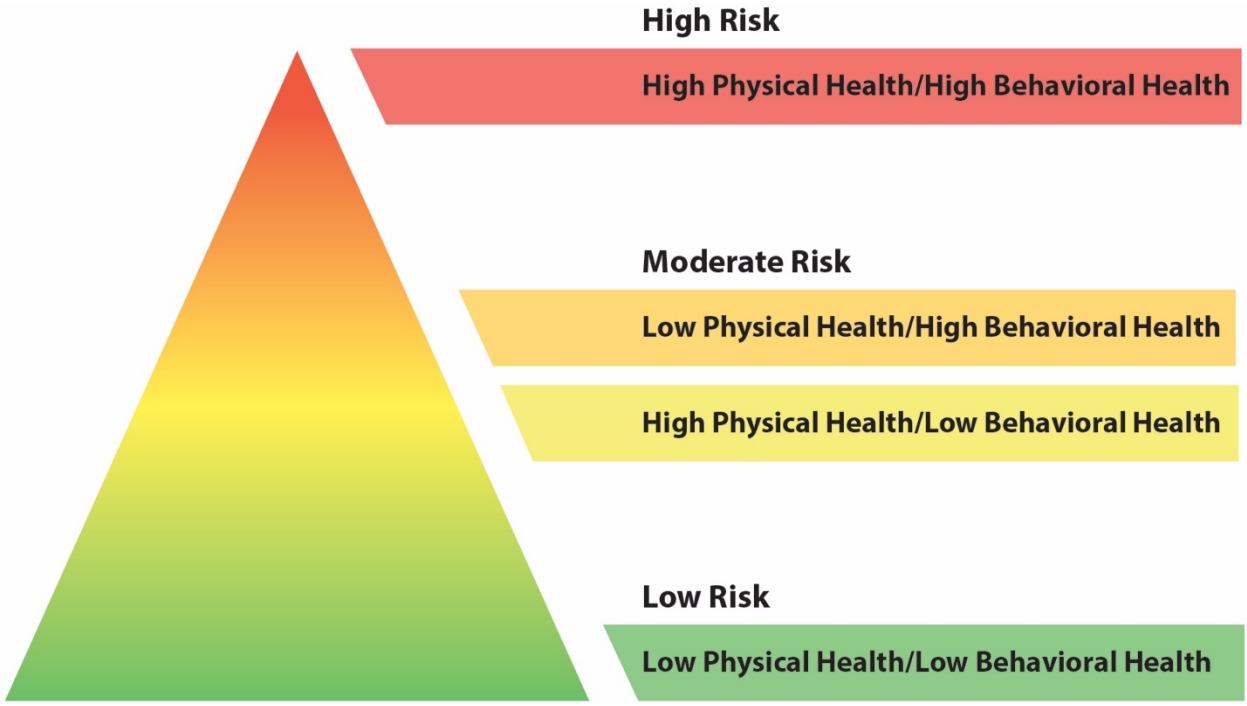
Potential outcomes:

Outcomes
• Increased screening rates for USPSTF A & B recommendations • Increased adult annual wellness exams • Increased adult annual dental exams • Increased attribution and engagement in a medical home

Appendix I - Description of Interventions

Name of Intervention: Access to Screenings, Promotions, Information, Rewards, and Events (ASPIRE)

Description:



ASPIRE:

The ASPIRE (Access to Screenings, Promotions, Information, Rewards, and Events) program is a member engagement program designed to encourage members to tell us how they want to be communicated with. The program is designed to target newly enrolled members across the risk spectrum to ensure the member understands their Medicaid benefits and what is available to them as a member of Colorado Access. Established members are also reached out to during their birthday month to grandfather them into the ASPIRE program. Program components include linking new members with a care manager to answer any questions they may have about Medicaid benefits; ensuring the member is enrolled into a medical and dental home; and educating the member about the benefits of an annual wellness exam and dental exam. As part of the initial outreach, members are also asked to give their preferences for how they would like to receive health-related communications, including text and email preferences. Members then receive communication messages from Colorado Access about health and wellness, including preventive screening reminders and incentive programs for completing an annual wellness or dental visit. Members also receive information about community health events and are invited to participate in giving feedback about their health care experience.

Please check one of the following three options

Evidence Based

Promising Practice

X Other

How the frequency of intervene will be determined:

The ASPIRE program is rolled out **monthly** to members who are newly enrolled in Medicaid. Members who enroll in the program will continue to receive communications and information routinely until the member chooses to opt-out of the program or becomes disenrolled in Medicaid.

How the method of delivering the intervention will be determined:

The ASPIRE program is delivered through multi-channel efforts based on the member-defined preferences. Channels include IVR, direct mail, text messages, and email. All channels proactively transfer the member into a care manager in order to provide immediate support.

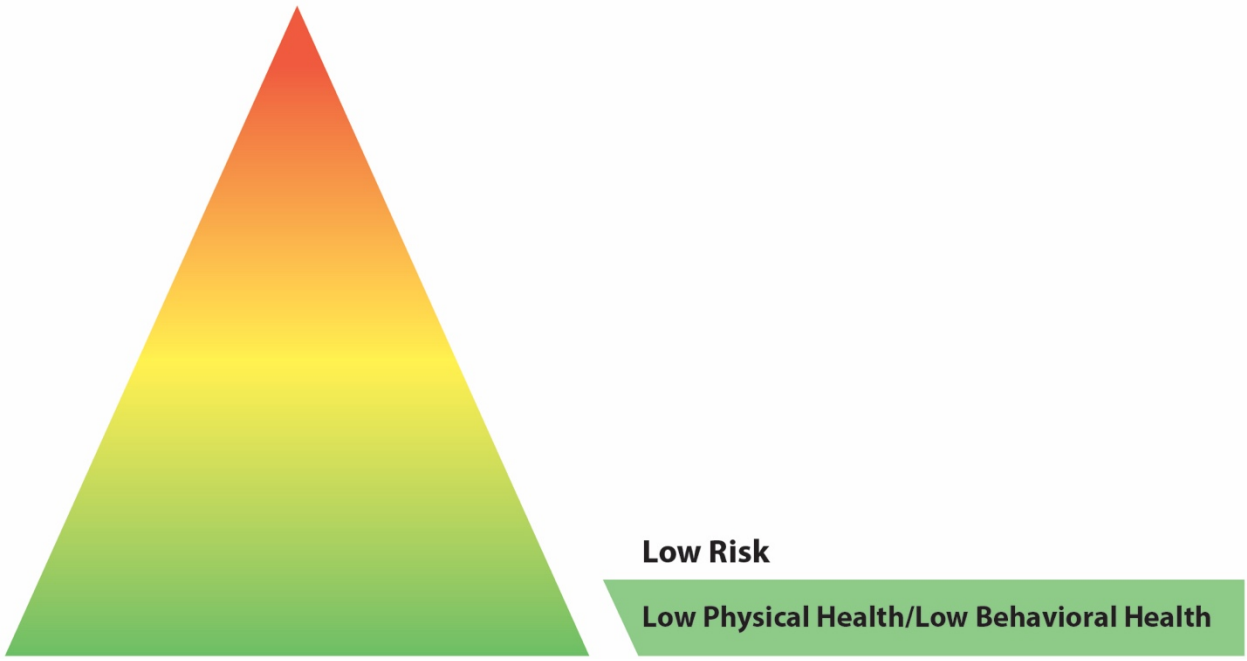
Potential outcomes:

Outcomes
• Increased annual physical health wellness exams • Increased annual preventive dental exams • Increased attribution and member engagement in a medical home

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Avoidable Emergency Department Program

Description:



Avoidable ED Program

Our Avoidable Emergency Department (ED) Program proactively outreaches to low risk populations in order to intervene and prevent unnecessary visits to the ED. An unnecessary visit to the ED is defined either as a visit that is inappropriate (e.g. could have been treated in a lower cost setting such as the PCP office), or a visit that could have been avoided if the condition had been managed within the primary care setting (e.g. ambulatory care sensitive conditions as defined by AHRQ). The program targets member populations who either have a history of an avoidable visit and/or have criteria that indicate they could likely have one in the near future. It also provides education about other sources of care the member could engage with first before visiting the ED such as the Health First Colorado Nurse Advice Line. The Avoidable ED program is a wrap-around program, meaning all members are connected with a care manager to provide follow-up support and to answer questions. As the RAE, we plan on exploring a telehealth program that can assist with on-demand clinical needs from this population.

Please check one of the following three options:

- [ ] Evidence Based
- [X] Promising Practice
- [ ] Other

How the frequency of intervention will be determined:

Interventions are rolled out **monthly** to newly identified target populations who either have a history of an avoidable visit and/or have criteria that indicate they could likely have one in the near future. The program is a high frequency (targeting a large number of people) low touch (a focused/brief interaction that may be one time or ongoing, but limited in nature).

How the method of delivering the intervention will be determined:

Interventions within the Avoidable ED Program are delivered through multi-channel efforts based on the member-defined preferences, and include IVR, direct mail, text, and email. All channels proactively transfer the member to a care manager in order to provide immediate support. A future telehealth component would be made available to members who have an identified clinical need.

