Regional Accountable Entity for the Accountable Care Collaborative

Technical Proposal Solicitation # 2017000265

Colorado Department of Health Care Policy and Financing

Reunion Health

July 28, 2017

Reunion Health in Partnership with Rocky Mountain Health Plans

TECHNICAL PROPOSAL – REGION 1

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Executive Summary

The contact person for this proposal is Patrick Gordon, who may be reached at Patrick.Gordon@rmhp.org or 720-515-4129. The Rocky Mountain Health Maintenance Organization, Inc. CORE VSS number is VC00000000061230.

Rocky Mountain Health Plans (RMHP) is very pleased to submit this proposal to serve as the Regional Accountable Entity for Region 1 in Phase 2 of the Colorado Accountable Care Collaborative. RMHP is a Colorado-licensed Health Maintenance Organization, headquartered in Grand Junction. RMHP has participated in the Colorado Medicaid program continuously since our founding in 1974, and is currently serving as a Regional Care Collaborative Organization (RCCO) in Phase 1 of the ACC. In March 2017, RMHP partnered with UnitedHealthcare, a recognized leader in health services. UnitedHealthcare's support affords RMHP the technical and financial resources of a national enterprise, which will strengthen our mission in Colorado.

ACC Phase 2 is a natural fit for our community

The vision of whole person health and integrated, community-based leadership established by the Department for ACC Phase 2 is wholly consistent with the strategy that Rocky Mountain Health Plans has advanced for more than forty years. RMHP has worked continuously – well outside the traditional scope of a benefits administrator – to provide the investment, expertise, technology, quality improvement, data sharing, workforce development, practice transformation and payment innovations required to build community capacity for whole person health. RMHP has extensive experience and success with several complex, large-scale federal demonstrations and Cooperative Agreements in each of these areas, including the **Accountable Health Communities Model (AHCM)** test recently awarded to ACC Region 1 by the Centers for Medicare and Medicaid Services (CMS). RMHP is also honored to sponsor the successful, full-risk **Payment Reform Initiative for Medicaid enrollees (Prime)**. Authorized pursuant to Colorado House Bill 12-1281, RMHP Prime has exceeded all quality improvement and total cost targets, as documented in the most recent *Legislative Request for Information* published by the Department to the Colorado General Assembly. Our community wishes to continue and build upon Prime in Phase 2.

Reunion Health: An innovative approach with strong partners

To best achieve the vision of community integration and whole person health set forth by the Department. RMHP's proposal is submitted in partnership with **Reunion Health** – a comprehensive network of **Community Mental Health Centers** (CMHCs) and **Federally Qualified Health Centers** (FQHCs) operating throughout Region 1. These organizations, which are enumerated and profiled in Offeror's Response 2, have organized to create a new, integrated service delivery entity, Reunion Health. Reunion Health organizations form the backbone of the primary care and behavioral health delivery system for Medicaid beneficiaries in Region 1, in a diverse array of urban, rural and frontier communities. Reunion Health is uniquely positioned, by virtue of shared values, mission, skills and resources to develop a high-performing, open and adaptive network of services that is far greater than the sum of its parts.

RMHP and Reunion Health have adopted an innovative approach to integrate the complex array of services, expertise, systems, licensure and accreditation necessary to achieve the goals set by the Department for ACC Phase 2. Under this arrangement, RMHP will serve as the licensed, contracting organization that is the **single point of accountability** to the Department for all facets of RAE operations and deliverables. Reunion Health will collaborate with RMHP under a Joint Operating Agreement (JOA) to ensure the delivery system is optimally organized to produce whole person health. In developing our approach, we sought to address the following key objectives:

- Organize the entire RAE model around the goals needs of individual clients, as whole persons, with aspirations, dreams and contributions to offer the community.

- Establish the locus of leadership and decision-making firmly within a local, multi-disciplinary, multi-sector community governance model.

- Achieve the deepest possible degree of integration among health, behavioral and human service organizations – and ensure that resources and talent at every level are put to the most productive use possible.

- Make the significant expertise, experience, technology, research and development and capital investment available within a national enterprise available to local leaders, with the autonomy required to close gaps, learn and innovate rapidly.

- Establish clear, straight, lines of accountability to the Department that allow for the efficient fulfillment of all deliverables and public reporting duties, with an appropriate separation of controls, checks and balances.

- Move well beyond the traditional, narrow "BHO carve out" and "third party" managed care models of operation, in a framework that ensures competence and continuity without sacrificing access or transparency.

Achieving these objectives necessitates an approach that transcends old-fashioned "delegation" concepts in managed care, as well as narrow "ownership" arrangements among a group of self-interested parties. RMHP, Reunion Health and stakeholders throughout Region 1 have adopted a smarter, more progressive model that will produce better results.

INCLUSION, INTEGRATION, CHECKS AND BALANCES

Additionally, a broader array of providers and community leaders will be empowered to provide direction to the RAE through **a community governance process** – as is necessary to achieve success within Phase 2 of the ACC. In ACC Phase 2, RMHP and Reunion Health will integrate our significant organizational resources with the expertise of leading provider organizations and local leadership in an authentic community governance process. The JOA structure creates transparency and a decision-making framework that distributes broad authority to local leaders regarding care model and community integration processes. Consumers, county agencies, community service organizations and network providers as well as the broader Health Neighborhood will have both **a voice and a vote** regarding the direction and performance of the RAE.

Likewise, the JOA also creates a separation of duties and authority between provider organizations and the RAE, which will comply at all times with Member access, safety, quality improvement and all other federal and state beneficiary protections. RMHP is the single, ultimate point of accountability to the Department, and has the right to act unilaterally within the JOA structure when necessary to ensure that covered benefits are delivered timely and fairly – and that all other contractual obligations to the Department are fulfilled in a manner that exceeds program standards.

Within our RAE governance model, a **Directors Committee** is comprised of senior representatives from RHMP and Reunion Health, as well as community leaders appointed by each six (6) stakeholder Advisory Councils, described below:

- **Member and Family Advisory Council:** Consumers and supporting organizations, representing a diverse array of families, children, underserved communities and people living with disabilities and other special needs will participate on this council, to ensure that feedback is conveyed, priorities are set and design improvements are executed throughout the RAE enterprise, Network, Health Neighborhood and Community.

- **Community Leadership Council:** This group will include leaders from the Community Health Alliance movement, Local Public Health, LTSS and other organizations, and will work to so that RAE initiatives and operations are aligned with broader community integration and capacity building initiatives, such as the State Innovation Model Regional Health Connector (RHC) program and the CMS Accountable Health Communities Model (AHCM).

- **PCMP Council:** This group will include participants from private primary care practices throughout the region, representing multiple specialties and forms of organization including small independent, system-owned, large multispecialty and others.

- **Behavioral Health Independent Provider Council:** This group will include participants from independent, non-CMHC behavioral health providers and groups throughout the region.

- **Hospital and Specialty Care Transformation Council:** Hospitals and health systems will participate in this group, as well as specialists from multiple fields. This group will focus upon the design and implementation of transformation and quality improvement projects that expand access, capacity, safety and transitions management for Medicaid enrollees.

- **Performance Improvement Advisory Committee (PIAC):** This group will be convened in accordance with requirements set by the Department, and will participate actively in discussions within both the Directors Committee, as well as in the statewide PIAC convened by the Department.

The Directors Committee, as well as the corresponding stakeholder Advisory Councils that support it, will meet regularly and be responsible for decision-making regarding RAE Services in the following domains:

- Population health management plan

- Health and community neighborhood advisory structures and processes collaborations, contracts, and data sharing arrangements
- Integration of other federal, state or foundation grants and model tests awarded to the Partners, as necessary to promote the success of the RAE
- Consumer engagement, consumer network development, design, feedback and process improvement
- Review and approval of prioritized contract deliverables to the Department
- Annual performance plan, quality targets
- Annual report and other public reporting functions

The Directors Committee and Advisory Councils in each major domain of ACC participation will be convened and fully staffed by RAE Community Integration personnel, in order to support productive engagement and use of leadership time.

THE VOICE OF THE CONSUMER

To be effective, RAE Member engagement strategies must involve the communities where Members live, work and play, enlisting a variety of trusted partners. Our strategy adopts the Colorado Department of Public Health & Environment (CDHPE) Office of Health Equity's Community Engagement framework,[1] adapted from the Annie E. Casey Foundation:

- Value and prioritize lived experience and community voice
- Commit to full transparency and accountability
- Acknowledge that there are institutional, systemic and structural barriers that perpetuate inequity, which has silenced the voice of the community over time
- Commit to partnership in the co-creation and co-ownership of solutions

Our vision for Member engagement is shared leadership in all of our communities. Recognizing historical barriers to optimal health, we seek Members from a variety of cultural groups, abilities and disabilities, and from all levels, to participate in leadership roles.

POPULATION HEALTH – IN THREE DIMENSIONS

We recognize that effective population health management requires a detailed understanding of the distribution of **health conditions** and **health-related behaviors**, and is further strengthened by consideration of the **social determinants of health (SDoH).** Our population health management strategy incorporates the needs of the Member as a whole person – *at all life stages* – moving beyond traditional data sources and strategies that contemplate a Member's health simplistically as the sum of diagnoses, prescriptions, costs and utilization. The Partners' approach is grounded in Member goals and preferences, expressed through direct engagement and participation in care planning, as well as the judgment of front line clinicians and skilled human and community services personnel. **Social risk factors** are an equivalent, if not greater, driver in any process to address root causes of avoidable disease, disability and

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[1] http://www.chd.dphe.state.co.us/CHAPS/Documents/Health%20Equity%20Model%20and%20Summary.pdf

diminished quality of life. The Partners will incorporate social factors in our stratification plan and a **3D interventions logic model** to better achieve whole person health for our Members.

CARE COORDINATION - A SHARED VISION AND WORKSPACE

We prioritize the development of care coordination processes in primary care, behavioral health and community-based settings among multiple providers and at different levels of care, through defined, inter-organizational workflows. We facilitate the exchange of Member-centered data among providers and community service organizations in an inclusive network of care. Accordingly, RMHP and Reunion Health have adopted CommunityCare, a shared, rights- and roles-based care coordination platform, which will support identification and documentation of Member needs, task assignment and workflow efficiency among care coordination teams in multiple locations and settings. We are uniquely positioned to succeed within this program structure by virtue of several key differentiators:

- Strong local relationships and established, inter-organizational business processes
- An interdisciplinary model for care coordination, which is staffed by medical and behavioral health clinicians, as well as social workers and peers -- all of whom are well versed in connecting Members to community resources
- Superior technology, data sharing and data management resources
- A well-defined, transparent and participatory program governance model directly connected to our communities
- The leadership, intellectual and financial capital necessary to achieve the Department's vision for ACC 2.0

We do not conceive of care coordination and management functions merely as a "set of services" that the RAE will provide for Members, providers or the Department. Rather, these functions are designed and delivered in a manner that serves a transformative purpose within the community and in the lives of Members.

INTEGRATED, ACTIONABLE DATA

Whole person care and community integration are not possible without a comprehensive strategy for data exchange, management and analysis. Data from traditional payer and provider sources must be integrated and assimilated with data from a wider array of partners in order to create a 360-degree view of each Member as a complete person -- and better anticipate personal health, behavioral, social and functions needs in a timely manner. Specifically, community data from four key domains must be utilized to *predict*, *prioritize* and *prevent* unnecessary health risks, functional losses and expenditures. These are: **Administrative, Clinical, Social** and **Member-Reported** data sources. Moreover, in our capacity as the RAE, RMHP will continue to be was adept at *sharing* information as we are at *collecting* information.

Thank you

RMHP, Reunion Health and our partners throughout Region 1 congratulate the Department upon the creation of an authentic, community-based policy framework for Phase 2 of the ACC. We are proud to live and work in a State that is maximizing the value of Medicaid to improve the health of its citizens and the prosperity of their communities. We are honored to submit this proposal and appreciate serious consideration of our vision, values and differentiators.

W-9

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

**Request for Taxpayer
Identification Number and Certification**

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

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

Rocky Mountain Health Maintenance Organization, Inc.

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

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

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

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

2775 Crossroads Blvd.

6 City, state, and ZIP code

Grand Junction, CO 81506

Requester's name and address (optional)

7 List account number(s) here (optional)

Part I — Taxpayer Identification Number (TIN)

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

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

Social security number

or

Employer identification number

8 4 – 0 6 1 4 9 0 5

Part II — Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and

3. I am a U.S. citizen or other U.S. person (defined below); and

4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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

Sign Here Signature of U.S. person ▶ Date ▶ 6/23/17

General Instructions

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

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

Purpose of Form

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

• Form 1099-INT (interest earned or paid)

• Form 1099-DIV (dividends, including those from stocks or mutual funds)

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)

• Form 1099-S (proceeds from real estate transactions)

• Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

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

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

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X

Form **W-9** (Rev. 12-2014)

Technical Proposal

Section 4.0 Offeror's Experience

Offeror's Response 1

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

a. Offeror's legal name and address, number of years in business under this legal name, total number of employees, including contracted staff, and the organization's location(s), including any in Colorado.

b. Documentation of the Offeror's licensure required to perform the Work and verification that the licensure is not suspended, revoked, denied renewal or found to be noncompliant by the Colorado Division of Insurance. If the Offeror is not licensed as required by the Colorado Division of Insurance at the time the proposal is submitted, the Offeror shall attest that the appropriate licensure shall be obtained prior to executing a Contract with the Department.

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

A. **Legal Name:** Rocky Mountain Health Maintenance Organization, Inc.

Address: 2775 Crossroads Blvd.
Grand Junction, CO 81506

Number of years under this legal name: 43 years. (Note: Rocky Mountain Health Maintenance Organization was formed on July 6, 1971. However, a Certificate of Authority to operate as HMO was issued on June 24, 1974).

Total number of employees: includes community-based staff who report to regional office
- Grand Junction Corporate Office: 404
- Denver office: 44
- Total employees: 448

Locations:

2775 Crossroads Blvd.
Grand Junction, CO 81506

6251 Greenwood Plaza Blvd., Suite 300
Greenwood Village, CO 80111

B. See Attached Documents:
- Uniform Certificate of Authority Application, Certificate of Compliance issued by Colorado Division of Insurance
- Proof of active HMO status
- Certificate of Fact of Good Standing issued by Colorado Secretary of State

C. I hereby attest that Rocky Mountain Health Maintenance Organization meets the requirements of a Primary Care Case Management (PCCM) entity and a Prepaid Inpatient Health Plan (PIHP) as defined by the RFP and in 42 CFR § 438.2.

Patrick Gordon
Associate Vice President

UNIFORM CERTIFICATE OF AUTHORITY APPLICATION, CERTIFICATE OF COMPLIANCE ISSUED BY COLORADO DIVISION OF INSURANCE

COLORADO
Department of
Regulatory Agencies
Division of Insurance

Marguerite Salazar
Commissioner of Insurance

Uniform Certificate of Authority Application
CERTIFICATE OF COMPLIANCE

State of Colorado
Office of Commissioner

I, **Marguerite Salazar** hereby certify that I am the **Insurance Commissioner** of the State of Colorado and have supervision of insurance business in said State and as such I further certify that **Rocky Mountain Health Maintenance Organization** of the State of Colorado is duly organized under the laws of said State and is authorized to transact the business of **HMO Commercial, HMO Medicaid, HMO Medicare** in this State.

I further certify that the said **that Rocky Mountain Health Maintenance Organization** is possessed of admitted assets in the amount of **$158,041,849** dollars, and has paid-in capital of **$356,889.** dollars and is possessed of a surplus of admitted assets over all liabilities, reserves and capital of at least **$44,092,258** dollars, as shown by its quarterly statement submitted to this Department as of September 30, 2016.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my seal of office at the city and county of Denver, this 30th day of January, 2017.

Marguerite Salazar

[signature]

Commissioner of Insurance

1560 Broadway, Suite 850, Denver, CO 80202   P 303.894.7499 Toll Free 800.930.3745 F 303.894.7455
www.dora.colorado.gov/insurance

Proof of Active Health Maintenance Org Status

Compliance Express ™   https://www.sircon.com/ComplianceExpress/Inquiry/consumerInquiry.do

Company Consumer Inquiry for the State of Colorado

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Rocky Mountain Health Maintenance Organization, Incorporated
2775 Crossroads Blvd.
Grand Junction, CO 81506
Phone : 970-244-7867
Domicile State : Colorado NAIC ID : 95482 Status Date : 06-24-1974
Active Company Type(s) : Health Maintenance Org

Displaying 1 - 1 (of 1 matching records)   Page 1 of **1**

Revise Inquiry

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Certificate of Fact of Good Standing issued by Colorado Secretary of State

OFFICE OF THE SECRETARY OF STATE
OF THE STATE OF COLORADO

CERTIFICATE OF FACT OF GOOD STANDING

I, Wayne W. Williams, as the Secretary of State of the State of Colorado, hereby certify that, according to the records of this office,

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INCORPORATED

is a

Corporation

formed or registered on 07/06/1971 under the law of Colorado, has complied with all applicable requirements of this office, and is in good standing with this office. This entity has been assigned entity identification number 19871231951 .

This certificate reflects facts established or disclosed by documents delivered to this office on paper through 05/26/2017 that have been posted, and by documents delivered to this office electronically through 05/31/2017 @ 14:57:14 .

I have affixed hereto the Great Seal of the State of Colorado and duly generated, executed, and issued this official certificate at Denver, Colorado on 05/31/2017 @ 14:57:14 in accordance with applicable law. This certificate is assigned Confirmation Number 10269905 .

Wayne W. Williams

Secretary of State of the State of Colorado

End of Certificate
Notice. A certificate issued electronically from the Colorado Secretary of State's Web site is fully and immediately valid and effective. However, as an option, the issuance and validity of a certificate obtained electronically may be established by visiting the Validate a Certificate page of the Secretary of State's Web site, http://www.sos.state.co.us/biz/CertificateSearchCriteria.do entering the certificate's confirmation number displayed on the certificate, and following the instructions displayed. Confirming the issuance of a certificate is merely optional and is not necessary to the valid and effective issuance of a certificate. For more information, visit our Web site, http://www.sos.state.co.us/ click "Businesses, trademarks, trade names" and select "Frequently Asked Questions."