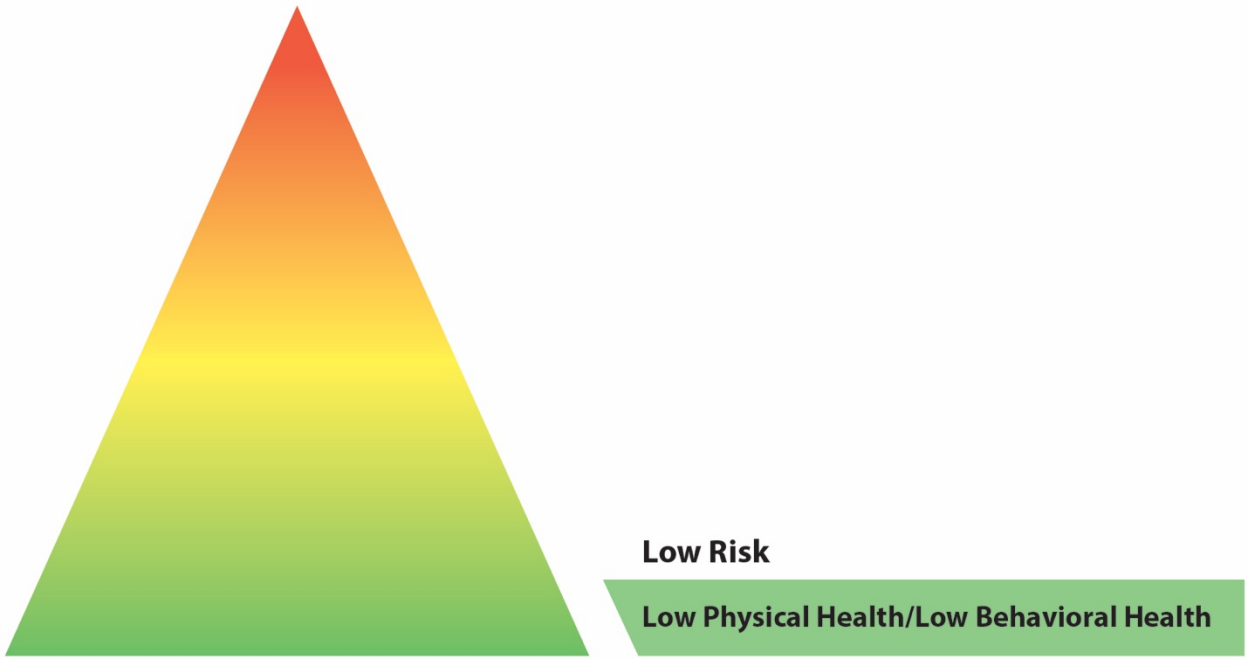
Potential outcomes:

Outcomes
• Total cost of care • Decreased avoidable and inappropriate ED visits • Decreased ED visits associated with Ambulatory Care Sensitive Conditions (ACSCs) • Increased attribution and engagement in a medical home • Increased annual wellness visits • Increased annual dental visits

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Child Wellness Program

Description:



Child Wellness Program

Our Child Wellness Program adopts the United States Preventive Services Task Force (USPSTF) A and B preventive screening recommendations and the American Academy of Pediatrics' Bright Futures guidelines and aligns these with evidence-based interventions that are proven to increase screening rates. Health topic areas include, but are not limited to, immunizations, depression screening, and obesity screening and counseling. Evidence-based interventions include member reminder/recall systems, reduction of barriers, member incentives, and provider assessment and feedback loops. Interventions are focused on both increasing screening rates as well as increasing member engagement with their provider about their health needs. We use administrative claims and pharmacy data to translate guidelines into clinical registries that are then used to both identify target populations in need of screening as well as prioritize practices that may benefit from our support to increase screening rates amongst their Medicaid members. Clinical registries are often stratified at the practice level and made available to providers to help prioritize where they should spend their time and effort. Interventions are evaluated every six months for both member engagement and screening rates, and outcomes are used to refine future approaches.

Please check one of the following three options:

- **X** Evidence Based
- Promising Practice
- Other

How the frequency of intervention will be determined:

Interventions for USPSTF A & B recommendations and Bright Futures guidelines included in the Child Wellness Program are run **at least monthly**, with many interventions spanning 3+ months due to tiered efforts (such as a direct mailing campaign followed by an IVR call). Target populations enrolled into the interventions are identified through clinical registries and are determined to be out of screening compliance.

How the method of delivering the intervention will be determined:

Interventions within the Child Wellness Program are delivered through multi-channel efforts based on the member-defined preferences and evidence-based research. Method of delivering interventions includes within the clinic system and through the RAE, creating a wrap-around approach for populations who need screening. Partnerships with pediatric-driven practice support organizations are also leveraged. Member communication channels include IVR, direct mail, text, and email. All channels proactively transfer the member to a care manager in order to provide immediate support.

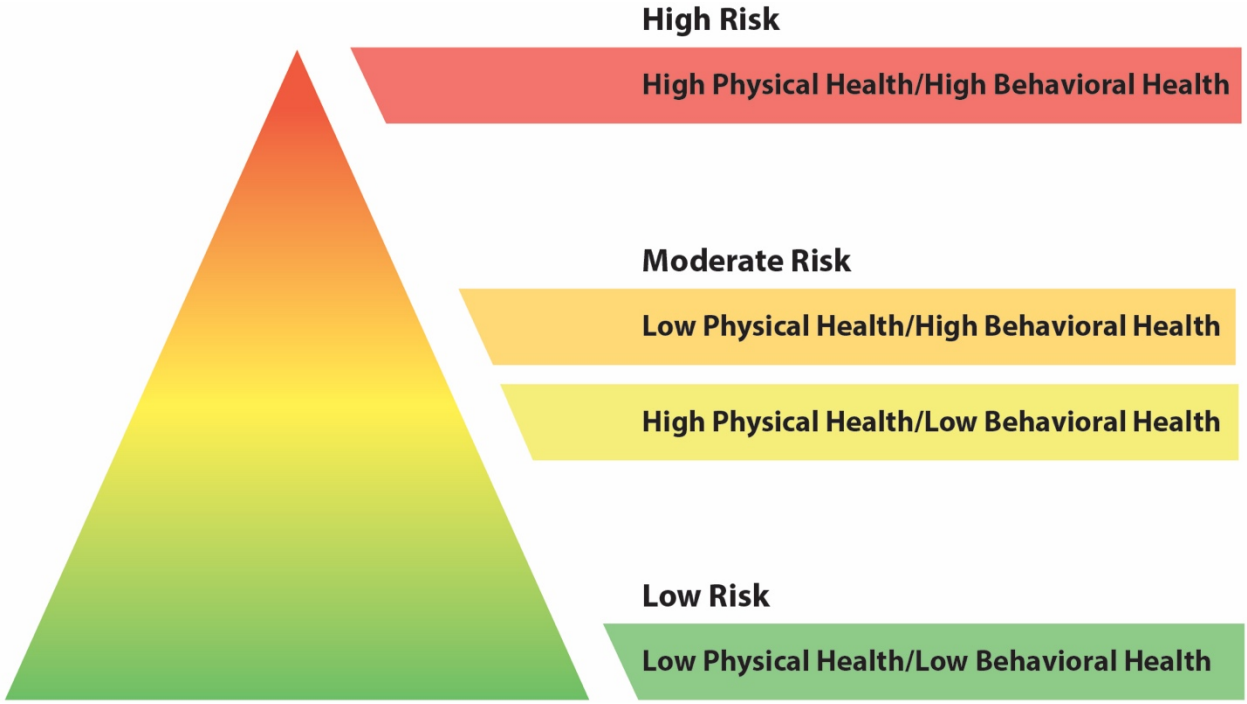
Potential outcomes:

Outcomes
• Increased screening rates for USPSTF A & B recommendations and Bright Futures guidelines • Increased adult annual wellness exams • Increased adult annual dental exams • Increased attribution and engagement in a medical home • Increased awareness of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programmatic elements and referral process • Increased enrollment into Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programming

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Chronic Disease Prevention and Management

Description:



Chronic Disease Prevention and Management

Our Chronic Disease Prevention and Management program is designed to meet the needs of members who we serve. Through our population management strategy, we have developed an initial set of chronic disease registries (diabetes, asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD)) to appropriately identify people who may need different levels of care management interventions to either prevent worsening symptoms or support members in managing their illness. The program is designed to provide members with education to support their self-management goals, provide help navigating the system of providers, and to assess for on-going barriers or social service needs.

Please check one of the following three options:

X Evidence-based

How the frequency of intervention will be determined:

The frequency of the care coordination intervention will depend on the member's needs and their risk/complexity. There are specific evidence-based interventions for each specific chronic disease program for which a member would be enrolled. Programs typically run for six to 12 months and have a variety of contact frequency that exists for each program. For example, if a member is enrolled into the Diabetes program, they

may receive two face-to-face visits with a care coordinator, which includes assessments, goal setting, medication support, and follow-up. A member will also receive supplemental education from their PCMP office during their normal visit schedule based on guideline care for diabetes (typically every 3-6 months), text messages for lab and appointment reminders (per requested need), and links to educational resources (monthly).

How the method of delivering the intervention will be determined:

These interventions will span the care coordination spectrum, meaning that some members will receive in-person care coordination, some will receive services through digital channel interventions, and some interventions will occur through their PCMP sites or other health neighborhood locations. We believe that through member incentives and offering a variety of options, members will engage in their care in the way that they prefer and have options that will meet their specific needs.

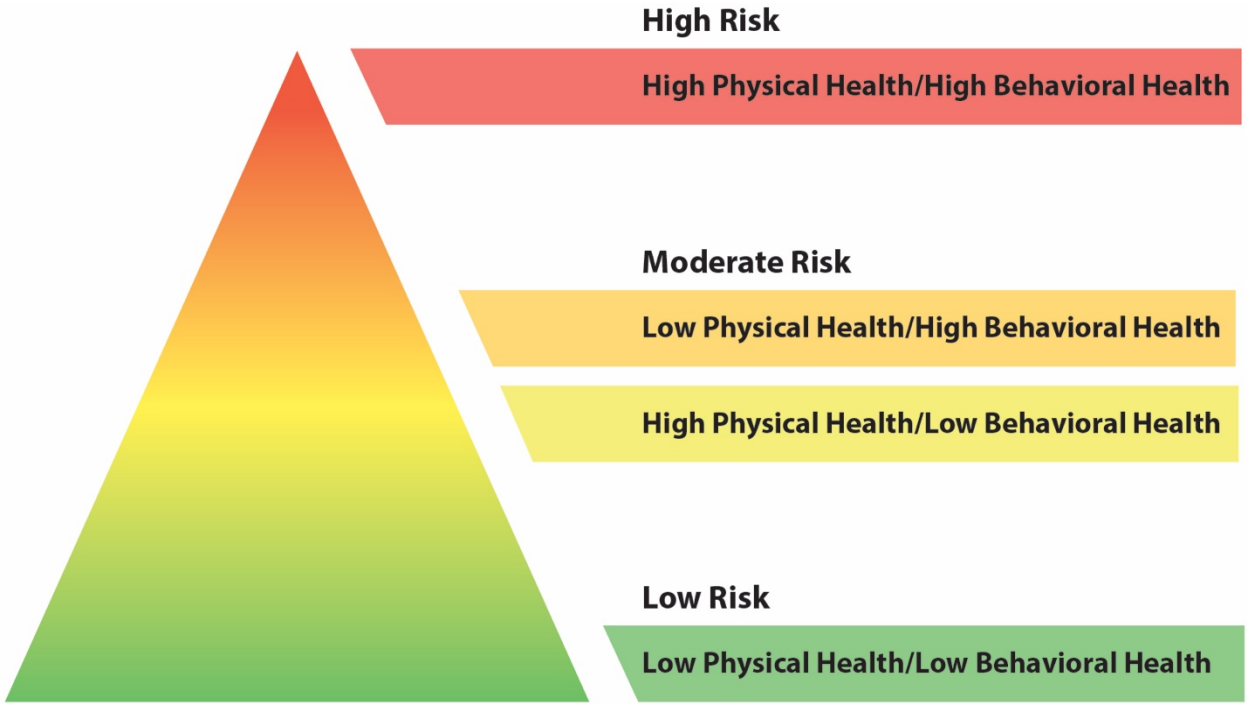
Potential outcomes:

Outcomes		
Diabetes	**Asthma**	**CHF, COPD, CAD**
• Improved blood pressure, lipid screening and levels, HbA1c screening and levels, and eye and foot exams	• Reduced total cost of care • Reduced acute office visits • Lower ED visits • Lower hospitalizations • Appropriate asthma medication ratios (AMRs) • Reduced use of emergency inhalers • Increased adherence to routine inhaler medication pick-ups	• Reduced total cost of care • Reduced hospital admissions • Reduced total cost of care

Appendix I - Description of Interventions

Name of Intervention: The Department's Client Overutilization Program (COUP)

Description:



Department's Client Overutilization Program (COUP)

COUP is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. Based on the member's utilization profile and individualized assessment, we will develop individualized care plans that also align with COUP outcomes, addressing needs such as linkage and engagement with PCMH, ED alternatives for urgent situations, medication adherence support, social needs, linkage and engagement with mental health and/or substance use services.

Please check one of the following three options:

X Other

How the frequency of intervention will be determined:

Members enrolled into the COUP program will receive a combination of in-person and telephonic care coordination to deliver appropriate interventions and follow up. The frequency of the intervention will be based on the individual needs of a member and the specific service that is being over-utilized will have a tailored frequency and follow-up plan to meet the member's need and the goals of the program.

How the method of delivering the intervention will be determined:

We will perform additional analysis of members identified by the Department for the COUP program, including assessing for: PCMH attribution, PCMH visits, ED visits, ED risk factors, previous quarter high-risk medication count, and diagnoses. Based on the member's profile and individualized assessment, we will develop a person-centered care plan that also align with COUP outcomes, addressing needs such as linkage and engagement with PCMH, ED alternatives for urgent situations, medication adherence support, social needs, linkage and engagement with mental health and/or substance use services. We will systematically track the outcomes of members in the COUP using a registry to measure the effectiveness of the interventions for this population and identify opportunities for refining its approach.

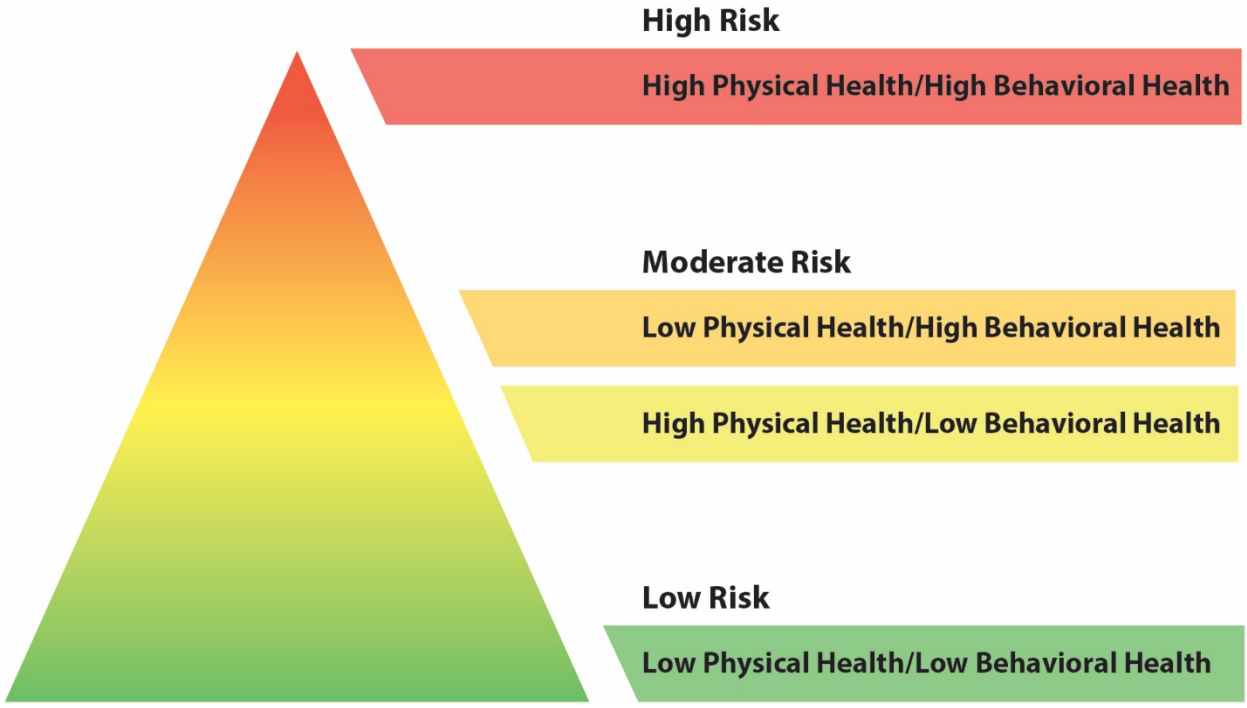
Potential outcomes:

Outcomes
• Total cost of care

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Emergency Department (ED) Follow-Up Program

Description:



Emergency Department Follow-Up Program

Our Emergency Department (ED) Follow-Up Program is an innovative program to support members who have emergency room visits. In regions where we have care managers placed in the hospital ED setting (i.e. UCH and Denver Health), members can be seen by our care coordinators while they're at the ED. These members are educated about ED usage, assessed for barriers to care, and referred to additional social services. Members using the ED may receive additional telephonic follow-up after they have returned home. For members who visit EDs where we do not have care managers placed, we provide telephonic interventions for those who meet the same criteria but are identified following the ED visit through various data sets.

Please check one of the following three options

X Promising Practice

How the frequency of intervention will be determined:

For members who are seen in the ED, they receive on-site care coordination with additional telephonic care coordination follow-up as needed. For other members who identified following their ED visit through data sets, they receive a telephonic intervention within one week of the ED visit. Once this initial telephonic screen is conducted, a care coordinator determines the duration and frequency of ongoing engagement with care coordination.