Offeror's Response 2

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

a. Managing projects of similar size and scope.

b. Serving Medicaid covered populations.

c. Administering managed care.

d. Managing financial risk for covered services.

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

INTRODUCTION

Rocky Mountain Health Plans (RMHP) is very pleased to submit this proposal to serve as the Regional Accountable Entity (RAE) for Region 1, in Phase 2 of the Colorado Accountable Care Collaborative (ACC). RMHP is a licensed Health Maintenance Organization, headquartered in Grand Junction, Colorado. RMHP has participated in the Colorado Medicaid program continuously since our founding in 1974, and is currently serving as a Regional Care Collaborative Organization (RCCO) in Phase 1 of the ACC. RMHP also provides comprehensive health benefit coverage and service delivery coordination to Coloradans enrolled in every category of health coverage – Medicare beneficiaries, employer groups, individuals who access insurance under the Affordable Care Act, and children eligible for the Child Health Plan Plus (CHP+) program. In March 2017, RMHP partnered with UnitedHealthcare, a recognized leader in health and well-being services. UnitedHealthcare's support affords RMHP the technical and financial resources of a national enterprise, which will enable us to sustain and strengthen our mission in Colorado.

RMHP works continuously – well outside the traditional scope of a benefits administrator – to provide the investment, expertise, technology, quality improvement, data sharing, workforce development, practice transformation, multi-payer alignment and payment innovations required to build community capacity. RMHP has also successfully executed several complex, large-scale federal demonstrations and Cooperative Agreements in each of these areas. Most recently we were awarded the *Accountable Health Communities Model* (AHCM) by the federal Centers for Medicaid and Medicare Services (CMS), one of 30 health systems selected from throughout the United States. Finally, RMHP supports the successful, full-risk Medicaid Payment Reform Initiative for Medicaid enrollees ("Prime") in ACC Region 1. Authorized pursuant to Colorado House Bill 12-1281, RMHP Prime has exceeded all quality improvement and total cost targets, as documented in the most recent *Legislative Request for Information* published to the Colorado General Assembly.

In order to best achieve the vision of community integration and whole person health set forth in in the Department of Health Care Policy and Financing's (Department) Request for Proposals (RFP), RMHP's proposal is submitted in partnership with a comprehensive network of Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) operating throughout Region 1. These organizations, which are enumerated and profiled below, have

organized to create a new, integrated service delivery entity, **Reunion Health**. Reunion members form the backbone of the primary care and behavioral health delivery system for Medicaid beneficiaries in Region 1, in a diverse array of urban, rural and frontier communities. Reunion Health organizations recognize that they are uniquely positioned, by virtue of the values, mission, skills and resources they share, to develop a higher-performing, open and adaptive network of critical services that is far greater than the sum of its parts.

Reunion Health members also recognize that working well beyond their walls and traditional operating models in an open, inclusive structure with RMHP, other clinicians in the Health Neighborhood, local service providers and consumer-support organizations in the ACC Community will create the capacity required to meet the diverse needs of Medicaid beneficiaries. *A new generation of leaders* within the Reunion Health network possesses the energy and progressive mindset necessary to confront the challenging health equity and population trends present in Region 1 as well as the limitations and gaps present in current health care, behavioral health and human service program models. Reunion Health has embraced uncomfortable changes – moving away from old "carve out" and "zero sum game" budgetary controls – toward an open, community-focused framework that will produce better health access, well-being and a brighter future for people in Colorado.

Reunion Health and RMHP (hereinafter referred to as "the Partners"), which operate as separate corporate entities, will implement a Joint Operating Agreement ("JOA" -- discussed later in the RFP response) to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals. Likewise, a clear structure for community-based decision-making, transparent operational and financial processes and a separation of duties and controls will be established for all RAE functions, permitting RMHP to efficiently fulfill its role as the single point of organizational accountability to the Department for all aspects of ACC Phase 2.

> *"**RMHP is a community partner in all senses of the word**. Throughout their region, just the mention of their name brings credibility. They have earned a very high degree of respect throughout the Western Slope, including Southwest Colorado and in Larimer County. They have this respect because they are an excellent community partner and they listen to others rather than dictate. They are members of their communities, not interlopers or temporary guests. **Their deep roots give them an investment in their communities that are unparalleled.** RMHP excels at bringing people together, and they have been able to do this in effective ways with decades of experience. They know how to get the right people to the right tables and are always eager to be a leader or participant (whichever is appropriate) in an effort to solve problems."*
>
> *--Julie Reiskin, Executive Director of the Colorado Cross-Disability Coalition*

ORGANIZATIONAL AND ADMINISTRATIVE APPROACH

A Powerful Partnership of Local Physical and Behavioral Health Leaders

The Partners will use our time-tested organizational experience as well as a "best and brightest" pool of talent to make the Region 1 RAE successful. We are excited about the opportunity to create an authentic, whole person network of support for Medicaid Members as we deliver physical and behavioral health services as one accountable system of care. Reunion Health members include:

- *SummitStone Health Partners:* SummitStone Health Partners (SummitStone) has provided unsurpassed behavioral health prevention, intervention and treatment services in Larimer County for 60 years. Its vision is to create a healthy, vibrant community built on active consumer involvement, enduring partnerships and a fundamental commitment to wellness that transforms lives through recovery, renewal and respect. SummitStone offers the most extensive network of comprehensive behavioral and mental health care in Northern Colorado, providing evidence-based treatment to the more than 10,000 individuals each year.

- *Uncompahgre Medical Center:* As a Frontier Clinic, Uncompahgre Medical Center (Uncompahgre) is committed to providing quality, cost-effective, accessible health care to all in the San Miguel River Basin. Uncompahgre is a nonprofit, independent medical center managed by a community board of directors, which means that the community makes the decisions regarding services. Uncompahgre has been serving Coloradans since 1979, when it received designation as an FQHC.

- *Mountain Family Health Centers:* Mountain Family Health Centers (MFHC) is the primary care, dental and behavioral health provider to more than 13,000 rural residents living in or near the Colorado Rockies. With five sites spread over 150 miles, MFHC providers, care teams and support staff are dedicated to delivering high-quality care, as evidenced by National Committee for Quality Assurance Level 3 Patient-Centered-Medical-Home recognition and state-of-the-art health information technology. MFHC is located in Avon, Basalt, Edwards, Glenwood Springs and Rifle, Colorado. Each Community Health Center (CHC) is as unique as the town in which it is located, but shares the same mission to provide high-quality, integrated primary medical, behavioral and dental health care in the communities it serves, with special consideration for the medically underserved, regardless of ability to pay.

- *Northwest Colorado Health:* Established in 1964, Northwest Colorado Health (formerly Northwest Colorado Visiting Nurse Association) began as a home health and public health agency in Routt and Moffat counties. Its mission is to improve quality of life for all Northwest Colorado residents by providing comprehensive health resources and creating an environment that supports community wellness. Its services include primary care at CHCs in Steamboat Springs and Craig, a wide range of Public Health programs in Routt, Moffat and Jackson counties and home health and hospice services in Routt, Moffat and Grand counties. In addition to the CHCs, Northwest Colorado Health operates the Haven Assisted Living Facility and Community Center in Hayden and the Rollingstone Respite House in Steamboat Springs.

- ***River Valley Family Health Center:*** The mission of River Valley Family Health Center (River Valley) located in Olathe, Colorado, is to provide access to quality integrated health care in a comprehensive and culturally respectful manner to individuals and families. To be responsive to community needs, River Valley has partnered with the Women, Infants and Children (WIC) program and the Center for Mental Health to provide services on-site. River Valley is an Outreach and Enrollment site, assisting patients with applying for Medicaid and insurance on Connect for Health.

- ***The Center for Mental Health:*** The Center for Mental Health was established in 1964 by a group of individuals with a vision to provide mental health services in rural Western Colorado. The Center has grown to more than 130 staff members providing services through seven offices and eight outreach locations to people in Delta, Gunnison, Hinsdale, Montrose, Ouray and San Miguel counties.

- ***MindSprings Health:*** Incorporated in 1972, Mind Springs Health (MindSprings) provides the full array of behavioral health services, including mental health services and substance-use disorder services, to all ages in a variety of settings. Its mission is to rebuild lives and inspire hope by providing exceptional mental health and addiction recovery care in the community. MindSprings has 14 clinics across 10 counties - Mesa, Garfield, Eagle, Pitkin, Summit, Grand, Routt, Jackson, Moffat and Rio Blanco counties. MindSprings is embedded in or has relationships with primary care clinics, CHCs, FQHCs and school-based health centers. In addition, community-based organizations make crisis referrals to MindSprings, which in turn makes post-crisis referrals to the community groups for follow-up. MindSprings currently operates five detox facilities across the Western Slope. It has provided Coloradans with behavioral health crisis services for decades.

- ***Marillac Clinic:*** The mission of the Marillac Clinic (Marillac) is to provide compassionate, innovative and essential health care to underserved Coloradans. Marillac provides a wide scope of primary health care services to all Mesa County residents regardless of income or insurance status. Marillac is the safety net health clinic for the low-income population and is currently pursuing FQHC designation to further increase capacity for primary care services and to reinforce its service delivery and infrastructure to meet the growing needs of the communities it serves.

- ***Summit Community Care Clinic:*** The mission of the Summit Community Care Clinic (SCCC) is to provide exceptional, integrated patient-centered health services designed to meet the needs of all patients, particularly those who experience barriers to accessing care, regardless of their ability to pay. Summit County Public Health established SCCC in 1993 as a one-night-a-week walk-in clinic staffed entirely by volunteers. In 2013, SCCC received its FQHC Look-Alike status and became a full FQHC in 2015. Over time its services have grown to include medical, reproductive health, oral health, counseling, physical therapy and group preventative health services.

- ***Salud Family Health Centers:*** Since 1970, Salud has been firmly committed to providing care to all community members regardless of finances, insurance coverage or ability to pay. Salud offers a sliding-fee scale based on family size and income. Insurance

enrollment assistance is available. Salud is a Health Center Program grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n). Today, Salud operates 13 clinics in nine communities throughout Northern Colorado and serves more than 74,000 patients annually.

- *Dove Creek Community Health Clinic:* The Dove Creek Community Health Clinic (Dove Creek) and Community Dental Clinic in Dove Creek, Colorado, offers health and dental care for Dolores County and the surrounding region. Dove Creek opened in 1975 and through the support of its parent organization, Dolores County Health Association, continued to increase capacity to support community need for specialty care, Dolores County Health Nursing Services and Dove Creek. Dove Creek is an FQHC.

- *Sunrise Community Health Clinic:* Sunrise Community Health Clinic provides medical, dental, behavioral health, laboratory, radiology, pharmacy, care management and health education. Sunrise has 10 clinics in Weld and Larimer counties, providing care to nearly 35,000 patients through nearly 143,000 visits in 2015. Sunrise is an FQHC.

UNIQUE CHARACTERISTICS OF OUR PARTNERSHIP

The Partners are uniquely qualified and positioned to advance the Department's goals for the next iteration of the ACC, which is to improve Member health and life outcomes and to use state resources wisely. Our qualifications include:

- RMHP's position as a respected payer, a collaborative partner and leader, and a nationally recognized Practice Transformation Organization (PTO)

- Commitment by all Partners, which includes RMHP, nine FQHCs and three CMHCs within Region 1, to take accountability for health, cost and patient outcomes in our communities -- and to change how we work together to improve the success of our mission

- Commitment to work beyond our core partnership and include a complete network of physician and hospital providers, long-term services and support (LTSS) entities, community service organizations, public health and human service agencies and civic leaders in the decision-making and strategic direction of the RAE

- Commitment to create clear communication channels with people served by the RAE, to openly listen and respond to concerns with integrity and to continuously expand and strengthen our connections with diverse, cultural networks of consumers throughout Region 1

- Commitment to integrate physical and behavioral health under **one accountable entity** to achieve our vision to create **an integrated community** that empowers patients to take charge of their health. Essential aspects of our skills and experience that support this vision and that are described in this response include:
  - Social determinants of health
  - Primary care and alternative payment models
  - Behavioral health integration and innovation
  - Technology and clinical quality improvement

- Specialty care, access and clinical practice transformation

Our time-tested organizational experience and skills enable us to fulfill the duties of the RAE efficiently while meeting the Department's requirements and deadlines, as described in our response.

ORGANIZATIONAL EXPERIENCE AND SKILLS

RMHP is currently the designated Western Colorado (Region 1) RCCO for the first phase of the Department's ACC, with more than 130,000 Members. As the RCCO, RMHP is responsible for the delivery and coordination of physical health care services spanning the continuum of care. RMHP has demonstrated our ability to build and manage a provider network and monitor and coordinate efficiently with all state and federal programs, including the State Innovation Model (SIM) initiative, the Comprehensive Primary Care Plus (CPC+) payment and Accountable Health Communities model, the No Wrong Door grant, long-term services and supports system, Crisis response and intervention system, the Community Health Alliance movement and local public health agency initiatives. In establishing and supporting community-based care teams, RMHP has developed strong relationships with local leaders and organizations. Within the ACC, RMHP has acted as a supportive convener and focused on merging the silos within the health care system. Thus, RMHP is ideally situated to support the next phase of the ACC, along with the Department's goals to improve Member health and life outcomes and to use state resources wisely.

RMHP was awarded authority to implement Colorado's first Medicaid Payment Reform pilot, pursuant to HB 12-1281. In September 2014, **RMHP Prime**, a full-risk comprehensive physical health payment reform initiative, began operating in six counties on the Western Slope. The simple goal of the program is to improve the health of individuals and the community while reducing costs and increasing patient activation. Our community-based approach brings together payment reform, population health management systems and whole person care. During calendar year 2016 RMHP Prime served **approximately 45,000 unique individuals with Medicaid coverage, including adults in the expansion categories, people with disabilities and dual Medicaid/Medicare eligibility** and **children with special health care needs.** RMHP, partnering with providers and community agencies, has met total cost and quality targets established by the Department two consecutive years in a row – State Fiscal Year 2014-15 and 2015-16.

During our 40-year relationship with Colorado Medicaid, RMHP has provided quality-improvement resources, care coordination, disease-state management services and customer service, working with our large statewide network of providers to deliver comprehensive health care services, spanning both the inpatient and outpatient continuum of care.

Local Impact, National Resources

Within Phase 2 of the ACC, RMHP will adhere to the same principles we have long followed, **empowering local leaders to make decisions** in the best interests of the communities they serve, while providing technical and financial support in a manner that makes a difference in their success. In this phase of the ACC, our mission will be augmented with the backing and **national resources** of UnitedHealthcare, which will afford RMHP, Reunion Health and our

community partners throughout Region 1 with significantly greater opportunity to deploy and scale critical differentiators that are essential to whole person, community-connected care.

Nationwide, UnitedHealthcare has more than **35 years** of Medicaid experience and serves more than **6.3 million** low-income beneficiaries and Members with complex needs, including:

- Managing health care benefits for beneficiaries in more than 81 active contracts in 26 states

- Supporting Medicaid and Medicare dually eligible individuals in CMS Special Needs Plans in 18 states and the District of Columbia

- Extensive services and supports for elderly beneficiaries and individuals with disabilities members in 21 markets

This broad national presence strengthens our ability to bring innovations to Colorado that improve the ability of Health First Colorado Members to direct their own care, while creating access to individually tailored, high-quality health care and behavioral health services.

Below are descriptions of our skills and experience pertaining to managing projects of similar size and scope, serving Medicaid-covered populations, administering managed care and managing financial risk for covered services, including our experience in Rural and Frontier areas.

A. MANAGING PROJECTS OF SIMILAR SIZE AND SCOPE
Our Successful Track Record in Efforts to Advance Whole person Care
RMHP has performed major project work in every domain of the Department's statewide strategy. We have successfully led multiple, large-scale, federal Cooperative Agreements, as well as several other demonstrations, initiatives and evaluation programs at the community and state level in our efforts to accelerate all facets of system transformation and whole person care. The following projects demonstrate our experience with social determinants of health, including community collaborations and partnerships, primary care and alternative payment models, behavioral health integration, specialty care and access, and technology and clinical quality improvement.

SOCIAL DETERMINANTS OF HEALTH
Accountable Health Communities Model
Demonstrating a Powerful Rural Network Model to Improve Health Equity
The Western Colorado community with RMHP as lead applicant was recently awarded funding for the Centers for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid Innovation (CMS Innovation Center) Accountable Health Communities Model (AHCM) opportunity. The AHCM initiative focuses on maximizing community systems integration and referral processes and measuring processes around those services. It relies on the "social bundles" concept of systematically addressing social determinants of health (SDoH) with the ultimate goal of advancing health equity. The process of implementing AHCM further prepared RMHP for the Health Neighborhood and Community components of this proposal. We received more than 111 memorandums of understanding (MOUs) from both community service and

clinical care providers who are eager to work together. RMHP has established a steering committee and regional leadership structure to support this initiative in Region 1.

Colorado Opportunity Framework

Using Evidence-Based Interventions to Remove Road Blocks to Economic Self-Sufficiency

RMHP is currently collaborating with the Department to implement the Colorado Opportunity Framework. The focus of this work is to create a structure within the ACC that incorporates the social determinants of health into the current delivery system and creates a model that can be sustained over time. Through the Colorado Opportunity Framework, we have implemented a number of projects, including **Evidence-Based Program (EPB) Integration in La Plata and Montezuma Counties**. These projects are designed to systematically increase enrollment and utilization of evidence-based programs, including Supplemental Nutrition Assistance Program (SNAP); Women, Infants and Children (WIC); Nurse-Family Partnership (NFP); Temporary Assistance to Needy Families (TANF); Earned Income Tax Credit (EITC); and other social-determinant resources by expanding partnerships, sharing technology and coordination information and increasing community knowledge of the eligibility and enrollment criteria. In both counties, we have improved "systemness" to identify, outreach, refer and coordinate services for Members who can benefit from EBP resources.