How the method of delivering the intervention will be determined:

Members who visit the ED receive follow-up support by telephonic care coordination, PCMP site and specialty provider follow-up, and the opportunity to engage with a care coordinator for a longer duration to assess any current or ongoing barriers to care and social service needs. If any referrals or appointments are made by the supporting care coordinator, these items will have continuous follow-up and support for the member.

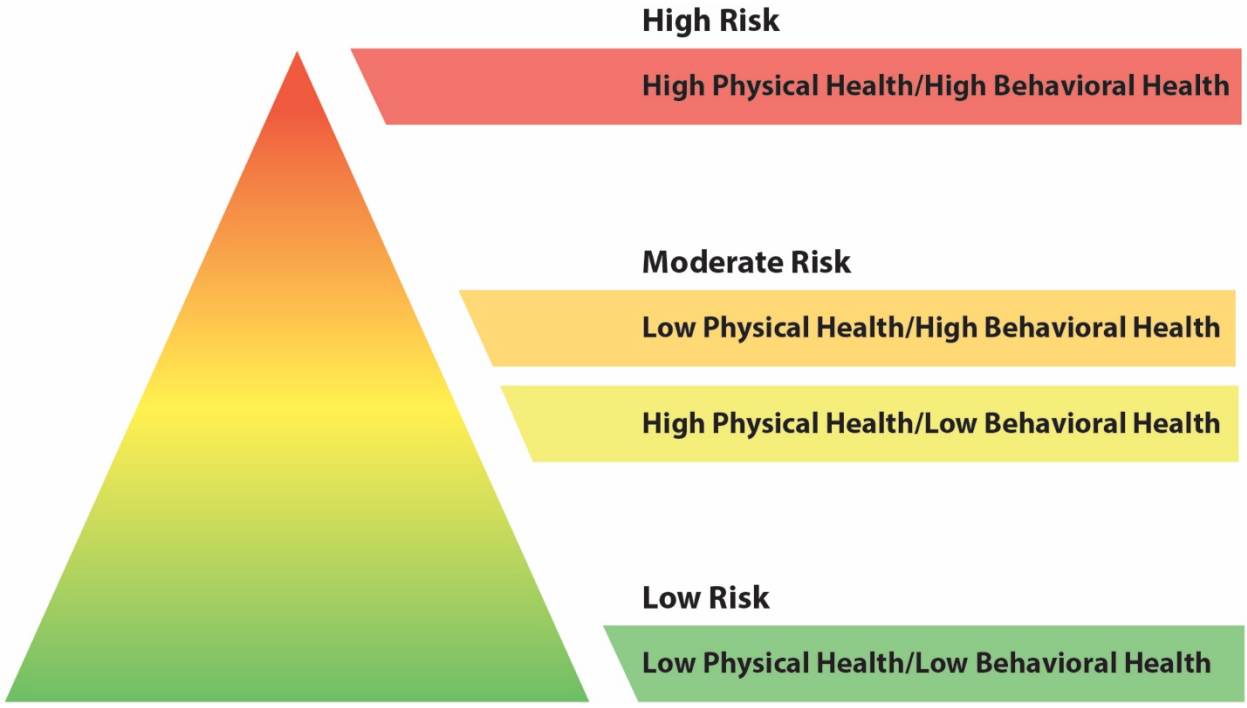
Potential outcomes:

Outcomes	
Reduced Total Cost of Care	**Behavioral Health**
• Reduced ED visits for ambulatory care sensitive conditions	• Reduced ED utilization for BH DX • Increased follow-up appointments for BH and SUD following ED visit

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Healthy Eating Active Living Program

Description:



Healthy Eating Active Living Program

Our Healthy Eating Active Living (HEAL) program is for adults and children across the risk spectrum to address and prevent obesity. The level and type of activity provided to the member is based on the member's level of engagement and motivation to improve their diet and/or increase their physical activity. Members are proactively outreached to about this program once they sign up for our ASPIRE (Access to Screenings, Promotions, Information, Rewards, and Events) program and select how they would like to receive communications. All members are proactively outreached to with education and resources about healthy eating habits and active living ideas, and are notified about resources within Colorado Access and local community programs that support the member in achieving, and maintaining, a healthy weight (e.g. diabetes prevention program classes or family cooking classes). Members who are interested in losing weight are invited to participate in our technology-supported, multicomponent coaching and counseling intervention to affect and sustain weight loss, which is aimed at improving weight-related behaviors and outcomes. The intervention consists of sessions focused on physical activity, nutrition, and weight delivered in the member's preferred communication format, including in-person, telephone-based, telehealth, text, email, or a combined hybrid approach.

Please check one of the following three options

X Evidence Based

Promising Practice

Other

How the frequency of intervention will be determined:

Members engaged in the HEAL program are outreached **monthly** with education and resources about healthy eating habits and active living ideas, including notification of upcoming community events and local programs they may be eligible to enroll in.

Members enrolled in our technology-supported multicomponent coaching and counseling intervention to affect weight and sustain loss receive biweekly interventions for a minimum of 90 days. Members are welcome to stay active in the program beyond the 90 days if they are interested.

How the method of delivering the intervention will be determined:

The HEAL program is delivered through multiple methods, including: IVR, text messages, email, telephonic coaching, and in-person coaching (or telehealth) delivered in the community and/or clinic setting. The method of delivery is based on the defined communication preferences of the member.

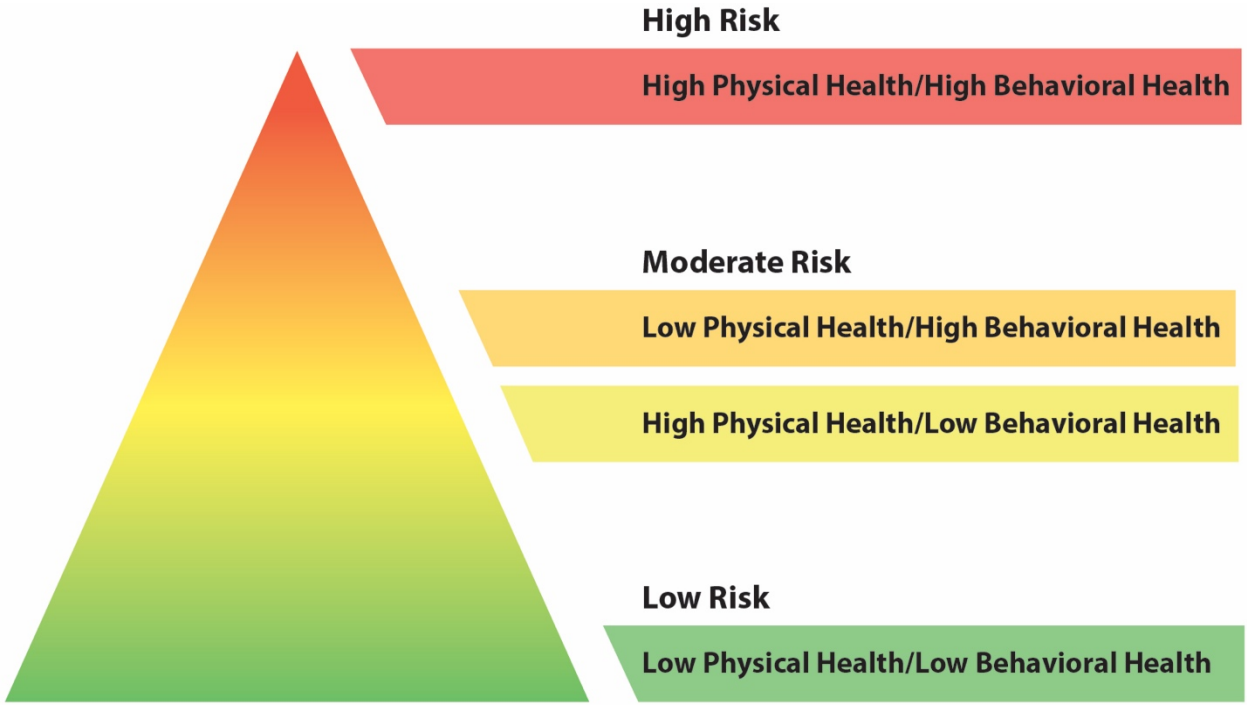
Potential outcomes:

Outcomes
• Increased physical activity amongst members enrolled in the technology-based multicomponent counseling to effect weight loss • Increased adult BMI screening in primary care offices • Improved nutrition amongst members enrolled in the technology-based multicomponent counseling to effect weight loss • Increased child BMI screening in primary care offices • Reduced sedentary behaviors members enrolled in the technology-based multicomponent counseling to effect weight loss • Reduced obesity rates within RAE region

Appendix I - Description of Interventions

Name of Intervention: Healthy Mom, Healthy Baby Program

Description:



Healthy Mom, Healthy Baby Program

Our Healthy Mom, Healthy Baby (HMHB) program is a multi-faceted, wraparound program for women both during their pregnancy and through 12 months postpartum. Women across the risk spectrum are enrolled in the program, and receive varying levels of intervention that aligns with their needs and levels of risk. The program includes an evidence-based curriculum designed to screen women for immediate needs, increase knowledge and self-advocacy about their pregnancy, educate on family planning resources post-delivery, and new motherhood resources to help women transition into this new, important role. Programming focuses on information and referrals to community-based resources for pregnant/postpartum women, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and home visitation programs, as well as reminders about the importance of attending their prenatal and postpartum visits. The curriculum is delivered through diverse digital channels that align with member preferences and their level of risk, including IVR, text messages, and email, as well as within routine care coordination sessions delivered either by telephone or within the clinic or community setting. The focus for low-risk members is education and resource connection, with ongoing access to a care manager as needed. Moderate risk members receive high touch care management, specifically prior to delivery and immediately postpartum. These members are also assessed by a care manager for behavioral health needs and are enrolled into appropriate integrated care efforts. High-risk members also receive high-touch care management as part of a team-based approach within the clinical setting, and are

actively supported by the care manager in addressing their behavioral health needs in an integrated care setting.

Please check one of the following three options:

X Evidence Based

Promising Practice

Other

How the frequency of intervene will be determined:

Given the sensitive nature of a pregnancy, we strive to ensure that patient privacy and choice are the pillars for enrollment into the HMHB program. The majority of women are proactively outreached through IVR about enrollment into the HMHB program upon declaring to Medicaid that they are pregnant. Women may also be referred to the program by a provider or community entity, or have the program delivered within the PCMP setting through delegated care management. Additionally, through health and wellness campaigns delivered as part of the ASPIRE program, women of reproductive age are educated about the signs of pregnancy and importance of early prenatal care, and are encouraged to reach out to their care manager and self-enroll upon finding out they are pregnant. Women enrolled in the program receive outreach and education **monthly**, and women identified as moderate and high risk are outreached at least monthly – with outreach and support increasing immediately pre and post-delivery. Women are enrolled in the program through their child's first birthday.

How the method of delivering the intervention will be determined:

The HMHB program is delivered by multiple methods, including: IVR, text messages, email, telephonic care management, and in-person care management (or telehealth) delivered in the community and/or clinic setting. The method of delivery of education is based on the defined communication preferences of the member. Activities for moderate and high-risk members are most frequently delivered within the clinic system, where we are providing practice-level technical support and transformation guidance.

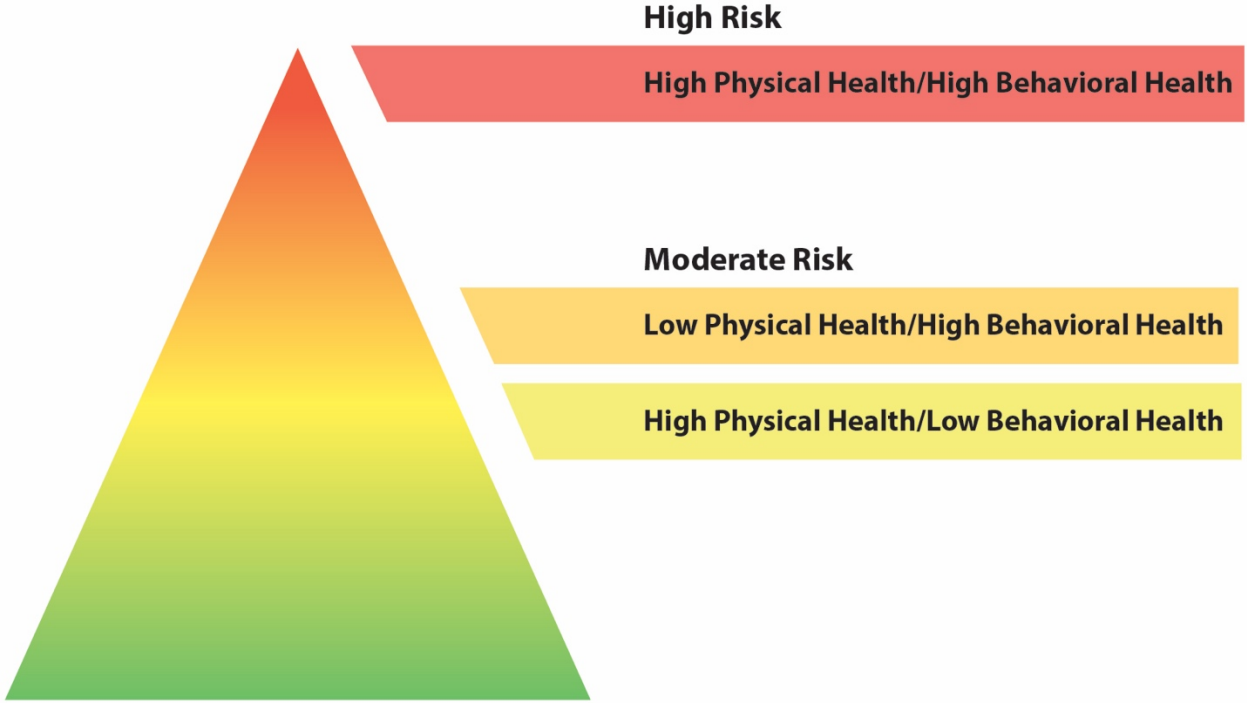
Potential outcomes:

Outcomes
• Increased initiation of prenatal care during first trimester or within 45 days of enrollment into Health First Colorado
• Increased attendance at routine postpartum follow up within 21-56 days postpartum
• Increased access to, and uptake of, long-acting, reversible contraceptives
• Increased engagement in evidence-based community programs, such as WIC, NFP, etc.
• Decreased low birth weight, defined as a live infant born at less than 2,500 grams
• Increased knowledge of, and screening for, maternal depression
• Decreased preterm birth, defined as a live infant born at less than 37 weeks gestation
• Increased intendedness of pregnancy, including appropriate birth spacing at minimum 18 months
• Increased treatment and support for women identified with maternal depression
• Reduced unnecessary/avoidable emergency department visits
• Reduced total cost of care

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Care Integrated Management Program

Description:



Colorado Access Integrated Care Management Program

We have the unique advantage of providing services to RCCO, BHO, and ALTSS Medicaid members. Through our experience, we have learned that for some members, they are actually enrolled into dual programs. To ensure members are getting the highest quality of service, we created the Colorado Access Integrated Care Management program. The goal of this program is to provide a single point of care coordination service to members who might be dually enrolled (BHO/RCCO or RCCO/LTSS or BHO/LTSS). This program has been a great opportunity to provide more member-centered care to members with multiple health care needs. Members are supported by one care coordinator who has the ability to provide the correct assessments for the member and any ongoing needs they may have. The one care coordinator is also supported internally by multi-disciplinary teams (physical health, behavioral health, long-term care) that can support any specialty needs a member may have.

Please check one of the following three options:

X Promising Practice

How the frequency of intervention will be determined:

Members who are dually enrolled in programs are seen in-person by care coordinators twice per year to conduct the necessary programmatic assessments. Additionally, these members have ongoing contact with a care coordinator to address any additional needs that they may have. Member preference of communication channels is also collected to ensure we are communicating with members in the way that best meets their needs (e.g. in-person, telephone, direct mail, text messages).

How the method of delivering the intervention will be determined:

Members who have been identified in dual Medicaid programs administered by Colorado Access will have the advantage of having one care coordinator who can address needs across programs. Services will be delivered by the care managers in a variety of settings (home, community, HX, nursing facilities, telephonically, with PMCP sites, and by additional service providers). Member data is refreshed monthly to match programs with the appropriate care manager skillset so that a lead can be properly identified. Many of these members are also supported by medical director surveillance to address their full continuum of care needs and ensure all of their physical health, behavioral health, and long-term care needs are being met.