Moms and Babies - Pregnancy and Post-Partum Outreach and B-4 Babies

Another Colorado Opportunity Framework project is our collaboration with **The Piñon Project**, which is the largest Family Resource Center in Colorado. The Piñon Project has committed to piloting an enhanced B-4 Babies model (which focuses on providing every new mother in the community with timely prenatal care) using Medicaid claims data. They have entered into an agreement with RMHP to capture outcomes data on the population. The Piñon Project is incorporating this model into its existing *Parents as Teachers* and *Incredible Years* programming to offer expecting and new mothers added support. The Piñon Project is also providing developmental screenings and additional referrals to community resources to support mothers and babies, including behavioral health referrals to address issues of maternal depression. With RMHP's assistance as RCCO, The Piñon Project is also working to identify and assess all pre- and post-natal women in Montezuma County who are enrolled in Medicaid and connect them to both evidence-based programs and other social-determinant related resources.

COMMUNITY CONVENING AND CARE COORDINATION

Accountable Care Collaborative Phase 1

As the RCCO for Western Colorado and Larimer County in Phase 1 of the ACC, RMHP has established and supported transdisciplinary **community-based care teams (CCTs)** that build on and enhance each community's leadership culture, strengths and resources to support care coordination. CCTs serve as the local experts and as capacity builders for the local Primary Care Medical Providers (PCMPs), hospitals and behavioral health providers by acting as practice extenders, supporting individuals with complex medical, behavioral and social needs. We have consistently achieved improvement on the program's Key Performance Indicators (KPIs) within our RCCO region and have excellent rankings, in absolute, risk-normalized terms, relative to statewide performance. RMHP is consistently rated first or second among all RCCO regions for postpartum care rates, emergency room utilization, 30-day readmissions and total cost of care.

All these achievements are highly influenced by the CCTs, which focus on care transitions across the medical, behavioral and social service needs a Member may have post-hospitalization and post-delivery. A lower cost of care is reflective of the Member getting the right care in the right place and at the right time, rather than utilizing higher-level services for an unmanaged condition.

Within the ACC, RMHP has worked to build bridges and close gaps within community services to improve integration and communication across systems. We have developed strong partnerships with PCMPs, CMHCs, Hospitals, Local Public Health Agencies (LPHAs), LTSS providers, Independent Living Centers and other community based organizations as we work collaboratively to more effectively serve the needs of the Medicaid population. The RAE framework established by the Department for Phase 2 of the ACC will be a very *natural evolution* of the groundwork we have laid in Phase 1 of the ACC.

PRIMARY CARE AND ALTERNATIVE PAYMENT MODELS

RMHP is uniquely positioned, as a major payer in every market and as a contracted PTO, to align with and support the Department's Alternative Payment Model (APM) strategy. RMHP works closely with provider organizations to provide workforce development, data, coaching support and other resources to make APM concepts clear and actionable, so that providers have the knowledge to be successful with comprehensive, community-connected care.

Comprehensive Primary Care Initiative and Comprehensive Primary Care Plus
Aligned Payer and Practice Transformation Organization for Payment Reform Initiative to Strengthen Primary Care

The Comprehensive Primary Care Initiative (CPCi) was offered through the federal CMS Innovation Center as a four-year multi-payer payment reform initiative designed to strengthen primary care. The four-year initiative ended in December 2016 and was succeeded by the Comprehensive Primary Care Plus (CPC+) program. CPC+ is offered through the CMS Innovation Center as a five-year multi-payer initiative designed after the CPCi program to strengthen primary care. This major, statewide initiative includes over 200 Colorado primary care Practice Sites, and commenced January 1, 2017.

RMHP is uniquely positioned to support the Department's effort to bring CPC+ APM models into alignment with the ACC. RMHP's role in CPC+ encompasses both practice transformation work and participation as an aligned payer, with APM agreements for PCMPs across all categories of coverage – Medicare, ACA Exchange and commercial groups as well as RMHP Prime for Medicaid enrollees. RMHP's practice transformation team provides technical assistance and learning collaborative support under a formal CMS subcontract to 33 PCMP sites in Region 1.

BEHAVIORAL HEALTH INTEGRATION
RMHP Prime
A Community-based Approach to Payment Reform and Improved Health Outcomes

RMHP Prime is a comprehensive, full-risk managed care program with an enhanced focus on integrating behavioral and physical health services. This initiative is Colorado's first Medicaid Payment Reform pilot, authorized pursuant to HB 12-1281. In September 2014, RMHP Prime

began operating in six counties on the Western Slope. Currently, approximately 38,000 people with Medicaid coverage are enrolled in Prime, including adults who qualify for Medicaid based on income, adults and children who have Medicaid because of their disability status, and individuals with Medicare and full Medicaid benefits.

The experience of the Partners working together within RMHP Prime is especially applicable to the work of the RAE. An Executive Committee, which includes community leaders representing PCMPs, CMHCs, hospitals, local public health, health information exchanges, consumers and a community- based organization, provides direction and transparent accountability regarding local, state and national policy objectives. Within RMHP Prime, payment, population health management and whole person care activities are aligned to promote improved physical and behavioral health outcomes. CMHCs receive significant shared savings, alongside PCMPs, when defined objectives are jointly achieved. For example, RMHP worked with Prime participating CMHCs and PCMPs to fund behavioral health training for community health workers (CHWs). These CHWs reach out to individuals who visit emergency departments frequently to better meet their health and social needs beyond the clinical care an emergency department can provide. Our successful experience with Prime, a full-risk agreement with operational integration across both PCMP and CMHC domains, has afforded RMHP valuable insights as the Department moves toward a comprehensive, value-driven payment model for Medicaid programs and services.

Colorado State Innovation Model
Aligned Payer and Practice Transformation Organization for Integrated Care Model
Colorado's SIM initiative is designed to facilitate a statewide evolution from the fragmented care to comprehensive systems that promote behavioral health integration. Similar to CPC+, RMHP participates in two ways in SIM: as an aligned payer and as a skilled Practice Transformation Organization.

- RMHP has an MOU with the SIM Office to serve as a PTO. Currently, 17 SIM Cohort 1 primary care practices are receiving support from RMHP practice transformation staff.

- RMHP also has an MOU with the SIM Office as a payer, participating in its payment reform, consumer and community-engagement activities.

SPECIALTY CARE AND ACCESS
Transforming Clinical Practice Initiative
Preparing Clinicians to be Successful with New Models of Value-based Payment Reform
The primary goal of the Transforming Clinical Practice Initiative (TCPi) is to prepare clinicians to be successful with models of value-based payment reform that require new models of care delivery, effective care coordination and demonstrated value of care. We believe this initiative is important because it includes specialists in addition to primary care practitioners. Cohort 1 began in the fall of 2016, and 29 practices are currently participating with RMHP.

In TCPi, RMHP serves as a PTO, operating under an agreement with the SIM Office and University of Colorado to develop and deliver content for the specialty practice transformation learning curriculum. This work is important to the ACC as it builds competencies in specialty practice settings to improve primary care and specialist communication, coordination and co-

management of shared patients. RMHP's specialty practice *Foundations* program enables providers to develop the competencies necessary to support critical ACC Phase 2 objectives, such as the adoption of the Colorado Medical Society's *Care Compact* model, implementation of expanded electronic consultation (e-consult) and telehealth modalities and interdisciplinary learning diffusion models such as Project ECHO.

TECHNOLOGY AND CLINICAL QUALITY IMPROVEMENT

HHS/ONC Beacon Community

Translating Investments in Health IT to Measurable Improvements in Cost, Quality and Population Health

In May 2010, a consortium made up of RMHP, the health information exchange Quality Health Network (QHN), an independent physician practice association, a hospital, and a coalition of Western Colorado businesses was awarded the prestigious Beacon Communities Cooperative Agreement Grant from the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (HHS/ONC). This project served seven predominantly Rural and Frontier counties in Western Colorado, and offered an opportunity for HHS/ONC and community participants alike to learn how to accelerate health information technology adoption and interoperability across practice sites in widely dispersed communities.

This Cooperative Agreement built on the prior efforts of RMHP and our community partners to accelerate data use and quality improvement competencies widely throughout RMHP's PCMP and Hospital Network. We achieved all technology adoption and quality improvement objectives set by ONC in the Cooperative Agreement. By the end of the program, more than 30 of the practice sites involved had advanced to sophisticated milestones in care management and population health. Nine of the Beacon practices went on to participate in CPCi.

Additionally, the Colorado Beacon Consortium demonstrated the power of a community governance model in driving system-wide transformation. "The CBC's experience demonstrates the critical role of a 'macro integrator' that can bring stakeholders together for delivery system transformation in a community or region. RMHP collaborated with Quality Health Network (a health information exchange organization) and several other sponsors to fulfill this role. RMHP "demonstrated extraordinary leadership by facilitating and promoting conversation" among stakeholders to "figure out how all the pieces fit together" for system transformation in the region, said Sue Williamson, portfolio director for health care at the Colorado Health Foundation.[2]

B. SERVING MEDICAID COVERED POPULATIONS

Colorado Experience

In the initial year of operations, RMHP contracted with the State of Colorado's Department of Social Services to enroll Medicaid clients. In 1975, RMHP first began serving Medicaid Members in Mesa County, and has continued to support Department initiatives ever since that time. During our 40-year relationship with Colorado Medicaid, RMHP has provided quality-improvement resources, care coordination and customer service, working with our large

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[2] McCarthy, D. & Cohen, A. The Colorado Beacon Consortium: Strengthening the Capacity for Health Care Delivery Transformation in Rural Communities. The Commonwealth Fund, April 2013.

network of providers to deliver comprehensive health care services spanning both the inpatient and outpatient continuum of care. Currently, the RMHP Prime and the ACC population in Region 1 include more than 160,000 Health First Colorado Members. During 2016, RMHP served more than 213,000 unique individuals with Health First Colorado coverage.

Reunion Health organizations are all Essential Community Providers, and possess tremendous experience, resources and skills in the delivery of Medicaid-covered services. Reunion Health's current Medicaid population statistics are as follows:

Reunion Health Organization	Number of Colorado Medicaid Individuals Served Annually[3]
Dove Creek Community Health Clinic	581
Marillac Clinic	9,465
Mind Springs Health	12,413
Mountain Family Health Centers	5,981
Northwest Colorado Health	1,466
River Valley Family Health Center	1,494
Salud Family Health Centers	39,977
SummitStone Health Partners	6,500
Summit Community Care Clinic	1,823
The Center for Mental Health	6,180
Uncompahgre Medical Center	640

National Experience

As indicated earlier, UnitedHealthcare has more than 35 years of national experience implementing Medicaid programs in rural, frontier and urban settings, providing managed care services to more than 6.3 million low-income beneficiaries and Members with complex needs in 26 states plus the District of Columbia. As part of UnitedHealthcare, RMHP can draw upon the knowledge, experience and evolving best practices from clinical, operational and cost-containment efforts from several other states.

C. ADMINISTERING MANAGED CARE

Colorado Experience

As noted earlier in this section, RMHP has administered managed care as a licensed Colorado HMO since it was formed in 1974, operating multiple managed care lines of business, including commercial, exchange, CHP+ (1998 - present), Medicare (1977 - present) and RMHP Prime (2014 - present). For non-Medicaid lines of business, RMHP is responsible for all covered services, including physical and behavioral health care services, under a capitated managed care model. RMHP Prime operates as a Medicaid managed care plan, administering physical health care services under a global payment model with shared savings for physical and behavioral health care providers.

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[3] Source: UDS Reports, Electronic Health Records, Department rate setting and claims data

National Experience

In addition to our extensive Colorado experience, RMHP and Reunion Health will leverage the national Medicaid managed care experience of UnitedHealthcare. The company has agreements in several states and markets, and deep experience supporting state Medicaid programs with varying degrees of behavioral health and physical health integration, pursuant to the vision and direction of each state partner. This includes programs from more traditional behavioral health carve-out models to fully integrated plans as described below.

- Fully integrated health plans responsible for members' physical and behavioral health and social determinant needs, where whole person health is addressed through aligned functional areas, processes and platforms (10 states serving 3.26 million members)
- A model that coordinates access to acute behavioral health services and delivers less intensive behavioral health services and supports within the plan (one state)
- Traditional behavioral health "carve-out" models (four states serving 1.2 million members)
- Traditional capitated managed care models, including physical health and behavioral health services, with some levels of integration including quality, grievances and appeals, clinical, claims and call center operations (22 states serving 4.3 million members)

D. MANAGING FINANCIAL RISK FOR COVERED SERVICES

Colorado Experience

RMHP has been responsible for managing financial risk for covered services since its inception for Medicaid, commercial and Medicare lines of business. RMHP is responsible for managing financial risk for behavioral health services for CHP+, commercial plans and our Medicare Cost plan. We have successfully managed full-risk benefit and service-delivery arrangements for over four decades, providing service in every market segment and coverage category. In addition to successful RMHP Prime and CHP+ risk arrangements, we have decades of experience serving Medicare, commercial groups, Individual markets and self-funded employers. For the purpose of the RAE agreement, we will use RMHP's HMO license, which has been effective in Colorado since 1974. In ACC Phase 2, RMHP will leverage the extensive experience of the CMHC partners in Reunion Health, along with the national experience of UnitedHealthcare, to deliver a superior Capitated Behavioral Health Benefit product within the integrated RAE scope of services.

National Experience

The Partners are supported with the financial strength of UnitedHealthcare. UnitedHealth Group ranked sixth on Fortune magazine's 2017 list of the top 500 companies in the United States, with revenues of more than $184 billion. Additionally, UnitedHealth Group is the top-ranking company in the insurance and managed care sector on Fortune's 2017 "World's Most Admired Companies" list. This is the seventh straight year UnitedHealth Group ranked No. 1 overall in its sector.

EXPERIENCE DELIVERING MEDICAID BENEFITS IN RURAL/ FRONTIER AREAS

The Partners have a long history of delivering Medicaid benefits in Rural and Frontier areas, in addition to major population centers. As described earlier in this section, the Partners are based in Rural and Frontier communities throughout Region 1. Our leadership team lives and works in the communities we serve. The first-hand experience of our neighbors, friends and family members has a direct impact on how we design supports for providers, Members and stakeholders throughout the Health Neighborhood.

Transportation is a challenge in Rural and Frontier areas. The Partners have incorporated transportation solutions into current ACC activities, such as local partnerships to deploy leased vehicles to Health Engagement Teams. As the RAE, we are offering additional value-added services to further address the challenges with transportation, including a Mobility Manager, transportation community grant/funding, and a Prius leasing program.

Access to care and sustainable capacity is also a challenge. Limited provider resources and large geographic expanses necessitate creativity and innovation in the delivery of Medicaid covered services. Team-based care is essential in this environment, so everyone in the practice is working as efficiently and comprehensively as possible to meet Member needs. We also invest heavily in technology, such as health information exchange, telehealth and care coordination solutions to expand provider capacity and extend services in locations where convenient physical access is not possible. As the RAE, we will expand these successful initiatives to further impact access and capacity in Rural and Frontier areas.

Offeror's Response 3

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

a.   The name and location(s) of each project;

b.   The population(s) served and number of covered lives;

c.   Whether the population served was Medicaid, Non-Medicaid or a combination;

d.   The primary health care services included in the project;

e.   Level of managed care and financial risk;

f.   Activities in Rural and Frontier areas, if appropriate;

g.   Any corrective action plans relating to contract non-compliance and/or deficient contract performance;

h.   Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;

i.   A Project Contract Manager with contact information

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

Rocky Mountain Health Plans (RMHP) as the Offeror and the single point of accountability for the performance of the Regional Accountable Entity (RAE), along with our partners in Reunion Health, have extensive, proven experience providing and arranging for the delivery and coordination of comprehensive physical and behavioral health services. Our experience is documented in the following tables.

For purposes of responding to this question, we have assumed that corrective action plans prepared in response to routine Site Reviews conducted by an external quality review organization (EQRO), which are publicly available on the Department's website, are not applicable.

PROJECT 1: COMMUNITY HEALTH WORKER HEALTH ENGAGEMENT TEAM
Accountable Care Collaborative (ACC)/Regional Care Collaborative Organization (RCCO)

Summary and Community Behavioral health care

As RCCO for Region 1, RMHP is responsible for providing care coordination services and is accountable for reducing potentially preventable Emergency Room (ER) visits. RMHP and its community partners reached out to the individuals who were accessing the ER at a much higher rate than others to understand their needs. Although the visits were for physical health diagnoses, many of the individuals had serious and persistent mental illness or substance use, and several had additional unmet social factors (e.g., homelessness) that affected their health care status.

To address this problem, RMHP partnered with Community Mental Health Centers to develop a targeted Community Health Worker initiative, in tandem with team-based supports

in advanced PCMP sites. Resources from RMHP, the CMHCs and PCMPS were integrated to create Health Engagement Teams. These teams include peers and skilled behavioral health providers employed by the CMHC, and provide direct interventions such as assessment, screening, health coaching, patient activation measurement and targeted intensive care management. PCMPs have benefited greatly from the HET resource, and expanded access to include additional "complex" and "resource intensive" patients that otherwise might have experienced barriers to primary care.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: RCCO for Region 1 • Location: Western Slope, including Larimer County (Region 1)
b. The population(s) served and number of covered lives;	133,000 individuals with Medicaid currently eligible for the ACC Program and enrolled in Region 1
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Medicaid, including individuals who are participating in the Department's Medicare-Medicaid Program.
d. The primary health care services included in the project;	Provide care coordination, primary care provider network and customer service for primary health care services.
e. Level of managed care and financial risk;	Operates under a federal Medicaid managed care primary care case management model. No financial risk.
f. Activities in Rural and Frontier areas, if appropriate;	Region 1 comprises eight Frontier areas and 12 Rural areas. This represents more than one-third (34.7 percent) of the State's total Frontier areas and half (50 percent) of the State's total Rural areas.
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None

Information Required	Description of Experience
i. A Project Contract Manager with contact information	Contract is between RMHP and the Department of Health Care Policy and Financing • Ben Harris, ACC Region 1 Contract Manager • Phone: 303.866.2399 • Email: benjamin.harris@state.co.us

PROJECT 2: INTEGRATION OF BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS

RMHP Prime

Summary and Community Behavioral health care

RMHP Prime is a Medicaid payment reform initiative that intentionally works to integrate services for whole person health by including mental health specialty care and PCMP providers in upside savings and downside cost-accountability agreements. Through its global budgeting model, organizations have the flexibility to pay for services that are not reimbursed in a traditional fee-for-service system.

Through this model, RMHP and its partner community mental health centers and advanced primary care providers developed, deployed and funded initiatives to support primary care practices caring for their most challenging patients, many of whom had serious persistent mental illness and/or substance use disorder. One such initiative was funding behavioral health practitioners within advanced primary care practices on an attributed, risk adjusted basis without the limitations created by fee-for-service volume coding. Team-based training and supports such as motivational interviewing, screening for depression and anxiety and connecting members to behavioral health providers when appropriate were all deployed. This initiative became an important element in RMHP Prime's activities to pay for value, not volume, which is possible under a global payment initiative.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: RMHP Prime • Location: Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco counties
b. The population(s) served and number of covered lives;	38,000 Medicaid-covered individuals, including low-income adults, adults and children who qualify based on disability status, and individuals with Medicare and full Medicaid benefits
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Medicaid, including some individuals who qualify for Medicare and Medicaid benefits.
d. The primary health care services included in the project;	Medicaid-covered services, including hospital pharmacy, physician, specialty and primary health care services. Carve-outs are defined in the Department's Appendix Z of this request for proposals.

Information Required	Description of Experience
e. Level of managed care and financial risk;	Full risk managed care plan
f. Activities in Rural and Frontier areas, if appropriate;	Within the six-county prime service area, two counties are Frontier areas (33 percent) and three are Rural areas (50 percent).
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None
i. A Project Contract Manager with contact information	Contract is between RMHP and the Department of Health Care Policy and Financing • Ben Harris, ACC Region 1 Contract Manager • Phone: 303.866.2399 • Email: benjamin.harris@state.co.us

PROJECT 3: COMMUNITY BEHAVIORAL HEALTH EXPERIENCE: SUPPORTIVE BEHAVIORAL HEALTH WRAPAROUND SERVICES

Cross-System Response for I/DD Behavioral Health Crisis Pilot Project

The Colorado Department of Health Care Policy and Financing awarded the Intellectual/ Developmental Disabilities Crisis Center Pilot Project (I/DD Crisis Center Pilot) to RMHP and its collaborative Community Centered Board (CCB) (which serve individuals with I/DD) and Community Mental Health Center (CMHC) partners in March 2017. The Pilot was supported by legislation developed in response to the limited access to behavioral health and crisis intervention services experienced by individuals who have an intellectual or developmental disability with a co-occurring behavioral health condition. The Pilot is in the participating counties of Mesa, Delta, Montrose, Garfield and Larimer counties.

RMHP, the Reunion Health CMHCs, and the CCBs in Mesa, Delta, Montrose, Garfield and Larimer counties created a system to identify if the individual has an I/DD upon presentation to the Crisis Centers. If identified, the CMHC calls the neighboring CCB to provide co-management and develop a plan for stabilization and therapeutic care. Therapeutic services can be provided in the individual's home or in a community home setting. Following the crisis, the CCB and CMHC providers create follow-up plans to support Members and their families with symptom management, treatment adherence, respite and other techniques that promote stability. The community providers work together to integrate behavioral health, medical, social and alternative services, long- term care supports and services (LTSS), intensive case management, housing support and medication management as wraparound services.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: Intellectual/Developmental Disabilities Crisis Center Pilot Project • Location: Delta, Garfield, Larimer, Mesa and Montrose Counties
b. The population(s) served and number of covered lives;	Individuals in crisis who also have an intellectual or developmental disability (I/DD). In the first eight months of the I/DD Crisis Center Pilot Project, the Pilot partners worked closely with more than 95 individuals to successfully manage crises.
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Combination. The legislation for this pilot is designed to help address service gaps for individuals who have both an I/DD and a mental health or behavioral health disorder and the services may not be available under an existing home and community based services (HCBS) waiver or covered under Colorado's behavioral health care system. Of the approximately 95 unique patients cared for by the Pilot from August 2016 through February 2017, only 19 of them were covered under a waiver or other insurance; the remainder were uninsured or had Medicaid but not HCBS waiver service coverage.
d. The primary health care services included in the project;	This project arranges and provides behavioral health crisis services, and connects clients to services that support individuals with developmental disabilities, medical care, eligibility-based benefits, like Medicaid and HCBS services and social supports, like housing and transportation.
e. Level of managed care and financial risk;	Limited funding legislative appropriation; RMHP is the fiscal agent.
f. Activities in Rural and Frontier areas, if appropriate;	Within the I/DD Crisis Center Pilot Project area, three counties are Rural areas (60 percent)
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None

Information Required	Description of Experience
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None
i. A Project Contract Manager with contact information	Contract is between RMHP and the Department of Health Care Policy and Financing • Cody Hickman, Cross-System Crisis Response Pilot Program Contract Specialist • Phone: (303) 866-5148 • Email: cody.hickman@state.co.us

PROJECT 4: INTEGRATED CLINICAL PHARMACY
Medication Therapy Management (MTM) and Medication Review Program (MRP)
Summary and Community Behavioral health care

RMHP began offering a Medication Therapy Management (MTM) program for our Medicare Part D Members in 2006. In November 2016, we implemented a formal Medication Review Program (MRP) for our RMHP Prime Members. Prior to this, we performed internal medication reviews on an ad hoc basis for Medicaid Members recognized as needing a review.

RMHP retains eight contracted pharmacists statewide – 6 for MTM and 2 for MRP. The pharmacists review the Members' current medication list, dosing, scheduling, potential side effects and adverse drug interactions. MTM/MRP team members also review barriers to access, potential cost savings opportunities in medication regimens, opioid intervention opportunities, over-utilization (poly-pharmacy) and gaps in care (e.g. post MI beta-blocker use). MTM/MRP team members consult with prescribers and members about ways to improve medication adherence and promote better pharmacy outcomes.

Finally, RMHP utilizes APM and RCCO resources to support and sustain clinical pharmacist practices directly within advanced and comprehensive care PCMP settings. Within these arrangements, RMHP payment agreements support PharmD FTE, who perform a variety of patient safety, medication consultation and cost-effectiveness analyses – directly onsite, in homes and community settings – for Members and clinician team members. At present, RMHP supports integrated pharmacists in three Network PCMPs: Salud Family Health Centers and Associates in Family Medicine in Fort Collins and Primary Care Partners in Grand Junction.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: Integrated Clinical Pharmacy • Location: Statewide

Information Required	Description of Experience
b. The population(s) served and number of covered lives;	For MTM, Members are recognized in various ways: 7 or greater Part D medications, 3 or more chronic disease states and/or exceeding a specific annual drug medication cost as dictated annually by CMS. For MRP, Members are recognized and will be in the program by the following reasons: medication adherence; 6 or greater chronic medications of the following classes of drugs (anti-platelets, anti-coagulants, anti-hypertensive, anti-hyperlipidemic, COPD/asthma medications, anti-depressants, anti-psychotics, medications for CHF, diabetes, and finally HIV medications), OR opioid management (3 or more opioid claims/month for the prior 4 months and 4 or more different providers) OR fragmented care (having prescriptions in the past 4 months from more than 8 different providers), OR Poly-Pharmacy (claims of 18 or more distinct medications in the past 4 months). RMHP currently contacts 250 Medicare members and 50 RMHP Prime Members per month.
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Combination of Medicaid and Non-Medicaid
d. The primary health care services included in the project;	RMHP clinical pharmacists and Colorado registered pharmacists assist Members in optimizing effectiveness of prescription drugs.
e. Level of managed care and financial risk;	APMs in full MCO risk as well as PCCM settings
f. Activities in Rural and Frontier areas, if appropriate;	The service area includes many Rural and Frontier areas
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	N/A
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	N/A
i. A Project Contract Manager with contact information	• Ben Harris, ACC Region 1 Contract Manager • Phone: 303.866.2399 • Email: benjamin.harris@state.co.us

PROJECT 5: INTEGRATED SCHOOL-BASED MENTAL HEALTH CARE
Comprehensive Community-Based Behavioral Health
Summary and Community Behavioral health care

Mind Springs Health, a Community Mental Health Center and a Reunion Health Partner in Region 1, provides school-based community behavioral health care in six Western Slope Counties: Routt, Moffat, Mesa, Eagle, Garfield and Pitkin, covering eight school districts. Services range from integrated behavioral health in a School Based Health Center, to Day Treatment Alternatives, as well as in-school therapy.

The Day Treatment Alternatives programs in Moffat and Routt School Districts serves children with serious emotional disorder who are at risk for placement outside of their home due to extreme behavioral concerns. Mind Springs staffs these smaller classrooms with a full-time therapist who works with the classroom teacher to support both behavioral and academic goals. The program lasts up to 18 months and includes home-based and group therapy as well as in-school therapy.

School-Based Therapy is a year round program that provides longer term and more intensive therapy to children and youth. Therapy is largely school-based with some limited home-based care.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: Rifle Middle School School-based Health Center; Location: Rifle; Garfield County (rural) • Name: Glenwood High School in-school Therapy; Location: Glenwood Springs; Garfield County (rural) • Name: Pitkin School District In-school Therapy; Location: Pitkin County (rural) • Name: Mesa County School District In-school Therapy; Location: Mesa County • Name: Battle Mountain High School In-school Therapy; Location: Eagle County (rural) • Name: Eagle Valley High School In-school Therapy; Location: Eagle County (rural) • Name: Red Canyon High School In-school Therapy (both campuses); Location: Eagle County (rural) • Name: Moffat County School District Day Treatment Alternatives; Location: Craig, Moffat County (rural) • Name: SOROCO School District School-based Therapy & Day Treatment Alternatives; Location: Routt County (rural) • Name: Hayden School District School-based Therapy & Day Treatment Alternatives; Location: Routt County (rural) • Name: Steamboat School District School-based

Information Required	Description of Experience
	Therapy & Day Treatment Alternatives; Location: Routt County (rural)
b. The population(s) served and number of covered lives;	• Eagle County Schools – served 82 children/youth in CY 2016 • Rifle Middle School (Garfield County) – Served approximately 100 children/youth in CY 2016 • Routt County Schools – Served approximately 135 families in CY 2016 • Moffat County Schools – Served approximately 12 families in CY 2016 • Mesa County Schools – served 100 children • Pitkin County Schools – served 80 children
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Combination of Medicaid and Non-Medicaid
d. The primary health care services included in the project;	In the Rifle Middle School Based Health Center (SBHC), Mind Springs Health licensed clinicians are part of a team-based model that provides comprehensive and integrated physical, oral health, and behavioral health services to children in need in the community. Health education and enrichment programs are also supported through the SBHC program. Clinical initiatives include preventive/ primary care, reproductive health, behavioral health, preventive dental health and restorative dental health.
e. Level of managed care and financial risk;	N/A
f. Activities in Rural and Frontier areas, if appropriate;	Noted above in item (a).
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None
i. A Project Contract Manager with contact information	• Kristi Grems, Program Director Eagle County • Phone: (970) 328-6969, ext 3507 • Email: kgrems@mindspringhealth.org

PROJECT 6: INTEGRATED MEDICAL AND BEHAVIORAL HEALTH SERVICES MANAGEMENT

Integrated Management of Medical and Behavioral Health Services in Tennessee

Summary and Community Behavioral health care

In Tennessee, our parent company provides integrated management of medical and behavioral health services, including utilization and quality management. They have increased access to substance use disorder, mental health and integrated dual disorder services. They have also implemented a recovery-based program, expanded peer- and family-run services, and reduced the administrative burden on providers by working cooperatively through our Quality Management (QM) Committee and with stakeholder groups.

In order to address the costly, excessive lengths of stay in regional mental health institutions that were failing to meet the needs of members with multiple health conditions, our parent company provided support for housing services for people with comorbidities. By providing a greater level of support in community settings, they are facilitating the release of individuals from state institutions into more cost-effective and comfortable living environments.

This program uses evidence-based practices and data-driven analyses to identify and coordinate services based on individual need, and includes work with peer-and family-run organizations in the community to support recovery, resiliency, and whole person wellness. In addition, our parent company is the first managed care organization in the state to support housing services for people with comorbidities. Housing initiatives include:

- Partnership with Carver House, a 10-bed supportive housing facility that enables people with multiple physical and behavioral health conditions and ongoing housing challenges to live safely and effectively in the community. The program provides participants with the necessary medical support and services to develop the self-care skills they need to return to traditional community living arrangements.

- Collaboration with providers to develop supported community living services for members who do not respond to psychiatric rehabilitation services of supportive housing, but who require structure and a supportive environment to remain in the community. This cost-effective alternative to supportive housing helps prevent repeated hospitalizations and helps control care expenses for the state.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: Integrated Management of Medical and Behavioral Health Services • Location: Tennessee
b. The population(s) served and number of covered lives;	Approximately 600,000 members statewide
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Medicaid and Dual Eligible Special Needs Plan (D-SNP)

Information Required	Description of Experience
d. The primary health care services included in the project;	Through this project, members receive substance use disorder, mental health and integrated dual disorder services, as well as access to recovery-based programs and peer- and family-run services.
e. Level of managed care and financial risk;	Full risk
f. Activities in Rural and Frontier areas, if appropriate;	Care coordination is provided for members across the state, including in Rural areas. Telehealth is used to provide several services to members in Rural communities.
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None since 2012
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None
i. A Project Contract Manager with contact information	• Tricia Lea, PhD, MBA, Executive Director, Behavioral Health, UnitedHealthcare Community Plan of Tennessee • Phone: (615) 493-9632 • Email: trica_g_lea@uhc.com

PROJECT 7: COMPREHENSIVE PROGRAMS FOR ADULTS WITH SERIOUS MENTAL ILLNESS, CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE, AND INDIVIDUALS WITH MULTIPLE DIAGNOSES

Comprehensive, Consumer-Centered Services, including Crisis Intervention, in Salt Lake County, Utah

Summary and Community Behavioral health care

Our parent organization manages Salt Lake County's Behavioral Health Services including county- and state-funded mental health services, substance use disorder and Alternatives to Incarceration (ATI) programs and a crisis outreach and intervention service for individuals in a mental health crisis facing incarceration. They manage programs (FAST, FASTER, Youth Crisis Response Team, DBT Day Program, IWrap at Valley Behavioral Health, KIDS, ACES, CBTU and school-based Family Resource Facilitators and In-Home Services) designed as diversionary options to acute mental health inpatient services for children and adolescents. Services include crisis intervention services, in-home therapeutic services, individual and family therapy, medication management, peer support and behavioral interventions. Programs empower

families and parents to succeed in maintaining children with mental illness in their homes, schools and communities.

Mobile Crisis Outreach Teams (MCOT) travel to individuals in need of support, wherever they are located, to provide rapid-response crisis intervention. Teams consist of a licensed mental health therapist and a specially trained peer specialist. Three teams are available, with one dedicated to children and adolescents. Law enforcement can call MCOT when responding to an individual experiencing a behavioral health crisis at home or in public. Rather than taking the individual to the hospital or jail, they call the team for an immediate on-site assessment and intervention. The team ensures that follow-up care is provided through established network providers and community support services.

In addition, the Receiving Center at the University of Utah Neuropsychiatric Institute serves as an alternative to jail. County law enforcement is encouraged to take nonviolent offenders with mental health issues to the Receiving Center, for timely and supportive crisis intervention, rather than taking them to jail. The Receiving Center provides a "living room" model that allows individuals to manage their behavioral health crisis in a safe and receptive home-like environment. Individuals can stay at the center for up to 23 hours to receive the services they need to resolve their crisis, including assessment, medication and other support. Follow-up services are provided by peer support workers, who help discharged individuals develop and maintain their recovery plan and provide guidance and connection to community resources. Law enforcement personnel are made aware of the Receiving Center and are taught when to make a referral.

Information Required	Description of Experience
a. The name and location(s) of each project;	• Name: Salt Lake County • Location: Salt Lake County, Utah
b. The population(s) served and number of covered lives;	The population of individuals served are classified by the State of Utah among 10 separate cohorts covering 110,000 lives countywide
c. Whether the population served was Medicaid, Non-Medicaid or a combination;	Medicaid
d. The primary health care services included in the project;	Through this project, members receive behavioral health services including County and State-funded mental health services, and substance use disorder services. Individuals in a mental health crisis facing incarceration receive access to Alternatives to Incarceration (ATI) programs and a crisis outreach and intervention service. Children with serious emotional disturbance receive access to crisis intervention services, in-home therapeutic services, individual and family therapy, medication management, peer support and behavioral interventions.

Information Required	Description of Experience
e. Level of managed care and financial risk;	An "at-risk" contract valued at $68 million annually. Level of managed care includes all higher levels of care: inpatient services, residential, day treatment, and intensive outpatient. The management is completed through a prior authorization and concurrent review process.
f. Activities in Rural and Frontier areas, if appropriate;	None
g. Any corrective action plans relating to contract non-compliance and/or deficient contract performance;	None
h. Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Offeror was (or is) involved;	None
i. A Project Contract Manager with contact information	• Tracy Luoma, Optum SLC Executive Director • Phone: (801) 982-3018 • Email: Tracy.Luoma@optum.com

Section 5.0 Statement of Work
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.