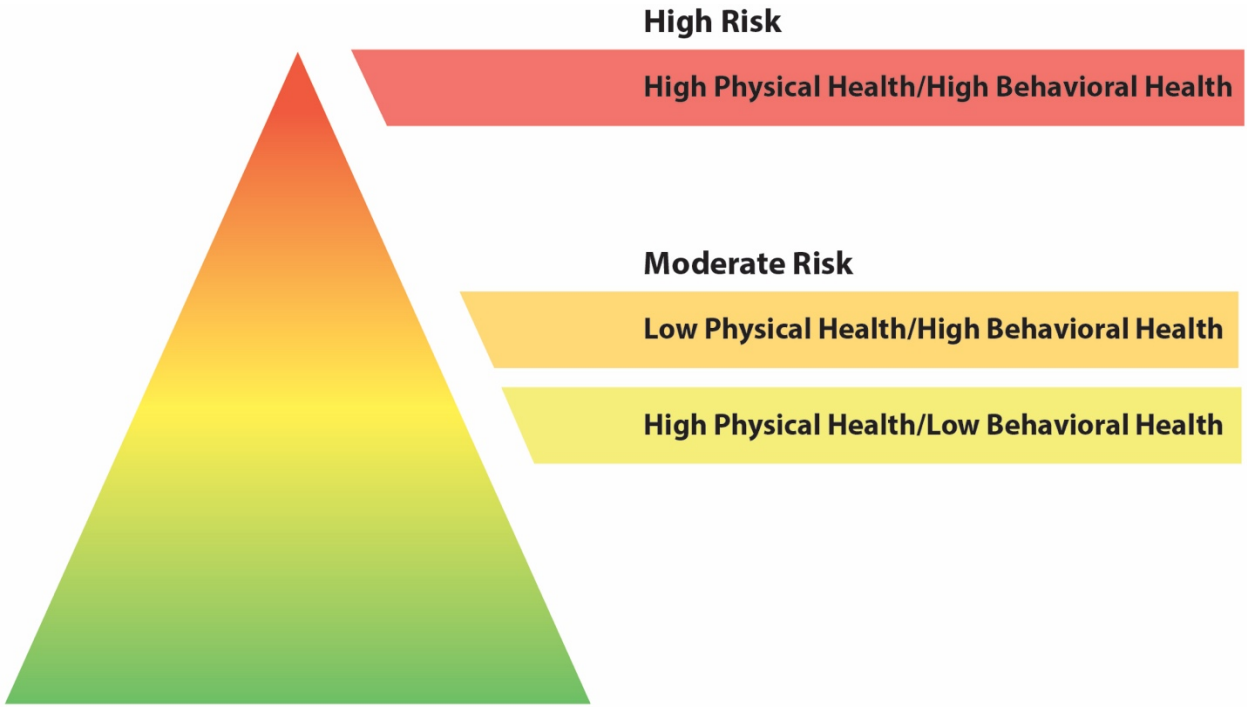
Potential outcomes:

Outcomes	
Total cost of care	**Behavioral Health**
• Emergency department visits for ambulatory care sensitive conditions	• Reduced hospital readmissions at 7, 30, 90, 180 days • Decreased inpatient utilization • Decreased ED utilization BH DX • Increased follow-up appointments for BH and SUD following ED visit

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Opioid Surveillance Program

Description:



Opioid Surveillance Program

Our Opioid Surveillance program is designed to address the diverse issues and needs across the health care system including prescribers, patient usage and education and multiple dispensing pharmacies. The goal of the Opioid Surveillance program is to proactively monitor members who would be at risk for opioid dependence behavior. Members are routinely identified through multiple data sets and we have developed a clinical registry that identifies members with increasing thresholds of risk, including filling prescriptions at more than one pharmacy, prescriptions from multiple providers, and concurrently filled prescriptions for benzodiazepines in the last 30 days. Our care coordinators collaborate with PCMPs, pharmacies, specialty providers, hospitals, and other aligning programs addressing utilization and opioid use.

Please check one of the following three options:

X Promising Practice

How the frequency of intervention will be determined:

The frequency of the Opioid Surveillance program is tailored to the member's individual needs. The program's care coordinators create a follow-up plan designed to meet the member's needs and achieve the goals of the

program. The program is designed as a primarily telephonic intervention, but our care coordinators may meet with the member in-person as needed. Once a member is identified, the ongoing use of opioids will be monitored and support services will be offered by care coordination.

How the method of delivering the intervention will be determined:

Members are identified from a clinical registry that combines both pharmacy and administrative claims data. The registry reflects a rolling 12-month period and is refreshed every 30 days with new data. We will systematically track the outcomes of members in the registry using multiple data sets to measure the effectiveness of the interventions for this population and identify opportunities for refining its approach.

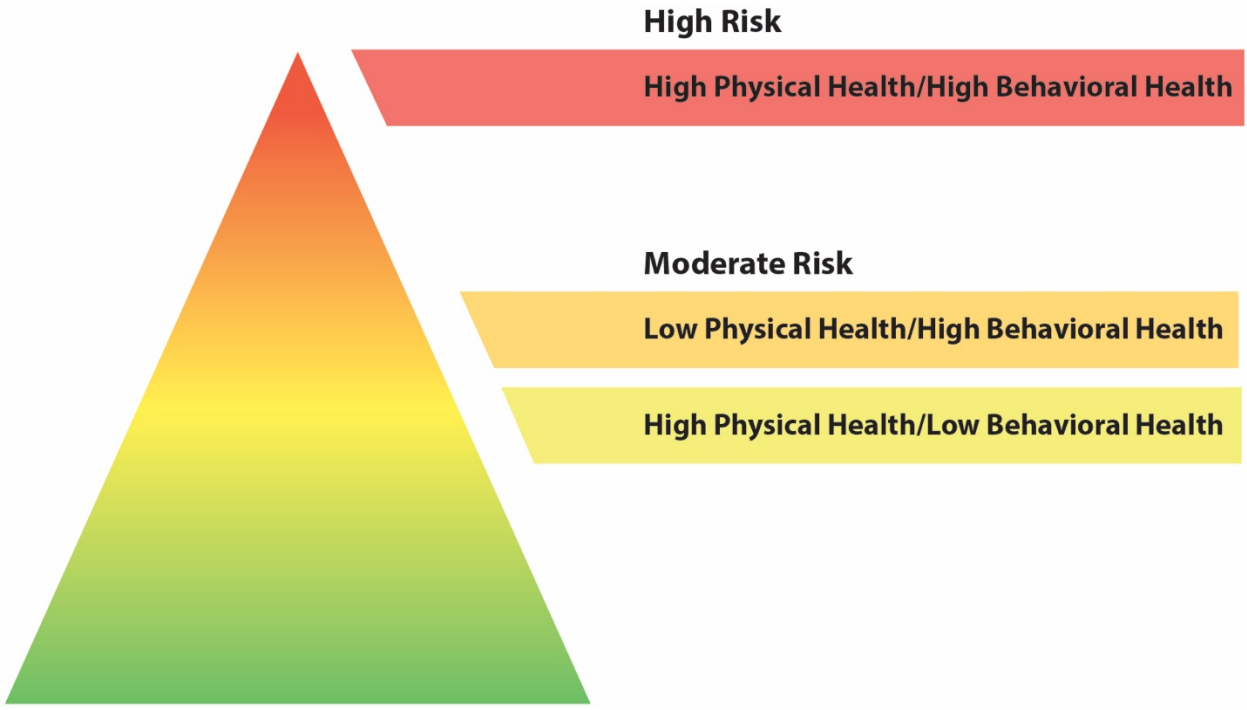
Potential outcomes:

Outcomes
• Total cost of care • Decreased risk behaviors associated with increasing dependence on opiates

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Opportunity Program

Description:



Opportunity Program

Our Colorado Access Opportunity Program (CAOP) adopts the Colorado Opportunity Framework and the Life Course Model to implement community-level systems coordination across interventions that serve Health First Colorado (Colorado's Medicaid Program) members. The CAOP conducts an iterative community-level resource scan to identify evidence-based interventions, promising practices, and entitlement programs that align with the framework indicators, address the social determinants of health, and support members in achieving economic self-sufficiency. Each intervention identified through the CAOP has its own set of process and outcome metrics that are measured at a local level, often in partnership with a community partner. The overarching CAOP establishes alignment across these diverse interventions by applying a systems-level approach focused on strengthening the entire network that serves the population at a particular life stage. The strength of a system is measured through evidence-based tools, such as the PARTNER Tool, and is strategically aligned with the work of the health neighborhood.

Please check one of the following three options

X Evidence Based

X Promising Practice

X Other

How the frequency of intervention will be determined:

Frequency of interventions identified through the Opportunity Program are reflective of individual intervention requirements, and **may be weekly, monthly, or even less often**. Community resource scans are conducted routinely, and the strength of the system is evaluated annually.

How the method of delivering the intervention will be determined:

Interventions identified within the Opportunity Program are delivered through multi-channel efforts based on the member-defined preferences. Channels include IVR, direct mail, text messages, and email. All channels proactively transfer the member into a care manager in order to provide immediate support.