PERSONNEL

RMHP and Reunion Health have developed an innovative organizational structure for ACC Phase 2, which reflects our core philosophy that community integration is the key to overcoming the fragmentation that exists within the current health and human services system. Our commitment to community entails a whole person approach to care in which all available assets and services are brought together in a comprehensive, person-centered structure. We also understand that clearly defined roles and lines of accountability are essential in such arrangements, and that "community partnerships" are only as good as what they actually produce for the people they purport to serve. Indeed, we note that the word *labor* is present in the word *collaboration*. In this section, we describe our program management and community governance structure, illustrating it with both functional and hierarchical organizational charts. We also provide a list of our Key Personnel along with their resumes including their work experience in behavioral health and other fields.

DESCRIPTION OF INTERNAL ORGANIZATIONAL STRUCTURE, INCLUDING A DELINEATED MANAGEMENT STRUCTURE.

The Partners' organizational structure is informed by successful clinical integration and accountable care arrangements in other markets, as well as the first phase of the Accountable Care Collaborative. We have adopted a matrix management structure that is focused upon the core *functions and goals* of the enterprise – not merely a hierarchy of silos that is based upon authority and specialized expertise. We also have adopted a governance structure that incorporates stakeholder direction in both *design and decision-making* – going well beyond basic advisory processes – while maintaining checks and balances to ensure that all participants are held accountable for program goals and deliverables.

Our proposed organizational model is uniquely positioned to achieve the ambitious objectives set by the Department for the RAE, now and over time, because it is driven by local, Colorado organizations and supported with the resources of a national enterprise. A diverse, multi-

sector, multi-disciplinary team will share accountability and problem-solving duties while working in an aligned structure to support whole person health for enrolled clients.

We know from decades of experience that this approach works. There is, however, a growing body of evidence from other industries, such as technology development, that multi-disciplinary, multi-organizational teams outperform traditional, corporate bureaucracies in several facets of success – including *agility, productivity* and *accelerated, adaptive learning*:

> " What is teaming? It's what happens when people collaborate—across boundaries of expertise, hierarchy, or geographic distance, to name a few. Teaming is a process of bringing together skills and ideas from disparate areas to produce something new— something that no one individual, or even a group in one area of expertise, could do alone. This is why teaming is crucial to innovation. When teaming works, the results are more than the sum of the parts, and those who participated are inspired by what they have created and by what they have learned. " [4]

RMHP and Reunion Health have developed a strong skill set with the resource pooling, challenges and opportunities present in this operational model -- over the course of executing several large scale, federal Cooperative Agreements, State and community demonstrations that necessitate productive collaboration.

Our management strategy for ACC Phase 2 is founded upon the assets and effective agency that the Partners possess over a complex array of services. The Partners will integrate their respective resources in an outcomes-focused management model, which, in turn, is governed within a balanced, community-based stakeholder structure. Within this structure, PCCM and behavioral PIHP objectives are integrated in a single *functional management system*, which establishes direct reporting relationships and clear lines of accountability. Within the management system, a matrix of interdependent responsibilities is established to ensure that the roles performed by Key Personnel are integrated, focus on outcomes and will not devolve into silos of authority and expertise, as illustrated below:

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[4] **Edmondson, Amy C. Teaming to Innovate. San Francisco, CA: Jossey-Bass, 2013.**

PROGRAM MANAGEMENT STRUCTURE
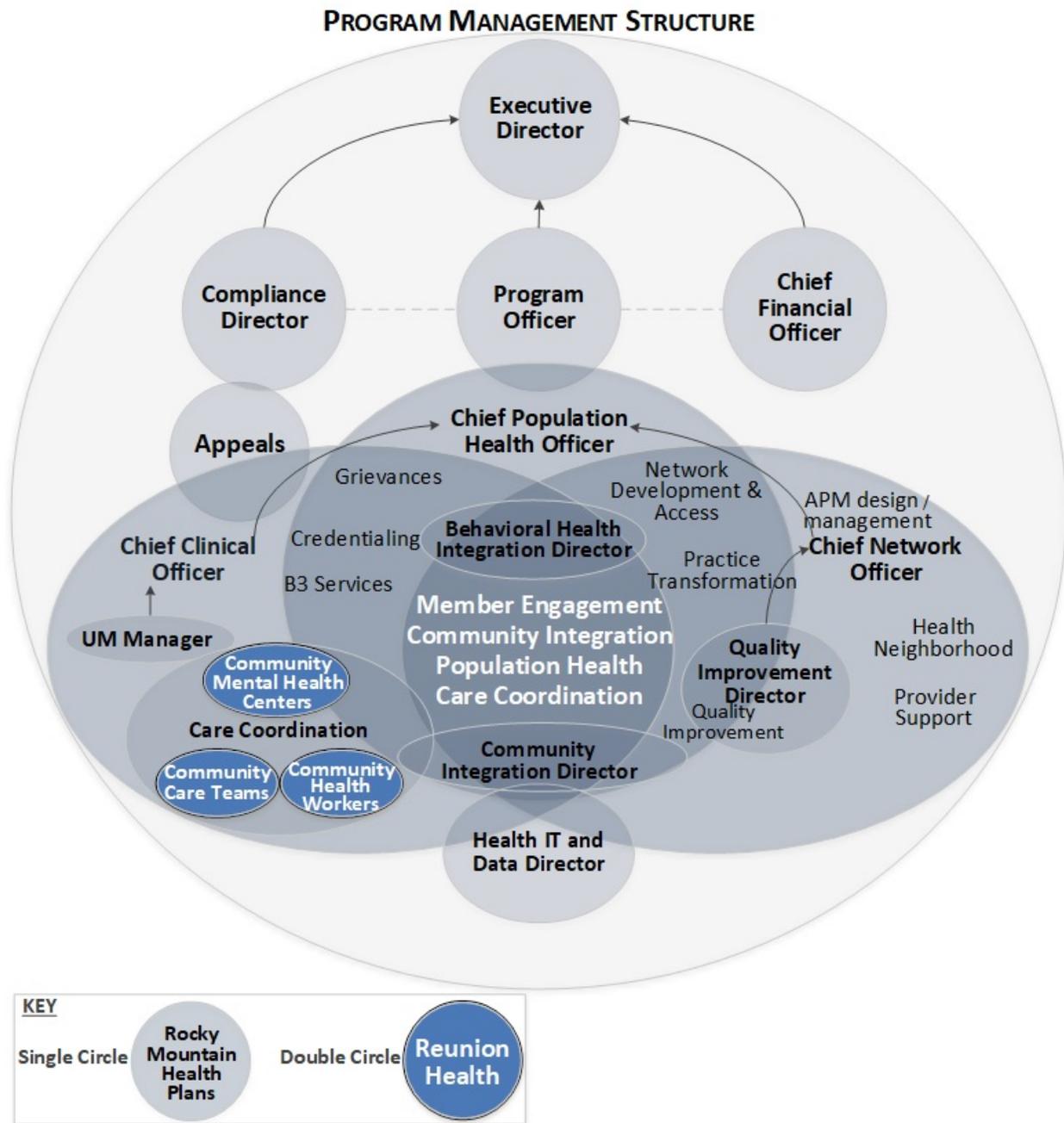
Within this structure, the positions staffed by Rocky Mountain Health plans are shaded in gray, while others staffed by Reunion Health at the point of care are shaded in blue. In order to ensure a direct relationship between Key Personnel specified by the Department in the RFP, and the Offeror's corporate enterprise, full accountability for the all aspects performance of RAE functions by Rocky Mountain Health Plans and its parent organization, UnitedHealthcare, is placed with the Executive Director, Patrick Gordon.

The management system is aligned within an inclusive and transparent **community governance structure**, which is shown graphically below. The community governance structure is

established pursuant to a Joint Operating Agreement (JOA), which is described in greater depth in Offeror's Response 8.
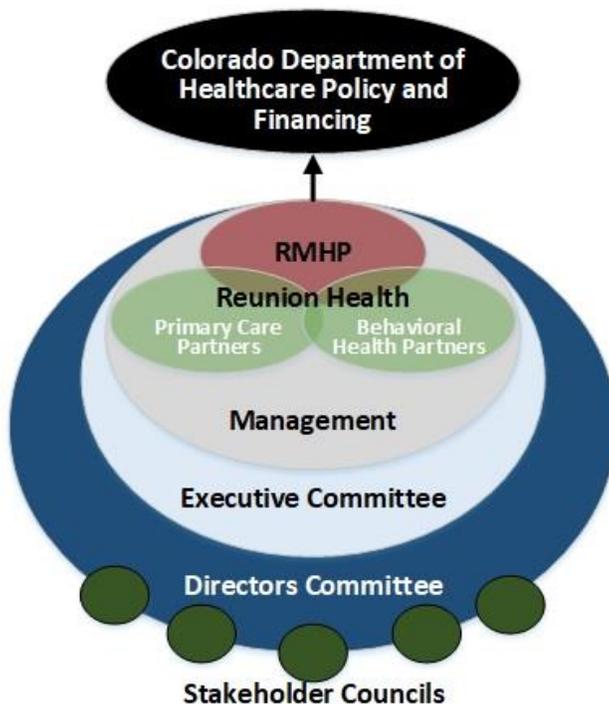
At the Executive Committee level of governance, RMHP and Reunion Health Partners share responsibility for oversight of the management team and overall operation of the RAE, while the Directors Committee performs transparent reviews of performance, validates key decisions made at the Executive level, and serves as the mechanism by which clearly defined Stakeholder Councils – including the Performance Improvement Advisory Committee (PIAC) – provide feedback and support for the development and implementation of RAE initiatives. RMHP, as the licensed and contracting entity, serves as the single point of accountability for all functions and deliverables under the RAE agreement with the Department.

ORGANIZATIONAL CHART

In addition to the functional management matrix diagram illustrated above, the Partners have prepared a traditional, hierarchical Organizational Chart, to demonstrate how all operational, management, reporting and oversight functions will be maintained for the RAE infrastructure. Within this chart, the names of all Key Personnel and corresponding subject area leaders and managers are shown below:

Organizational Chart:

Executive Director
Patrick Gordon

RAE Compliance Director
Tim Sherman

Chief Population Health Officer
Lori Stephenson

● RAE Program Officer
Amy Gallagher, PhD

● Chief Financial Officer
Jeanne Duncan, CPA

● Chief Clinical Officer
Steve Bishop, MD

Member Engagement Director
Marci O'Gara

Chief Network Officer
Dale Renzi

Behavioral Health Integration Director
Alex Schmidt, PhD

Community Integrations Director

● HIT and Data Director
Boris Kalikstein

Practice Transformation Director
Cindy Mattingley

Internal Audit Manager

Appeals

Care Coordination
Carol Ann Hendrikse, RN

● Utilization Manager
Kila Watkins, RN

Provider Network Management
Greg Coren

● QI Director
Maura Cameron, RN

Housing Specialist

MyMobility Manager

CMHC Intensive Care Coordination

Community Health Workers

Community Care Teams

PCMP Offices

OneCall Support

Grievances

Credentialing

Accountable Health Communities Model Program Lead

Community Experience and Education Specialist

Colorado Opportunity Framework Liaison

● *denotes Key Personnel*

KEY PERSONNEL

The leaders we have appointed to manage the RAE Scope of Work possess tremendous expertise, experience and skill within our management structure. More importantly, these leaders have longstanding, collaborative relationships with stakeholder groups throughout Region 1 and the broader Colorado community. These Key Personnel and the human capital they generate will be critical in achieving the objectives set by the Department for the RAE:

- RAE Program Officer: Amy Gallagher, PhD*
- Chief Financial Officer: Jeanne Duncan, CPA
- Chief Clinical Officer: Steve Bishop, MD*
- Quality Improvement Director: Maura Cameron, MSN
- Health Information Technology and Data Director: Boris Kalikstein, BS
- Utilization Management Director: Kila Watkins, RN*

* These individuals have the majority of their professional experience in the field of behavioral health management. Comprehensive resume documentation for all Key Personnel is included in Attachments 4-1 through 4-6 at the end of this section.

In addition to the Key Personnel set forth in the RFP, RMHP will employ a full time **Behavioral Health Integration Director**, Alexandra Schmidt, Ph.D. Dr. Schmidt has extensive experience training resident physicians and mental health clinicians in integrated behavioral health practices, leading multidisciplinary consultation groups in care management, and assisting with grant management supporting integrated behavioral health in rural and smaller practices in western Colorado. In her role as Integration director, she will work to ensure that day-to-day operations and organizational culture within the Region 1 RAE adhere to the Partners principles and standards for integrated, whole person, team-based care.

RMHP will obtain the Department's written approval for individuals we propose for assignment to Key Personnel positions before they begin work under the Contract. Once approved, we will provide all required notifications to the Department, within applicable timeframes, for any voluntary changes, temporary replacements, or replacements of Key Personnel who leave our employment. Our matrix organizational model allows for operational continuity, as well as rapid replacement, whenever turnover or other personnel transitions occur. That said, we will not appoint any new Key Personnel to fill a vacancy until the Department has approved the candidate.

For Key Personnel or Other Personnel required to maintain professional licensure or certification, we will submit all current professional licensure and certification documentation within five business days of receipt of updated licensure or upon request by the Department. Separate and distinct individuals shall fill each Key Personnel position.

Key Personnel and Other Personnel assigned to the Contract will be available for meetings with the Department during regular business hours. They will also be available outside of normal business hours or on weekends with prior notice from the Department. Key Personnel and Other Personnel will be available for all regularly scheduled meetings with the Department and they will have authority to represent and commit RMHP regarding work planning, problem resolution and program development.

We will also make our Key Personnel and Other Personnel available at the Department's direction to attend meetings as subject matter experts with stakeholders both within state government and with external parties.

Our personnel will attend meetings with the Department or stakeholders in person, unless the Department gives permission to attend by telephone or videoconference.

We will always respond to Department telephone calls, voicemails and e-mails within one Business day of receipt.

EXECUTIVE AND KEY PERSONNEL SUMMARY

Executive Director - Patrick Gordon, MPA

Patrick Gordon joined RMHP in 2004 as the Director of Government Programs, and has worked in health care for almost 20 years. As Executive Director he will provide internal corporate accountability for the RAE within RMHP and its parent organization, UnitedHealthcare. Mr. Gordon has strong ties to Colorado. As a fourth generation Coloradan, he was born in RAE Region 5, grew up in RAE Region 6, and is well known throughout RAE Region 1 because of his work at RMHP as Associate Vice President for Community Integration. He has led the state's movement toward innovative payment models, including a successful global budget payment reform initiative for Colorado Medicaid. Mr. Gordon has published on integrated care, advanced payment models, and practice transformation. He has held several positions on state and national advisory boards for improving the health care system, including the PCMH Standards Advisory, National Committee for Quality Assurance. Mr. Gordon received his Master of Public Administration in Health Policy & Economics from the University of Colorado, and received certification from America's Health Insurance Plans Executive Leadership Program. Prior to joining RMHP, he held various positions within the Colorado Department of Health Care Policy & Financing related to Medicaid, CHP+ and Nursing Facilities policy development and program management.

KEY PERSONNEL RESUMES

Attachment 4-1

Program Officer – Amy Gallagher, Psy.D.

Summary of Behavioral Health Experience: Almost 20 years of training and employment in behavioral health, including oversight of behavioral health professional from doctoral-level to

frontline. Experienced program designer responsible for implementation, data collection, and evaluation. For the last ten years, has worked with RMHP partner organizations. Experience with pediatric and adult patients and a variety of conditions, work with military and families, Crisis Response, and Early Childhood.

Education
Argosy University, Seattle, WA, 2004-2008
Psy.D. in Clinical Psychology
M.A. in Clinical Psychology
Loyola College, Baltimore, MD, 1997-1999
M.S. in Clinical Psychology
LeMoyne College, Syracuse, NY, 1993-1997
B.A. in Psychology, Magna cum Laude

Professional Experience
Vice President, Whole Health, LLC, Grand Junction, CO, September 2013-Current
- Trained and supervised post-doctoral fellows, licensed psychologists, community health workers, and integrated care clinicians. Oversaw communication between Whole Health and external entities including health plans, LPHAs, hospitals, and partner organizations. Managed $950,000 operating budget including contracts. Directed program design, evaluation, data collection, and implementation.

Training Director, Colorado West Regional Mental Health, Grand Junction, CO, 2009-2013
- Oversaw pre-doctoral interns, maintaining APPIC compliance. Organized didactic trainings. Conducted outpatient therapy for families, individuals, and groups including adults and pediatrics clients. Crisis Response for children and adolescents.

Post-Doctoral Fellow, Colorado West Regional Mental Health, Grand Junction, CO, 2008-Current
- Psychological Assessments, intakes, and therapy for children and adolescents. ADHD group. Assisted with supervision for pre-doctoral interns and students.

Pre-Doctoral Internship and Practice, Various Locations, 1998-2007

Certification and Licensure
Co License PSY-3347

Attachment 4-2
Chief Financial Officer – Jeanne Duncan, CPA
Summary of Managed Care Experience: Over 20 years accounting and finance experience in managed care. Expertise in finance-related provisions such as Risk Adjustment, Risk Corridor, Reinsurance, and Cost Share Reduction reconciliation. Skilled in audits and forecasting.

Education
University of Nebraska at Omaha, Omaha, NE, 1993
- Accounting Emphasis

Kearney State College, Kearney, NE, 1985
- B.S., Business Administration-Finance Emphasis

Professional Experience

Director of Financial Administration

Rocky Mountain Health Plans, Grand Junction, CO, 2015-Present

Responsible for health plan's overall budget and forecasting. Implemented ACA finance-related provisions, including Risk Adjustment, Risk Corridor, Reinsurance, and Cost Share Reduction reconciliation. Integrated financial operations into UnitedHealthcare. Led finance-related projects within the department.

Health Care Reform Implementation Manager

Rocky Mountain Health Plans, Grand Junction, CO, 2012-2014

Led ACA implementation throughout RMHP. Represented RMHP at industry workgroups. Analyzed compliance options for organization alignment with ACA.

Strategic Financial Analyst

Rocky Mountain Health Plans, Grand Junction, CO, 2006-2012

Improved annual budgeting process in conjunction with 35 departments and 7 VPs. Performed analyses and research under CFO. Developed forecasts. Medicare Part D audits.

Quality Improvement Research and Analysis Manager

Rocky Mountain Health Plans, Grand Junction, CO, 2001-2006

Oversaw HEDIS project. Improved credentialing process from 120 days to 45 days.

Quality Improvement Data Analyst and HEDIS Coordinator

Rocky Mountain Health Plans, Grand Junction, CO, 1997-2001

Project manager for HEDIS on external chart review. Implemented new software vendor and data analysis. Led a 4-person team that recovered $400,000 in inaccurate claims.

Staff Accountant

Rocky Mountain Health Plans, Grand Junction, CO, 1996-1997

Budget analysis and general ledger accounts. Led Oracle software upgrade.

Certification and Licensure

Colorado CPA License, 1995

Professional Memberships

Board Director, Rocky Mountain Health Plans Foundation, 2010-2015

Attachment 4-3

Chief Clinical Officer – Steve Bishop, MD

Dr. Bishop is a Colorado physician leader with almost 40 years of experience practicing psychiatry, educating future doctors, and directing behavioral health organizations. Board Certified in Psychiatry and Child Psychiatry, Dr. Bishop has provided leadership in psychiatric care for private practices, large hospitals, and health plans. In his administrative work, he has done utilization review, quality assurance, and risk management. He has chaired committees for both local and national psychiatric organizations. He has worked with RMHP for 5 years.

Education

1970 – 1974, Williams College, Williamstown, MA

- B.A. in Chemistry, Phi Beta Kappa
- Gargoyle Society - Senior Honor Society

1974 – 1978, Tulane School of Medicine, New Orleans, LA

- M. D.
- Frick Award in Psychiatry

Professional Experience

Psychiatric Medical Director

- 01/2012 – present, CNIC Health Solutions/Rocky Mountain Health Maintenance Organization, Denver, CO

Psychiatrist

- 12/02 – present, The Centre for Behavioral Health, Porter Adventist Hospital, Denver, CO

Assistant Clinical Professor

- 1984 – 91, UCHSC – Psychiatry, Denver, CO
- 1991 – present, UCHSC – Psychiatry, Denver, CO

Psychiatric Medical Director

- 7/01 – 10/02, Physician Health Partners, Denver, CO

Psychiatric Medical Director

- 10/99 – 7/01, KidSmart Health Partners, Denver, CO

Psychiatric Consultant (Utilization review, risk management and quality assurance.)

- 3/99 – 9/99, Pacificare Behavioral Health, Englewood, CO

Medical Consultant (Mostly clinical practice, but including some utilization review, risk management and quality assurance.)

- 3/88 - 8/98, MCC, Greenwood Village, CO

Psychiatric Consultant to Pediatrics

- 7/84 - 4/89, Denver General Hospital, Denver, CO

Child, Adolescent and Adult Psychiatry

- 7/84 – present, Private Practice, Denver, CO

Psychiatric Consultant for Developmental Disabled

- 11/91 – present, North Metro Community Services, Westminster, CO

Psychiatric Consultant for Developmentally Disabled

- 7/84 - 6/93, Laradon Hall, Denver, CO

Child Psychiatry Fellow, Chief Fellow, Pediatric Consultation

- 7/82 - 6/84, UCHSC, Denver, CO

Career Resident

- 7/81 - 6/82, Institute for Forensic Psychiatry, Pueblo, CO, Colorado State Hospital

Psychiatry Resident

- 7/79 - 6/81, UCHSC, Denver, CO

Rotating Intern

- 4/78 - 6/79, University of Colorado Health, Denver, CO, Sciences Center (UCHSC)

Certifications and Licensure

Psychiatry - January 1985, # 26680

Child Psychiatry - September 1985, # 1918

Colorado # 22371, since June 22, 1979

Professional Memberships

American Psychiatric Association, Fellow 12/92, Chair of Subcommittee on ACCME Accreditation (6/94 - 5/97)

Colorado Psychiatric Society, President (6/94 - 7/95), Program Committee Chair (6/85-11/96)

Colorado Child and Adolescent Psychiatric Society

American Academy of Child and Adolescent Psychiatry, Fellow (9/89)

Medical Records Committee Chair, Bethesda Hospital, (1/91 - 12/96) Chair of Peer Review Committee (1/96 - 12/96)

Attachment 4-4

Quality Improvement Director – Maura Cameron, RN, CNM, MSN

Summary of QI and BH experience: Experienced quality manager with strong professional and clinical skills. Over 10 years of experience with quality improvement in a variety of positions within Rocky Mountain Health Plan, General Dynamics, and Q Mark. Experience in QI in information technology. Broad experience with NCQA and HEDIS standards and guidelines.

Education

2000, University of Colorado School of Nursing, Aurora, Colorado

- Masters of Science in Nursing

1988, University of Colorado School of Nursing, Aurora, Colorado

- Bachelor of Science in Nursing

Colorado State University, Fort Collins, Colorado

- Undergraduate Studies

Professional Experience

Interim Director Quality Improvement (6/2017 to present)
Rocky Mountain Health Plans, Grand Junction, CO

Responsible for day to day operations and management of busy Quality Improvement Department. Department duties include Provider Credentialing/ Re-credentialing, NCQA Accreditation, Annual HEDIS Project, CAHPS Surveys, Member/Provider Satisfaction Surveys, Member/Provider Education and Outreach, Quality Interventions and Improvements Specific to Stars, QRS, HEDIS and CAHPS Ratings, QI Oversight of Government Regulatory Contracts and Compliance Requirements, Continuing Medical Education (CME) Program.

Quality Improvement Manager: HEDIS; CAHPS; Quality Interventions (6/2014 to 6/2017)
Rocky Mountain Health Plans, Grand Junction, CO

Management and oversight of all aspects of HEDIS and CAHPS projects to include hiring, training and evaluation of temporary and in-house HEDIS staff, data collection and review, compliance and audit requirements, project assessment and evaluation of outcomes, and implementation of activities for improvement. Responsible for vendor oversight, interdepartmental collaboration and other quality activities.

HEDIS/CAHPS Coordinator & Project Manager (11/2013 to 6/2014)
Rocky Mountain Health Plans, Grand Junction, CO
Team lead responsible for coordination and management of HEDIS/CAHPS Project, including creation, development, and implementation of training materials. Managed all aspects of HEDIS operations including chart request and retrieval, onsite and remote abstraction, Inter-Rater Reliability activities and successful completion of the compliance audit processes; including Roadmap submission, Site Audit and Medical Record Review Validation (MRRV). Responsible for coordination of CAHPS and HOS surveys including vendor-related oversight.

Functional Analyst; MRR & QI Services (06/2012 to 11/2013)
General Dynamics Information Technology, Baltimore, Maryland
Senior Project Manager for Medical Records Review and QI. Developed and created policies, procedures, training, and testing materials for HEDIS Medical Record Review process. Managed all aspects of HEDIS data collection. Conducted on-site and remote training, Maintained oversight of the Inter-Rater Reliability Process, Compliance Audit. Expertise in HEDIS Hybrid Technical Specifications and NCQA Guidelines.

OB/GYN Triage Nurse (09/2007 to 09/2012)
Exclusively RNS, Colorado Springs, Colorado
Phone triage for busy home-office based call center that provided after-hours coverage for over 30 practices and 200 physicians in 7 states.

Senior Project Manager 02/2008 to 06/2012
Q Mark, Indianapolis, Indiana
Senior Project Manager and HEDIS Team lead for oversight of 7 Project Managers and 55 contract employees. Coordinated HEDIS abstraction process.

RN Flu Clinic (08/2009 to 02/2012)
Kaiser Permanente, Denver, Colorado
Administered vaccines and immunizations for multiple large sites and clinics.

Professional OB/GYN Research Nurse (01/1994 to 12/1997)
University of Colorado Health Sciences Center, Denver, Colorado
Responsible for patient enrollment, data collection, study follow-up, and case reporting.

Labor and Delivery RN/Charge Nurse (05/1988 to 02/1994)
Denver Health and Hospitals, Denver, Colorado
Team lead for busy hospital labor and delivery unit. Responsible for labor, delivery, and recovery of obstetrical patients.

Certifications and Licensure
Certified Nurse Midwife/American College of Nurse Midwives
Registered Nurse: Colorado, California and Illinois

Attachment 4-5

Health Information Technology and Data Director – Boris Kalikstein

Summary of Health IT Experience: Over 15 years of experience in organizational strategy development, business intelligence, implementation and team management. Defined strategic plan for Clinica Family Health Services and implemented numerous initiatives around service, quality and affordability goals. Focused on care team redesign and development of decision support tools for teams. Implemented numerous regional Primary Care initiatives for Kaiser Permanente. Developed an audit database designed to support the Coding Education Project and analyzed Medicare submission data for Kaiser Permanente. Extensive EHR experience with Epic and NextGen.

Education

2003, Colorado School of Mines, Golden, CO

- B.S. Mathematics, Minor in Electrical Engineering

Professional Experience

Founder and CEO, Pivotal Moment Consulting, 2017-present

Founded a healthcare consulting firm designed to help organizations innovate to drive transformational team-based care. Expertise with Business Intelligence, Population Health and Change Management. Specific focus includes developing action-oriented decision support tools, applied population health solutions, team-based care, care delivery transformation, value based reimbursement and strategic planning.

Vice President of Strategic Support and CIO, Clinica Family Health, 2011-2016

Developed strategies to reduce ER utilization and hospital readmission rates utilizing CORHIO systems. Developed and implemented a comprehensive Business Intelligence data warehouse. The BI system composed of operational, clinical and financial data drove care delivery and process improvement at Clinica. This tool has been presented at IHI, CMS and has been sold to private practices. Helped Clinica achieve Level 3 Patient Centered Medical Home recognition at each site and NCQA recognition in diabetes outcomes.

Executive Consultant & Regional Strategy Program Manager, Kaiser Permanente, 2007-11

Implemented Regional Initiatives around Access Improvement for Primary Care, Continuity, Service, Quality and Affordability.

Analytic Specialist, Kaiser Permanente, 2006-2007

Implemented and developed a relational database designed to provide audit results for providers.

Software Engineer, Lockheed Martin Space Systems, 2003-2006

Lead Software Engineer, Rocky Mountain Musculoskeletal Research Laboratory, 2000-2003

Laboratory Technician, University of Colorado Health Sciences Center, 1998-2000

Attachment 4-6

Utilization Management Director – Kila Watkins, RN

Over two decades of experience in nurse leadership, behavioral and medical care management, utilization management and QI.

Education

1994, Mesa State College, Grand Junction, Colorado

- Associate Degree in Nursing

2014, Colorado Mesa University, Grand Junction, Colorado

- Bachelor of Science in Nursing

Professional Experience

Clinical Manager Care Management

Rocky Mountain Health Plans, Grand Junction, Colorado (07/13-Present)

Directs and evaluates the daily activities of Utilization Management (UM), which includes onsite and telephonic hospital utilization reviews, pre-authorizations and complex cases.

- Conducts appropriateness reviews of inpatient behavioral health admissions & discharges
- Reviews behavioral health level of care requests and determinations for adherence to clinical protocols and appropriateness.
- Developed 3 programs to meet NCQA standard for continuity and coordination between medical care and BH care. Includes 1) Opiate Safety, 2) Exchange of information between behavioral and medical healthcare providers, and 3) Appropriate diagnosis, treatment and referral of behavioral health disorders commonly see in primary care.
- Developed program to monitor appropriate follow up after BH facility discharge.
- Oversight of program that support patients with comorbid medical, behavioral and social issues that frequent the emergency room.
- Develops and maintains procedures with BH coordination standards for NCQA accreditation, including shared medical record compliance, and release of info procedures.
- Develops and maintains procedures for MAT oversight, network management and Member navigation, and Opioid utilization analysis
- Co-Chairs BH Oversight Committee, QI and multi-disciplinary case review process
- Assists in program development (e.g. drug safety, high ER, disease management) to best meet the needs of the members. DM and CCM Programs achieved NCQA accreditation.
- Monitors over and under-utilization to ensure alignment with quality, best value care.

Manager Quality Improvement

Rocky Mountain Health Plans, Grand Junction, Colorado (07/13-Present)

Oversight of team responsible for population health outcomes. Gather and analyze data and research best demonstrated practices and develop strategic interventions. Develop guidelines that are evidence based medicine and current practice standards. Provide education on ADHD, anti-depressant med management and follow up after hospitalization.

Acute RN, Facility Administrator and Group Facility Administrator

DaVita Dialysis, Grand Junction and Denver, CO (11/08-07/13)

Provided oversight of 4-5 dialysis and 3 outpatient facilities on the Western Slope. 1 hospital based program and 1 unit. Provided chronic disease behavioral health support and training for staff and for patients living with chronic kidney disease.

Home Care RN/Nursing Supervisor

Human Touch Home Care, Grand Junction, CO (4/08-11/08)

Responsible for performing comprehensive assessments, developing care plans and providing care to patients in home environment.

Charge Nurse, Transitional Care Unit

Mantey Heights Rehab and Care Facility, Grand Junction, Colorado (2/07-3/08)

Provided comprehensive medical /surgical care to patients post hospitalization. Oversaw rehabilitative services and managing progression to the most appropriate level of care.

Clinical Manager, Facilities Team

Hospice and Palliative Care of Western Colorado, Grand Junction, Colorado (5/05-1/07)

Oversight of hospice patient care in long term care environment and assisted living facilities. Coordinated care and services: medical, behavioral and spiritual.

Utilization Manager, Western Slope

Rocky Mountain Health Plans, Grand Junction, Colorado (9/98-5/05)

Responsible for medical and BH UM services. Directed and evaluated daily activities for all areas of UM, including member appeals, hospital utilization reviews, census, referrals, pre-authorizations, DME, and case management. Worked with UM staff and legal to assure that members' Benefits were correctly administered. Reviewed member and provider appeals.

Certification and Licensure

Registered Nurse, State of Colorado, License #105632

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.

PERSONNEL

Rocky Mountain Health Plans (RMHP), as the bidding and contracting entity, has experienced, dedicated and talented personnel available to fulfill the Contract requirements. We will combine RMHP's experience in Primary Care Case Management, capitated risk management as a Managed Care Organization with full NCQA Medicaid accreditation and seamless behavioral health integration at the point of care to fulfill the objectives set for the RAE by the Department. Our extensive experience and success with Medicaid PCCM and risk management will be augmented significantly by our partnership with the Community Mental Health Centers and Federally Qualified Health Centers in Reunion Health. We are well-prepared to implement a staffing strategy that effectively supports our capability to perform and carry out all functions, requirements, roles and duties required by the Contract. Further, RMHP has the resources of our parent company, UnitedHealthcare, at our disposal. We will leverage that experience to incorporate lessons learned from work in several other states to inform our staffing plans and procedures.

Our talented workforce, and our exceptional ability to develop productive community relationships, differentiates us in our strategy to serve Members and providers within the RAE. Our mission and organizational culture attract and support the retention of exceptionally high quality, highly productive personnel for leadership, management and analytical functions. Along with the creativity and innovation that have long been a part of our organization, our employees are inspired to perform their jobs effectively and efficiently. In this section, we discuss our approach to staffing, training and support, and filling vacancies.

A. ENSURE ADEQUATE ESSENTIAL PERSONNEL TO PERFORM THE FUNCTIONS OF THE CONTRACT

RMHP recognizes that our ability to develop and maintain a staffing level appropriate for supporting all Contract requirements and performance standards is a critical function of a successful organizational structure. RMHP has more than 40 years' experience in accurately forecasting the volume of staff required to support health plan operations, based on numerous variables including membership estimates and services to be provided.

At all times, RMHP will employ an optimal number of administrative and clinical staff to maintain compliance with all Contract requirements and performance standards. If needed, RMHP will leverage temporary staffing solutions or staffing support from our parent company to maintain staffing levels. We maintain our own internal pool of staff made up of both individuals who have worked for RMHP but want the flexibility of intermittent or part-time work, as well as individuals who were hired and trained specifically as contingency staff to fill in

at peak times or replace staff on vacation. This flexible pool of talent understands our procedures and culture, and has the necessary experience and knowledge to step in and efficiently fulfill duties throughout our organization when necessary. Flex staffing addresses vacations, family or medical absences, spikes in workload, or temporary vacancies until permanent staff is hired. We also cross-train Member-facing staff to minimize disruption if there are temporary changes in workload. When we use external staffing agencies, we limit our engagements to those that provide individuals with specialized skills, such as clinical operations, customer service or claims.

RMHP's **OneCall Center** operations reflect our commitment to a staffing strategy that supports the needs of Members. We regularly monitor metrics such as average length of call, average wait time and call abandonment rates. By analyzing this information, we are able to adjust our staffing so that we have the appropriate number of customer service representatives available to handle peak call periods. The average year-to-date response rates for live chat and email are 1.5 minutes and 1.0 hour respectively and the average hold time for the center is 46 seconds. RMHP provides robust training and supervision. Five percent of paid hours are dedicated to training and three percent of all interactions are reviewed for content and interpersonal skills. The call center has maintained its management team for the past three years and the call center has only had one turnover to its staff in 2017.

Upon notification of award and preparation for readiness review, RMHP will implement a comprehensive staffing assessment in core areas, such as the call center, care coordination and provider network management functions, and promptly implement scaling plans to ensure complete staff capacity for "Day 1" operations.

B. Train and Support Personnel to Ensure the Contract is Carried out as Effectively as Possible

RMHP understands that providing training and support to employees is essential for carrying out our contractual duties. It is also important for developing and expanding our employees' abilities to serve our Members and providers effectively. We employ a training model that includes both centralized corporate and department-level functional training. Most departments use a subject-matter expert to develop and provide training to their employees. Additionally, many use webinars, seminars and national conferences. Our Human Resources Department provides assistance in the coordination of trainings offered across departments or corporate wide.