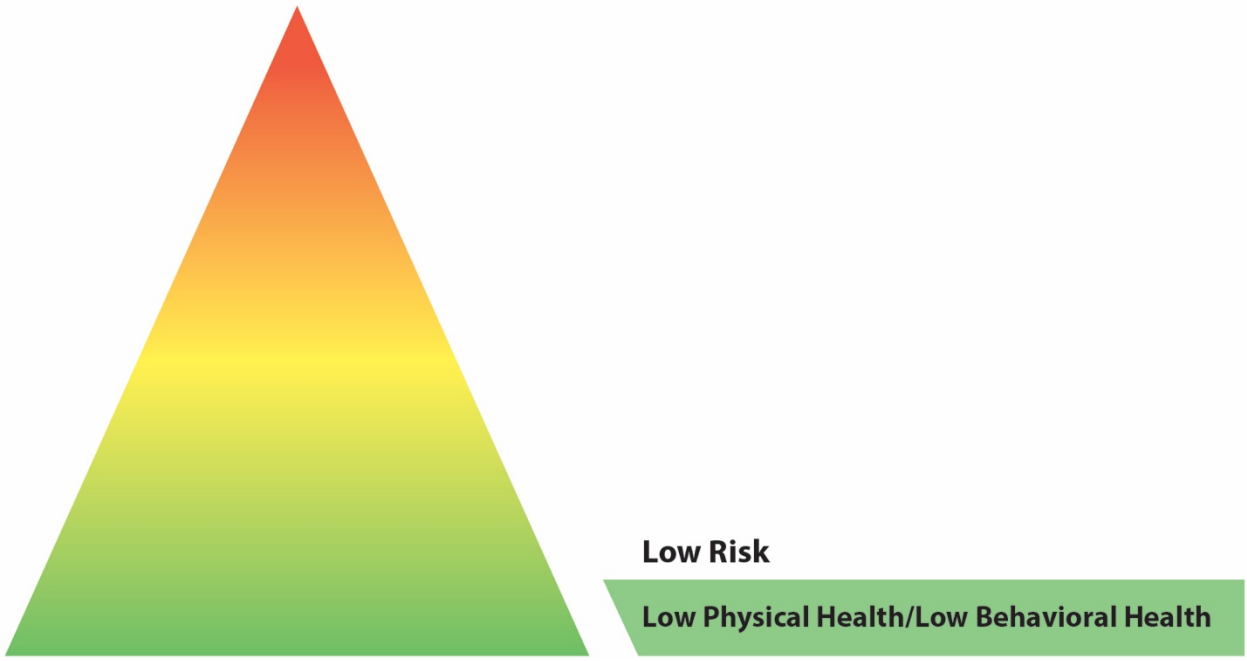
Potential outcomes:

Outcomes
• Completion of community resource scans that identify relevant community-level evidence-based interventions, promising practices and entitlement programs • New community partnerships established and/or enhancement of existing relationships with community entities • Coordination across the RAE, clinical systems and non-clinical systems to improve alignment with serving Health First Colorado members • Increasing enrollment and/or utilization of community-level evidence-based interventions, promising practices and entitlement programs

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Tobacco Dependency and Prevention Program

Description:



Tobacco Prevention & Cessation Program

Our Tobacco Dependency and Prevention program is designed to proactively screen and identify members for tobacco use and then gauge their motivational level for tobacco cessation through a health screening or in-depth health needs assessment. Depending on member engagement and interest to quit, care management will provide the member with tobacco cessation resources, referrals to evidence-based cessation programs (i.e. QuitLine, DIMENSIONS, Baby and Me Tobacco Free), as well as recommended follow-up with PCMP.

Please check one of the following three options

X Promising Practice

How the frequency of intervention will be determined:

The frequency of the Tobacco Dependency and Prevention program is based on clinical recommendations for tobacco cessation. Frequency of the program's telephonic care management is determined by a health needs assessment for ongoing care coordination and member motivation level for behavior change.

How the method of delivering the intervention will be determined:

Members will be screened by our Tobacco Dependency and Prevention program care coordinators and depending on the member's motivation level, referrals will be made to appropriate evidence-based cessation

programs best suited for the member's needs (i.e. members who are pregnant are referred to Baby and Me Tobacco Free).

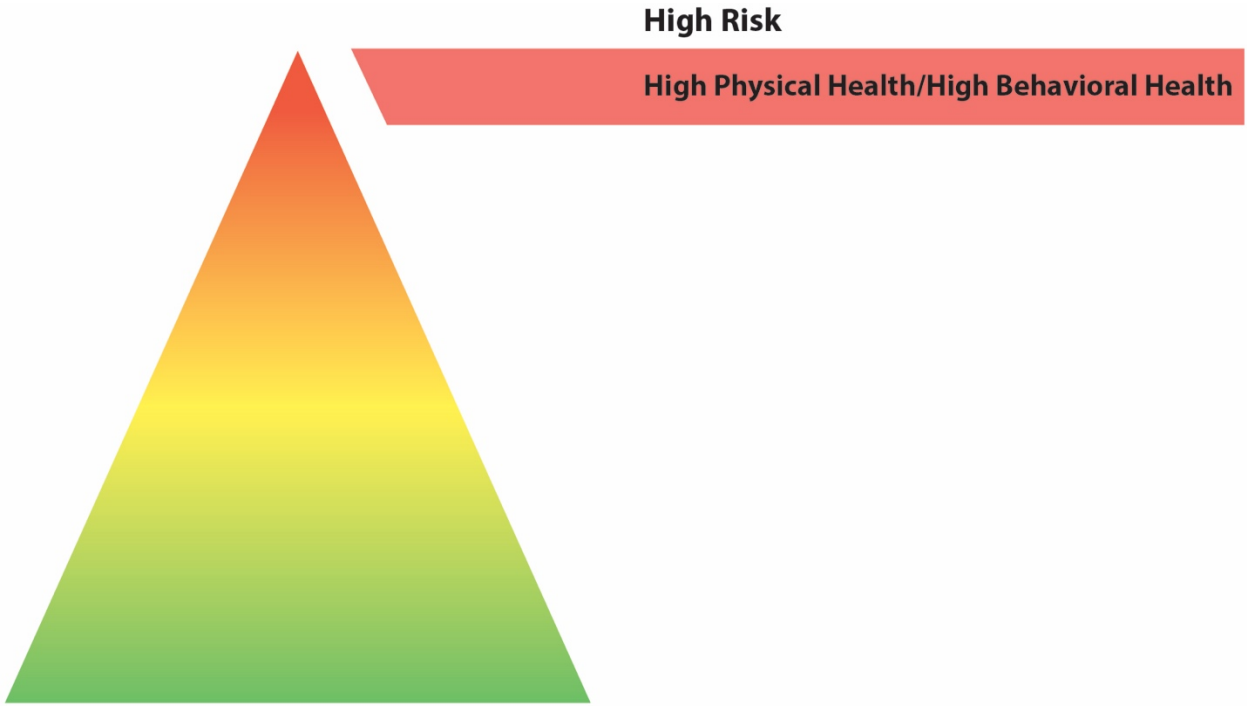
Potential outcomes:

Outcomes
• Increased first attempts by Medicaid members to quit smoking • Improved sustained cessation rates among Medicaid members • Reduced numbers of Medicaid members who start smoking

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Transitions of Care (TOC) Program

Description:



Transitions of Care (TOC) Program

We have a well-established Transitions of Care (TOC) model that has demonstrated effectiveness during the past five years. Adapted from the evidence-based Coleman model, this intervention is systematically applied to members who are being discharged from inpatient settings and have characteristics that predict high risk for adverse outcomes, including hospital readmission within 30 days. The goal is to stabilize members in their home or community setting and provide a bridge for members who are recovering post an impatient stay.

Please check one of the following three options

X Evidence-based

How the frequency of intervention will be determined:

Members enrolled into this program will have a variety of options for in-person and telephonic care coordination. This is a 30-day intervention for physical health stays and a 30 to 90 day intervention for behavioral health stays. However, the intervention can be shorter or longer based on member needs. Some innovative aspects of this program are due to the continued collaboration and relationships that we have with PCMPs and local hospital partners. In some hospitals, care coordinators meet the member in the hospital setting and are

able to participate in the discharge planning for the member. This "warm handoff" between hospital staff and our care coordinators has been extremely beneficial in stabilizing the member at home. Another aspect of this program is that our care coordinators can support members by attending their seven-day follow-up visit with their PCMP to further facilitate the transition home, understanding new orders and medications reconciliation.

How the method of delivering the intervention will be determined:

Our care coordinators cover a caseload of local hospital partners and use multiple data sets to assess appropriate interventions and engage with members. This model delivers a standard set of evidence-based interventions that are modified based on member need and preferences, including: post-discharge care coordination services, support back to home setting/social/environmental needs, discharge care plan education and support, illness and self-management education, medication education and assistance, coordination and support for outpatient follow-up visits, and medical case review from the medical director. This program has demonstrated its effectiveness by decreasing 30-day readmission rates, increasing seven-day outpatient follow-up appointment rates, and improving medication adherence.