Once a vacancy or new position has been filled, our first step is to orient the employee to the overall scope of RMHP's enterprise and mission, and to communicate values, personal supports and other critical aspects of our "intentional culture." We work to attract and retain individuals who share our passion for Colorado, our measurement and quality improvement discipline, our commitment to "doing the right thing" even when it is uncomfortable and our organizational orientation for continuously pushing beyond the status quo. Upon hire and annually, all employees receive training on our mission; contractual requirements; general cultural competence and diversity; harassment; confidentiality and information security; compliance and security; and fraud, waste and abuse. Each department provides supplemental new-hire

and ongoing training specific to the employee's responsibilities including culturally and linguistically appropriate services (CLAS) orientation. This may also include department and individual performance goals, specific roles and responsibilities, and related policies, procedures and workflows. When replacement employees are hired, we work to support a knowledge transfer from the existing employee. For example, with care coordinators, we make every effort to provide a warm handoff between the exiting employee and new care coordinator.

All employees undergo Customer Experience training, which creates understanding and awareness of feedback provided by RMHP's own Members. Customer Experience training provides insight into how each employee's job impacts the experience of our Members, whether they speak to them directly or support those who do. Each training is designed for maximum engagement by employees, and includes question and answer sessions, group activities and presentations in addition to didactic lecture.

Our training methods include both classroom- and computer-based trainings coupled with testing to measure understanding. New-hire training typically takes one day and occurs on the first day of employment. Department-specific training varies in length and timing, depending on scope and complexity of the job function.

Training is also based upon selected studies and reviews of our own performance. For example, we record all of our calls and conduct sample audit reviews based upon the experience level of the customer service representative. We conduct a higher volume of call reviews for new representatives, while experienced representatives are tested periodically for adherence to corporate standards as well as the incorporation of new content. We also modify our training curriculum if we identify areas where our approach to handling a certain type of call should be changed to be more effective. We also review calls to identify trends that may indicate areas of Member education to emphasize.

We plan to develop a curriculum that provides a review of the roles and responsibilities of all Partners in the RAE – including those working in external and remote settings. This baseline assessment of RAE responsibilities and our partnership-based organizational model will enable RMHP to effectively participate in cross-functional, process improvement activities that are essential to success in the RAE.

TRAINING IN CULTURAL RESPONSIVENESS

RMHP is committed to providing and facilitating the delivery of services in a culturally responsive manner to all Members, including those with Limited English Proficiency, diverse cultural and ethnic backgrounds, or disabilities, and regardless of gender, sexual orientation or gender identity. As part of our commitment, we will require all staff that interact with Members to complete more intensive cultural competency and awareness training that includes:

- Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services
- The health risks associated with the Member population's racial, ethnic and socioeconomic conditions

- *Bridges Out of Poverty* trainings
- *Diversity Awareness* training

Bridges Out of Poverty

Bridges Out of Poverty is a nationally recognized curriculum that provides key lessons to participants in understanding and working with individuals living in poverty. RMHP Care Management staff has been providing this training to care coordinators and providers. We plan to expand the offering to Partner organizations and their Member-facing staff. The program educates staff about the daily challenges facing many Members such as poverty; low literacy; behavioral health conditions; and lack of shelter, food, childcare and social supports. It provides effective tools staff can use in their work to help Members bridge the gap from poverty to a more sustainable lifestyle.

RMHP's experience has been that the *Bridges Out of Poverty* training is well-received by participants. They have described it as interesting, eye-opening and thought-provoking, noting that it has made them more aware of the difficulties Members experience. One participant from a community health center remarked, "Everything I've been taught here I will be able to utilize in my work to help patients understand their health better." Participants commonly cite the information presented on reflective listening to be one of the key takeaway tools they plan to use in their roles going forward.

Cultural Awareness

A core competency for employees at RMHP is Cultural Awareness. We expect that our employees' behaviors will align with our values. Employees are measured annually on a performance evaluation for demonstrating Cultural Awareness indicated by how the employee:

- Relates to others in an open and accepting manner; seeks to understand and appreciate differences
- Is aware of and sensitive to the needs of individuals with diverse backgrounds
- Modifies behaviors and communication to accommodate these differences.
- Understands the nature of culture and how it impacts health as well as the importance of community links to solve health issues
- Ensures effective, understandable, and respectful care and services are provided in a manner compatible with the Members' cultural health beliefs and practices and preferred language

After employees have completed training, they will understand our expectations for Cultural Awareness competency, be aware of diversity related laws, and have the tools and understanding to be able to:

- Explore the value of differences
- Discuss how to recognize and manage their own biases
- Discover ways to find common ground

Other Support for Staff

Support of our staff also includes offering a generous benefit package that allows for tuition reimbursement and, for some positions, the flexibility to work remotely as appropriate. We also support our staff in ways that might not be expected from a large health insurer. For example, when staff experience significant life events, we make an effort to assist them in adjusting to their new circumstances. This might mean, with their consent, staff visiting them in the hospital or providing a home-cooked meal. We make every effort to engage with our staff and provide support so that they are able to maintain a satisfactory work-life balance, and do their very best work for our Members when they are on duty.

We understand that relationships in our business mean everything – and that this begins with the quality of our relationships with employees. RMHP encourages employees to be involved in their communities and capitalizes on employee-led community initiatives that are consistent with our vision for Member engagement and healthy neighborhoods. Often, this does not require a financial investment on our part. Rather, we allow flexibility in role definition and support our employees' work-related interest by encouraging investments in time. Not only does this approach result in maximizing connections to the community, it accrues benefits to RMHP and our clients through our employees' high productivity and job satisfaction. They can pursue their passions, knowing that their employer is committed to supporting initiatives that are meaningful to them and create sustainable bonds with the community.

One example of how RMHP encourages our employees to pursue their interests involves Sheila Worth, a human resources professional who has been with RMHP for more than 18 years. Sheila worked collaboratively with RMHP and community leaders to start the Western Colorado Bridging Communications group because of her passionate resolve for change in the deaf community. It all began with a Facebook group that today has about 80 members. When members of a particular community are empowered, they rise up, take ownership and change becomes sustainable. A tangible result was our partnership with the Colorado Cross Disability Coalition (CCDC) and Disabled Resource Services (DRS) to assist the Larimer County Group for Deaf Rights in Healthcare. The group facilitated a town hall and learning collaborative for providers in November 2016. Our employees assisted in arranging this event and benefited from the information presented. We discuss this initiative in detail in Offeror's Response 11.

C. Fill personnel vacancies to fulfill Contract requirements

Our mission and organizational culture attracts and supports the retention of exceptionally high quality personnel at all levels. We also prioritize hiring qualified candidates from the local communities we serve. Our active role in the community has helped establish us as a leader and the reputation we have developed also serves as a recruitment tool. People want to work at RMHP because they know we make a difference in the community and they want to be part of a positive, future-focused culture.

We also promote from within, so we post positions both internally and externally. We find internal promotion is advantageous to RMHP because:

- We identify staff with cultural alignment to our organization.

- We know the skills and limitations of our staff and how they would adapt to the new position.
- We create internal continuity in operations as well as in external partnerships.
- Staff already have basic knowledge of how our organization functions.
- It creates positive culture when we invest in our own staff.

An example of how internal promotion reaps benefits for our Members, the employee and our organization involves Eve Presler. Eve advocated and negotiated systems of care for vulnerable and high-risk populations for 20 years before being hired by RMHP as a part-time care coordinator in January 2015. At the time she started work, she was completing her Masters in Social Work. Around the time Eve finished her classes, she was promoted to be the Colorado Opportunity Project Liaison to the Department because we recognized her strong skills in community organizing and data-driven decision-making. Because of her training in public policy systems, she was also involved in preliminary planning for the Accountable Health Communities Model grant we applied for and received. Eve's skills and local relationships throughout southwest Colorado have been invaluable as we have worked to advance several social determinants of health initiatives. She is also certified as a Bridges Out of Poverty trainer. Eve's role is flexible; in addition to these activities, she continues to provide direct care coordination services in her community because she loves the work, carrying a small caseload of dual-eligible and parolee Members.

Eve is an example of the type of employee we seek to hire – someone with a diverse skill set eager to take on new roles aligned with our mission that both interest her and bring her satisfaction. We hire people for their attitudes and aptitudes, and work with them to develop the skills and knowledge necessary to perform to their fullest professional capacity. Our experience is that demonstrating trust and confidence in our employees creates an extremely healthy work environment that fosters creativity and learning, as well as a motivated workforce. This benefits our Members, the Department, RMHP and the employee.

RMHP's reputation for serving the underserved and its processes and strategies that result in better outcomes for the Member help to attract the best candidates. RMHP has a unique and effective recruitment strategy that has enabled us to identify and hire the best of the best. RMHP finds the right person to fit the job. While many companies cave to deadline pressures to quickly fill a vacancy, RMHP is nimble and flexible, shifting things as needed to ensure deadlines are met while holding out for the optimal candidate. We have a target candidate, not a target hire date. We look for the right fit and sometimes that takes longer. However, we are able to adjust workloads and strengths and resources as needed.

When a vacancy does occur with personnel necessary to fulfill contract requirements, we act immediately in a well-coordinated process to recruit and hire a qualified candidate for the position. The process is accelerated by the relationships we have worked to create with community organizations. On a regular basis, we interact with a wide range of organizations such as workforce and vocational rehabilitation centers, military outreach centers, independent living centers, and universities. We participate in community job fairs and the United Way. Many of our employees serve on the boards of community organizations and volunteer with

organizations that may serve our Members. Because we participate in community events with so many of these organizations, they know RMHP and they provide a channel for us to recruit from among individuals they may be serving, such as military veterans. We recognize that people with community connections are important and we find that by hiring local, we are better able to serve our community.

Rocky Mountain Health Plans is very experienced with vetting and background clearance requirements established in state and federal regulations. Our hiring process includes an extensive background check to verify that staff have the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. We also verify that prospective employees are not included in the Office of Inspector General's List of Excluded Individuals and Entities (LEIE) database. Additionally, for clinically credentialed staff, we track the status of clinical licensure and renewal to prevent any lapses in credentials that may affect an employee's ability to perform their assigned duties.

Should a vacancy occur with any Key Personnel, we will notify the Department and seek approval for any replacement we propose in accordance with the requirements in the RFP

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.

Rocky Mountain Health Plans (RMHP) and Reunion Health have adopted an innovative approach to integrate the complex array of services, expertise, systems, licensure and accreditation necessary to achieve the goals set by the Department for Phase 2 of the Accountable Care Collaborative (ACC). Under this arrangement, RMHP will serve as the licensed, contracting organization that is the single point of accountability to the Department for all facets of RAE operations and deliverables. Reunion Health, a distinct entity formed by FQHCs and Community Mental Health Centers across Region 1, will collaborate under a Joint Operating Agreement (JOA) with RMHP that spells out the obligations and expectations of all the parties involved in completion of RAE functions and deliverables. Additionally, a broader array of providers and community leaders will be empowered to provide direction to the RAE through a community governance process – as is necessary to achieve success within Phase 2 of the ACC.

In developing our approach, we sought to address the following key objectives:

- Organize the entire RAE model around the goals needs of individual clients, as whole persons, with aspirations, dreams and contributions to offer the community

- Establish the locus of leadership and decision-making firmly within a local, multi-disciplinary, multi-sector community governance model

- Achieve the deepest possible degree of integration among health, behavioral and human service organizations – and ensure that resources and talent at every level are put to the most productive use possible

- Make the significant expertise, experience, technology, research and development and capital investment available within a national enterprise available to local leaders, with the autonomy required to close gaps, learn and innovate rapidly

- Establish clear, straight, lines of accountability to the Department that allow for the efficient fulfillment of all deliverables and public reporting duties, with an appropriate separation of controls, checks and balances

- Move well beyond the traditional, narrow "BHO carve out" and "third party" managed care models of operation, in a framework that ensures competence and continuity without sacrificing access or transparency

Achieving these objectives necessitates an approach that transcends old-fashioned "delegation" concepts, as well as narrow "ownership" arrangements among a group of self-interested parties. Such concepts have been in use for decades, and have produced limited progress toward improved integration and access to care. Indeed, these traditional approaches sometimes devolve to a point at which "delegation becomes abdication," while "ownership" produces little more than control.

The approach adopted by RMHP and Reunion Health will promote success, because it establishes a clear decision-making framework for community leadership, as well as a separation of powers that ensures accountability for performance. Within the JOA, Reunion Health and community stakeholders will participate as directors – not merely advisors -- with full responsibility for oversight of all critical RAE operations, including:

- Care model design
- Performance accountability and quality improvement
- Network access, provider recruiting and maintenance
- Data sharing and technology
- Measurement and public reporting
- Budgeting, contracting and payment

RMHP participates "at every table" in this framework, but with a limited share of decision-making authority. That said, major decisions, such as the implementation of new payment models, require consensus. Further, RMHP, in its role as the licensed, contracting Offeror, retains final authority over all matters related to compliance, accountability and risk management.

This approach is markedly different from traditional "delegation" arrangements, in which a narrow scope of services is contracted with a provider group, but little integration of leadership or services is achieved between the parties – let alone other community stakeholders. Likewise, simple "provider ownership" models, in which clinical, payer and state contracting functions are combined within a single entity, can lead to misaligned interests, conflict with Department objectives and other accountability issues.

Further, within the organizational management matrix described in Offeror's Response 4, a continuous integration of expertise and functional focus is integrated *throughout the enterprise*, with Reunion and RMHP staffing positions at multiple levels, and with clear reporting relationships among Key Personnel. Again, this approach is decidedly different than traditional delegation and ownership arrangements, because staffing and expertise are *integrated* – not "farmed out" to third parties or distant partners.

The Joint Operating Agreement developed by Reunion Health and RMHP for Phase 2 of the ACC is substantially and demonstrably more sophisticated than a simple "subcontract" arrangement between a payer and provider entity. It is also vastly more transparent, open to the community and *accountable by design* than a traditional "provider LLC" or corporate managed care model.

The JOA will also require that RMHP will comply with the provisions of the subcontractor limitation set forth at Section 5.2.14.2 of the RFP and maintain it at all times. The integrated management and operational functions performed by Reunion Health members are primarily focused on PCCM and behavioral health services best provided at the point of care, such as navigation, care coordination, assessment, care planning and referrals, outreach and Member activation. RMHP will fulfill functions that ensure the integrity and efficiency of the entire RAE, such as claims payment and encounter submission, call center platform maintenance, data

analysis, technology development and licensing, security, compliance and public reporting. Additionally, all Key Personnel of the RAE will be employed by RMHP. Accordingly, no more than 40 percent of the total value of the agreement with the Department will be subcontracted by RMHP to Reunion Health or any other entities – net of PCMP and Health Neighborhood funding requirements, as well as the cost of the Offeror's own operations.

Offeror's Response 7

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

Effective population health management and whole person care cannot be produced through a fragmented operating model. Nor will a mere "reincarnation" of the old behavioral health "carve out" concept be sufficient to achieve the Department's objectives for Accountable Care Collaborative (ACC) Phase 2.

Achieving a fully integrated system for delivering comprehensive physical and behavioral health care presents several major challenges. Beyond the performance of basic contractual functions, the RAE and its partners will need to re-engineer where and how behavioral health care services are delivered and reimbursed, and forge a more unified culture among providers and the communities in which they deliver care.

A fundamentally different leadership and administrative structure is necessary to produce transformative impact. The partnership between Rocky Mountain Health Plans (RMHP) and Reunion Health represents a significant departure from outdated "BHO" and "third party" care management models. The Joint Operating Agreement (JOA) between RMHP and Reunion Health will create the alignment, checks and balances necessary to integrate the previously separate PCCM and PIHP program functions. More importantly, the approach proposed by the Partners will create a backbone for an inclusive, transparent, community governance process – directed by consumers and multi-disciplinary leadership from throughout the Health Neighborhoods and broader ACC Community. Change can be uncomfortable, but the Partners have embraced the opportunity present in ACC Phase 2 to build upon prior successes, lessons learned and local relationships to create a better system. RMHP, Reunion Health and supporting stakeholders throughout Region 1 are excited and eager to implement the RAE delivery system model.

Reunion Health and RMHP have worked creatively and persistently for years in the diverse communities we serve, to achieve successful, sustainable integrated care. We have encountered and overcome countless barriers in our efforts, and developed extensive insight regarding the changes necessary to scale whole person care throughout the Region. In our experience, barriers to effective integration of behavioral health must be addressed in three key areas: **Operational, Financial** and **Clinical** domains of service delivery. Our proposal for RAE services is intentionally designed to overcome the divides between behavioral health and primary care in these areas. We describe our approach below.

Barrier	Planned Solution
Fee-For-Service environment	Utilize flexibility inherent in RAE payment models to address gaps in reimbursable procedures, such as health and behavior codes in primary care settings and integrated care in advanced settings

Barrier	Planned Solution
Separate funding streams and non-aligned incentives	Form a region-wide alliance with shared values to align incentives and equitably share the burdens and benefits associated with innovation and integrated, accountable care
Savings accrue to system, not organization that made initial investment	Establish clear, competency and accountability criteria, in which both PCMPs and behavioral health providers, including independent network participants, can share equitably in the new incentive and APM opportunities planned by the Department for ACC Phase 2
Communication between providers	Implement system interfacing, data aggregation and a shared platform across PCMPs, CMHCs and the RAE to complete assessment, care planning, task assignment, referrals and documentation in a single application
Cultural clashes between behavioral health and primary care providers	Provide extensive, step-wise, in-person Practice Transformation services to Network providers, which focus upon developing defined competencies in integrated, team-based care
Divided leadership and low staff engagement	Create accountability at every level, within management and across the Network for the achievement of integration objectives and data-driven quality improvement; reward success and learn constructively from failure

In response, the Partners have adopted an organizational structure for the delivery of Regional Accountable Entity (RAE) services that will overcome these barriers at the root level *by design*. The JOA for Region 1 transcends traditional carve out and managed care "delegation" models, with an organizational infrastructure to promote a whole person system of care throughout the Health Neighborhood and clear processes for shared workflow, measurement, accountability and management focus. Points of differentiation in our strategy are as follows:

OPERATIONS, MANAGEMENT & COMMUNICATIONS

- **Governance:** The Partners' integrated, transparent and community-based governance model, which extends well beyond RMHP and Reunion Health leaders, will hold the management team accountable for community priorities and performance (such as better access to care and healthier, more self-sufficient Members). Representatives from the broader ACC Network, Health Neighborhood and Community will have **both a voice *and* a vote** in the direction and operation of the Region 1 RAE.