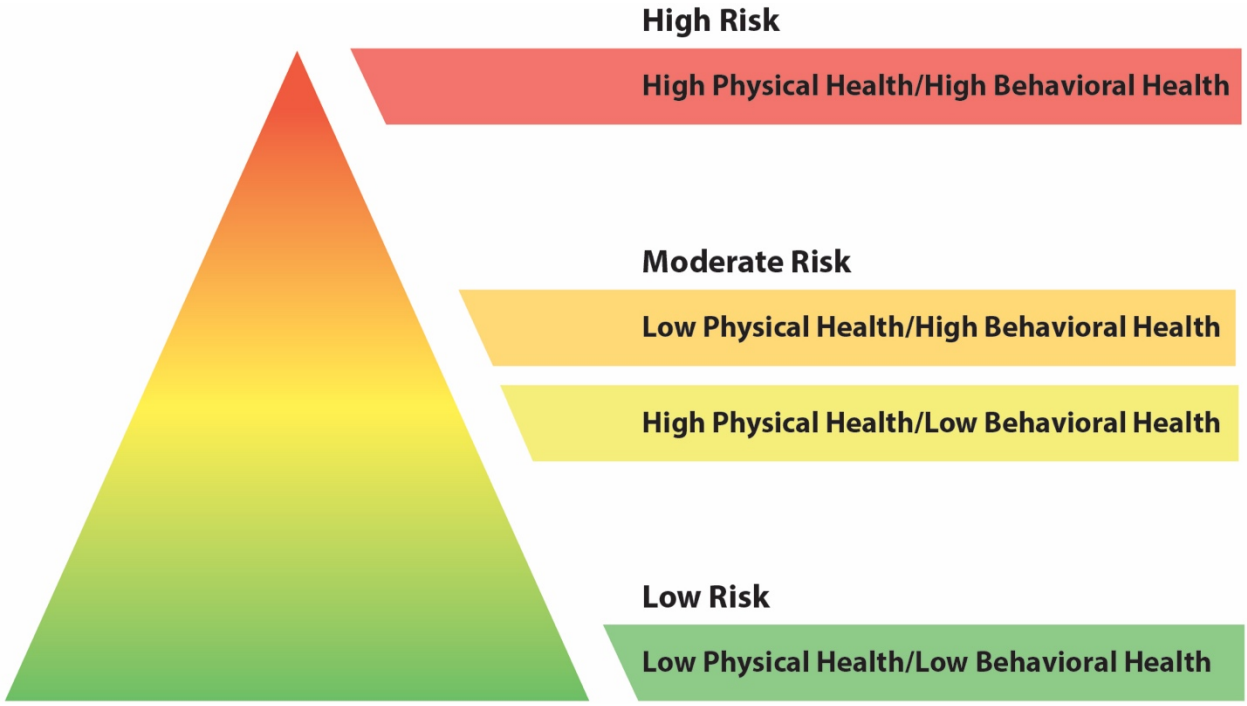
Potential outcomes:

Outcomes	
Total Cost of Care	**Behavioral health engagement**
• Decreased emergency department visits for ambulatory care sensitive conditions	• Decreased hospital readmissions at 7, 30, 90, 180 days • Decreased inpatient utilization • Decreased ED utilization BH DX • Increased follow-up appointments for BH and SUD following ED visit • Increased suicide risk assessment MDD in children and adolescents • Increased suicide risk assessment MDD in adults

Appendix I - Description of Interventions

Name of Intervention: Colorado Access Vulnerable Populations Program

Description:



Vulnerable Populations Program

Our Vulnerable Populations Program is an integrated, wrap-around care management program for populations identified as needing extra support in coordinating their care. These populations include, but are not limited to, refugees, children and youth with special healthcare needs, foster children, and individuals transitioning out of hospital or institutional settings. The Vulnerable Populations program often shares management of a population with a community or clinical entity that is also providing the member with support. Care coordination interventions for these populations are determined by assessing the member's physical, behavioral, psychosocial, and cultural/religious barriers and needs to create a member-driven plan of care.

Please check one of the following three options:

X Promising Practice

How the frequency of intervention will be determined:

The Vulnerable Populations program provides in-person care management combined with telephonic follow-up. Members included in the Vulnerable Populations program are enrolled in this care management program for a minimum of 30 days, with most populations staying enrolled in the program for 60 days or more. The frequency of the care coordination intervention depends on the member's needs and their risk/complexity.

How the method of delivering the intervention will be determined:

The Vulnerable Populations program is administered as a combination of both in-person and telephonic care management services. Members will be engaged in their care in the way that they prefer and have options that will meet their specific needs.

Potential outcomes:

Outcomes	
Total Cost of Care	**Behavioral Health Engagement**
• Reduce ED visits for ambulatory care sensitive conditions	• Reduce hospital readmissions at 7, 30, 90, 180 days • Increase follow-up appointments for BH and SUD • Med adherence for schizophrenia DX • Diabetes screening (schizophrenia/bipolar) disorder on antipsychotic RX

Attachment E

Appendix S

Region 3 #2017000265

Colorado ACCESS

Caring for you and your health

Appendix S – 1915 (b)(3) Waiver (Alternative) Services Plan – Region 3

Service	Service Description	Availability (times)	Locations	Member Capacity	Special Populations (if any)
Vocational Services	MHCD Supported Employment	M-F	456 Bannock St. Denver	280	18 and older
Vocational Services	MHCD Supported Education	M-F	456 Bannock St. Denver	200	18 and older
Vocational Services	AllHealth Network	M-F 7:30am-7:00pm	5545 S. Prince St. Littleton and 821. S. Perry in Castle Rock	Variable	16 and older
Vocational Services	Aurora MHC Vocational Program	M-F	Provider's Resource Clearinghouse (PRC) 14500 E. 33rd Place	Variable	Any client desiring support with employment
Intensive Case Management	MHCD Service Coordination Team	M-F	Dahlia Campus for Health and Wellbeing, 3401 Eudora Denver, CO 80207	Variable	Birth to 17
Intensive Case Management	Aurora MHC Adult Intensive Services Team	M-F	791 Chambers Rd; 10782 E. Alameda Ave; 11059 E. Bethany Drive	Variable	18 and older
Intensive Case Management	Jefferson Center for Mental Health	M-F	Multiple Locations in Jefferson County	Variable	18 and older
Intensive Case Management	AllHealth Network	M-F 7:30am-7:00pm	6509 S. Santa Fe Drive and 5545 S. Prince St.	Variable	All ages
Intensive Case Management	Community Reach Center	M-F	Multiple Locations in Adams County	Variable	18 and older
Prevention/Early Intervention Activities	MHCD PEARL Team Early Childhood Prevention and Intervention Services	M-F	Dahlia Campus for Health and Wellbeing, 3401 Eudora Denver, CO 80207	150	Birth to 5
Prevention/Early Intervention Activities	Aurora MHC provides screening and consultation services in multiple locations with many different populations	M-F	Multiple locations	Not limited	All ages

Service	Service Description	Availability (times)	Locations	Member Capacity	Special Populations (if any)
Clubhouse and Drop-In Centers	MHCD Resource Drop-in Center	M-F	1075 Galapago St. Denver, CO	250	18 and older
Clubhouse and Drop-In Centers	CHARG Drop-In Center	M-Sa	920 Emerson St. Denver, CO	Not limited	18 and older
Clubhouse and Drop-In Centers	Community Connections run by Behavioral Healthcare Inc. (BHI)	M-F	12455 East Mississippi Ave. Suite 104 Aurora, CO	Not limited	18 and older
Clubhouse and Drop-In Centers	Rainbow Center run by Behavioral Healthcare Inc. (BHI)	M-F	690 W. 84th Ave. Thornton CO	Not Limited	18 and older
Clubhouse and Drop-In Centers	Center Point (AllHealth Network)	M-F 9am – 2pm is drop-in; 8am – 5pm is peer support	2200 W. Berry Ave. Littleton CO	Variable	18 and older. Peer support for families as well
Assertive Community Treatment	MHCD ACT Teams	24/7	Various Denver locations	551	18 and older
Assertive Community Treatment	AllHealth Network	7 days per week with evening coverage by our crisis response on-call team	5545 S Prince St. Littleton and community-based in Arapahoe and Douglas counties	Variable	18 and older
Recovery Services	MHCD Peer Support Services	7 day/week	456 Bannock St. Denver, CO	100	18 and older
Recovery Services	Aurora MHC	M-Sa	Several locations for adults and children/adolescents	Not limited	All ages
Recovery Services	AllHealth Network	M-F 7:30am -7:00pm	5545 S. Prince St. Littleton and 821 S Perry in Castle Rock and Community based	Not limited	15 and older
Recovery Services	Community Reach Center	M-F	Multiple locations	Not limited	All ages
Recovery Services	Jefferson Center for Mental Health	M-F, and evenings	Multiple locations	Not limited	All ages
Respite Services	Mount Saint Vincent Home	24/7	4159 Lowell Blvd. Denver, CO	2	Children ages 5 to 12
Residential	Denver Children's Home	24/7	150 Albion St. Denver, CO	4335	Child & adolescent

Service	Service Description	Availability (times)	Locations	Member Capacity	Special Populations (if any)
Residential	Griffith Centers for Children	24/7	Multiple Locations	47	Child & adolescent
Residential	Mount St Vincent Home	24/7	4159 Lowell Blvd. Denver	36	Children ages 5 to 12
Residential	Devereux Cleo Wallace	24/7	Multiple Locations	118	Child & adolescent
Residential	Savio House Inc.	24/7	325 King St. Denver, CO	27	Child & adolescent
Residential	Third Way Center Inc.	24/7	Multiple Locations	88	Child & adolescent
Residential	Excelsior Youth Center	24/7	15001 E. Oxford Ave. Aurora, CO	150	Child & adolescent
Residential	Shiloh Home Inc.	24/7	6400 W. Coal Mine Ave. Littleton, CO	74	Child & adolescent
Residential	Jefferson Hills	24/7	421 Zang St. Lakewood, CO	142	Child & adolescent
Residential	Remington House	24/7	729 Remington Ave. Ft Collins, CO	15	Child & adolescent
Residential	Tennyson Center for Children	24/7	2950 Tennyson St. Denver, CO	21	Child & adolescent
Residential	AuMHC Residential Facilities	24/7	Various locations	Varies by location, 16 beds is average	18 and older