- **Leadership:** The leadership team for the Reunion Health and RMHP partnership will integrate a balanced mix of expertise with individuals from the various Partners in key roles. This leadership matrix will provide a shared vision and decision-making process for financial, clinical, measurement and operational aspects of the RAE.

- **Management:** Clearly defined spheres of responsibility for each deliverable set forth in this Request for Proposals, and direct reporting relationships among all Key Personnel are established in a functional, outcomes-oriented matrix, with RMHP serving as the

single point of accountability to the Department for the entire enterprise as the licensed and contracting RAE organization.

- **Communication and Information Sharing:** Universal adoption and access to CommunityCare, a care management platform that supports broad access to Members' comprehensive care plans and information sharing among care team members and Members themselves. As a shared, rights- and roles-based technology solution, CommunityCare supports population health management through care coordination and integration of community and human services resources. (See Offeror's Responses 16, 21 and 22).

  - RMHP, as well as all Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) within Reunion Health, will use CommunityCare to provide efficient, team-based coordination of assessment, documentation, care planning and service delivery functions within the RAE.

  - Additionally, the shared care coordination tool deployments established by RMHP in Phase 1 of the ACC will be expanded and refined. CommunityCare will be made available to other PCMPs, health systems, Community Care Teams, Community Health Workers, as well Local Public Health Agencies, Single Entry Points, Community Centered Boards, Family Resource Centers and other community providers.

  - Further, RMHP will promote adoption and sustain the technical and legal solutions we have developed in Phase 1 to enable CommunityCare use cases for *all populations* – including uninsured populations and individuals with other forms of health coverage – without limitation to the RAE enrolled population.

  - Finally, CommunityCare will be directly accessible to *Members themselves*, so that they can set goals, monitor progress within their care plans, request care coordination support and fully engage in self-directed support and services.

- **Data management and analytics:** The Partners are uniquely positioned to fully realize the program design envisioned by the Department for ACC Phase 2, in a single accountable regional structure in which all data management, analytic, planning and evaluation functions will be performed. In addition to the CommunityCare shared management platform, the community governance structure established in the JOA will enable the Partners and stakeholders to integrate, share and act collectively upon business intelligence – generated to support our Population Health Management plan – in an efficient and proactive manner. In collaboration with leaders from Colorado Community Managed Care Network (CCMCN), Quality Health Network (QHN), Mesa County and other counties in Colorado, the Partners have created a comprehensive framework for whole person data management supporting all key domains of administrative, clinical, social and Member-reported data. The sophisticated framework includes formal data sharing arrangements, advanced technology, and locally-based, best-in-class expertise and resources for data analytics and data sharing. Moreover, RMHP has extensive experience exchanging data with the Department, and received

approval for a full spectrum of encounter submission and reconciliation processes in June 2017 from the Department's *interChange*.

FINANCIAL INTEGRATION

RMHP and Reunion Health will build upon the substantial success of the Payment Reform Initiative for Medicaid Enrollees ("Prime") initiative in which a community infrastructure was established for collaborative oversight of all aspects of quality and financial performance. Within Prime, a transparent, open process has been implemented to distribute performance data to a wide array of executive-level public health, human services, hospital, independent behavioral health providers, business leaders and consumer representatives, in addition to CMHCs, FQHCs and other PCMPs. We will build upon this structure for financial management integration within the RAE, in which all resource allocation, network design and payment model decisions will be made. Core aspects of RAE financial management include:

- **Budget:** Detailed operational budget development processes and related decisions – for both PCCM and the capitated behavioral health benefit – will be shared by the Partners in a transparent process. Regular reports showing total revenues and actual expenses in the key functional categories defined by the Department will be published to stakeholders participating on the Directors Committee established within the JOA.

- **Audits:** Corresponding RAE financial, compliance and program audits – and any corrective actions suggested or required by the Department – will likewise be published to stakeholders participating on the Directors Committee.

- **Network:** Objective criteria for PCMP and independent behavioral health provider participation in the network, at progressively accountable and sophisticated tiers (as described in Offeror's Responses 11 and 17), will be jointly established by the Partners through the JOA framework, in a manner that may be reported clearly and independently evaluated by the Department and community stakeholders.

- **Payment:** All design and decision-making functions regarding Alternative Payment Methodology (APM) alignment, enhanced payment for PCCM functions and incentives for performance will be completed through the JOA structure. Further, the JOA structure will be used to make decisions regarding practice criteria and performance expectations for enhanced "global payment," in which non-volume reimbursement is made by the RAE for health and behavior procedures not reimbursed through the Colorado Medicaid Fee schedule, to sustain behavioral health specialists on PCMP care teams in practices that meet Advanced and Comprehensive criteria (discussed in Offeror's Response 17). These decisions will be supported by comprehensive, state-of-the-art evaluation and first-hand assessment reports provided by the RMHP Practice Transformation team.

CLINICAL INTEGRATION & CULTURAL CHANGE

Clinical integration and cultural change are perhaps the most challenging aspect of a whole person system that provides both health and behavioral supports for every Member. Substantial, practical work has been developed to assess progress toward clinical integration and culture change within a well-aligned overall system of support. The Partners have adopted

the *Standard Framework for Levels of Integrated Care*[5] published by SAMHSA, in alignment with the Colorado State Innovation Model (SIM) initiative:

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION PARTLY INTEGRATED	FULLY INTEGRATED
• Separate systems • Separate facilities • Communication is rare • Little appreciation of each other's culture	• Separate systems • Separate facilities • Periodic focused communication; most written • View each other as outside resources • Little understanding of each other's culture or sharing of influence	• Separate systems • Separate facilities • Regular communication, occasionally face-to-face • Some appreciation of each other's role and general sense of large picture • Mental health usually has more influence	• Some shared systems • Same facilities • Face-to-Face consultation; coordinated treatment plans • Basic appreciation of each other's role and cultures • Collaborative routines difficult; time and operation barriers • Influence sharing	• Shared systems and facilities in seamless bio-psychosocial web • Consumers and providers have same expectations of system(s) • In-depth appreciation of roles and culture • Collaborative routines are regular and smooth • Conscious influence sharing based on situation and expertise
"Nobody knows my name. Who are you?"	*"I help your consumers."*	*"I am your consultant."*	*"We are a team in the care of consumers."*	*"Together, we teach others how to be a team in care of consumers and design a care system."*

The establishment of a fully integrated structure at the RAE level, pursuant to the criteria set forth in the right-hand *Fully Integrated* column above, is present in the JOA between RMHP and Reunion Health. Adherence to these criteria at the level of RAE operations is essential to promoting the fullest possible degree of integration throughout the Network. Likewise, clear standards and a comprehensive set of clinical supports for **practice assessment**, **transformation**, **shared learning**, **workforce development** and **culture change** must be provided by the RAE to improve the scope and depth of integration in provider sites throughout the Region. The Partners possess extensive resources and organizational expertise in these areas, and will promote the expansion of integrated care.

Practice Assessment

The Partners have substantial experience assessing and reporting practice integration status in order to align learning and payment supports. Accordingly, RMHP has well-developed processes

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Heath, B., Wise Romero, P., & Reynold, K.A. (2013). A standard framework for levels of integrated healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions.

to apply the *Integrated Practice Assessment Tool* (IPAT), in alignment with the *Standard Framework*. The logic model used by the RMHP team for this purpose is straightforward:
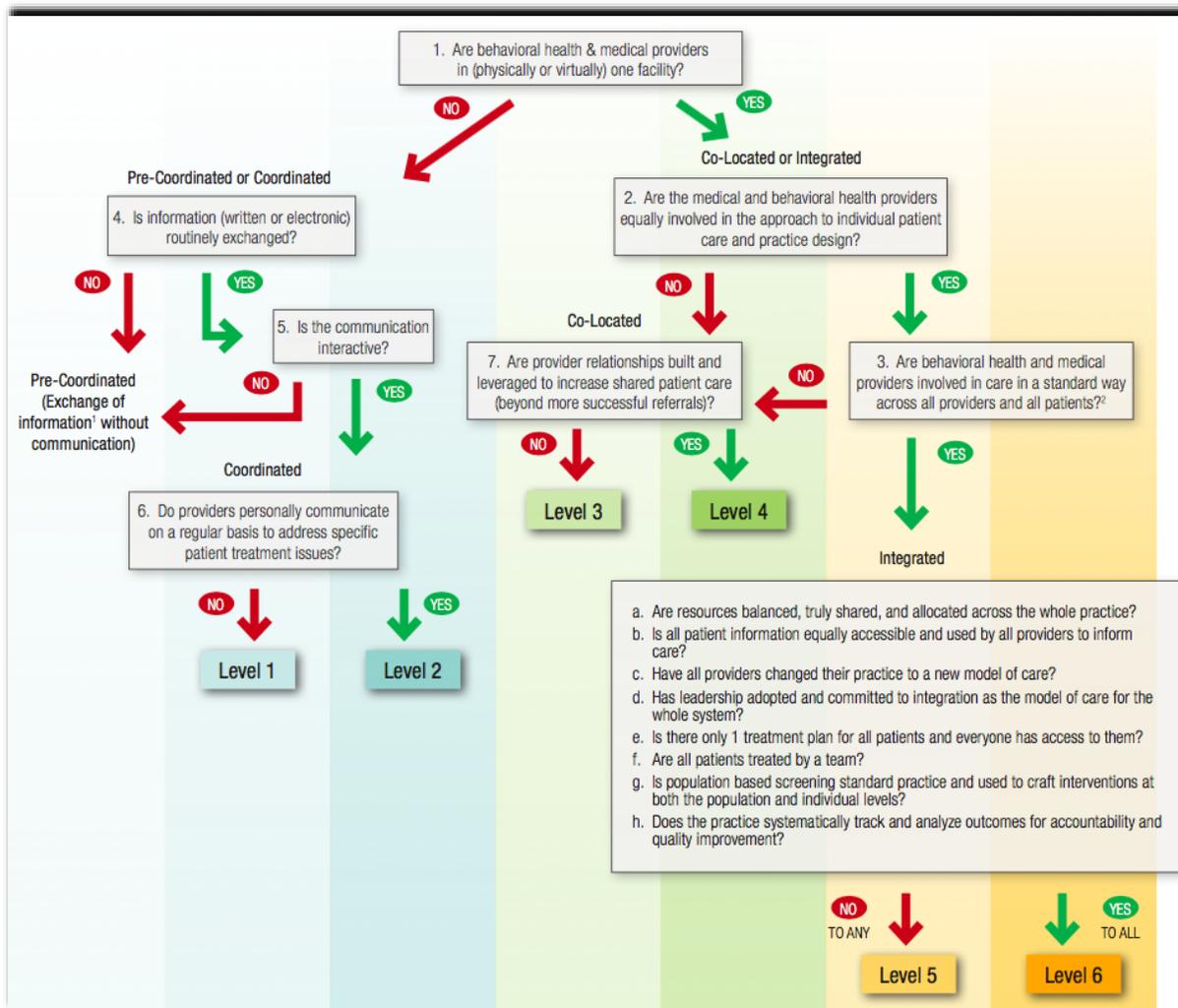
Practice Transformation

RMHP has developed a robust, comprehensive practice transformation program, which is designed to meet a wide array of practice learning and competency development objectives – including integrated behavioral health. *Quality Improvement Advisors* and *Clinical Informaticists* currently fulfill formal practice transformation deliverables under contract with CMS for the Comprehensive Primary Care Plus (CPC+) advanced payment model test, as well as with the University of Colorado for the Colorado SIM initiative. Behavioral health integration learning tracks and curricula are developed to address team-based, quality improvement processes as well as cultural evolution within the practice. Key features of the curricula include three discrete learning tracks, several specific learning objectives and defined practice deliverables as follows:

- **Coordinated Care Track**: For primary care clinics wanting to improve their existing staff's ability to address behavioral health issues and to collaborate with behavioral health clinicians in the community (three to four months for completion)

- **Co-Located Care Track**: For primary care clinics wanting to embed a behavioral health clinician (six to eight months for completion)

- **Integrated Care Track**: For primary care clinics who already embed behavioral health clinicians and now want to create a fully integrated model—clinical services, payment, documentation and leadership (12+ months for completion).

- **Bi-directional integration track**: For behavioral health clinics that seek to address the significant health disparities seen in patients with serious mental illness (SMI). May work to coordinate, co-locate or provide integrated primary care services in the behavioral health setting

Program Objectives (vary between tracks):

- Screening and tracking psychiatric conditions in primary care
- Screening and tracking medical conditions in behavioral health
- Primary care counseling and behavioral intervention skills
- Basics of coordinated care
- Basics of co-location
- Basics of integration
- Care management
- Business practices
- Human resources and leadership
- Health information technology (HIT)
- Quality improvement (QI) and change management

Practice Deliverables:

- Initial self-assessment upon entrance into the program
- Attendance at an annual CO-EARTH (Colorado is Expanding Access to Rural Team-based Healthcare) learning collaborative, usually in June
- Monthly internal QI meetings pertaining to CO-EARTH work
- Monthly team conference calls with St. Mary's and RMHP Quality Improvement Advisor
- Narrative to summarize progress and plans for continued growth upon completion of the program

Shared Learning

RMHP has extensive experience developing and sustaining large-scale, collaborative learning programs, which have accelerated region-wide engagement and practice evolution across several major Cooperative Agreements and model tests. These include the CMS Innovation Center's Comprehensive Primary Care Plus (CPC+), State Innovation Model (SIM), Transforming

Clinical Practice Initiatives (TCPI) and the AHRQ-sponsored Evidence Now Southwest initiative. Previous engagements included the "CPCi classic" model test and *Beacon Communities* initiative, sponsored by the HHS Office of the National Coordinator for Health Information Technology (ONC). Founded on the *Breakthrough Collaborative Series* first pioneered by Don Berwick, MD and the Institute for Healthcare Improvement, RMHP has optimized a flexible, efficient approach to collaborative learning and peer-based support for several learning objectives, including behavioral health integration

Workforce Development and Culture Change

A comprehensive organizational strategy and robust inventory of practice supports is necessary, but not sufficient, to scale and sustain fully-integrated, team-based care across the entire network. A shortage of skilled providers with an understanding and aptitude for integrated care must be addressed through an intentional workforce development process. Likewise, a community-wide approach to continuous evaluation and culture change is essential to create an environment in which integrated care can become *the norm and expectation* among both clinicians and Members – particularly in rural areas where resources are scarce. To that end, RMHP has partnered closely with the Caring for Colorado Foundation and University of Colorado to develop **CO-EARTH** (Colorado is Expanding Rural Access to Team-based Healthcare), delivered in tandem with the St. Mary's Family Residency Program. Any primary care office from a rural community, or a smaller office (one to six providers) from a larger community is eligible to apply. System- and independently-owned practices are welcome. CO-EARTH services include a one-day training visit, monthly support phone calls, and a one-day multi-site learning collaborative. Additional services can include one- to three-week rural rotations with family medicine residents trained in integrated care and assistance in applying for the State Innovation Model (SIM) program.

BASIC, INTEGRATED MEMBERS AND PROVIDER SUPPORT SERVICES

Beyond the strategic operational, financial and clinical integration supports described above, RMHP and Reunion Health will fully integrate basic operational supports for Members and network providers – a simple but significant change that will create efficiencies and improved experiences for both. RMHP has substantial, established operational platforms that will be used to support these functions, with access to additional tools and efficiently scaled services available from UnitedHealthcare.

OneCall Center

RMHP will operate a local call center in Grand Junction where provider relations staff and customer service staff will be based. Our technology, policies and procedures also allow customer service representatives to work from locations other than RMHP corporate office in Grand Junction – and fully integrate benefit, claims, authorization and provider information on one platform. This will ensure that our team responds to Member and provider calls with local context, as well as to maintain business continuity when weather and driving conditions impair employee travel to the office.

We will maintain, staff and publish **one toll-free number that Members and providers** can call for assistance with any issue. Whether a provider needs help with a claim or a Member is

inquiring about benefits or needs a referral, our system permits routing the caller to the staff capable of addressing the concern and resolving it. Our technology supports warm transfers to participating providers, such as FQHCs or CMHCs, for scheduling or other support requested by Members. These call center supports help establish the RAE as a valued partner for Members, with effective help in navigating the system and the support the need to engage in their own care and wellness.

Single Website

We will develop and maintain a single comprehensive website for the RAE that will provide online access to information for Members, their family members and advocates, as well as providers. The site will be fully responsive and feature an easy-to-use navigation system common to all RAE partner organizations. It is tailored to meet the needs of Members and providers.

Provider Administration

RMHP's current approach to provider support is already fully integrated and we will continue that approach as the RAE. Our provider specialists are regional representatives who are not only experts on the geographic region they serve but can also support providers within their territory on any issue – whether related to physical or behavioral health.

Grievances and Appeals

RMHP has over 40 years of experience administering federally regulated managed care programs, including managing and implementing compliant and effective grievances and appeals systems. We possess the knowledge, operating infrastructure and skill set necessary to administer a responsive, compliant Grievance and Appeal system, whether the issue concerns physical or behavioral health.

Quality Improvement

RMHP's quality improvement program will align with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care for both physical and behavioral health. RMHP will lead all quality improvement activities and will work with our Reunion Health partners to sustain an integrated, data-driven, continuous assessment and performance improvement program. Our strategy integrates the strengths of each partner organization and will produce actionable feedback within our management structure and transparent community governance process.

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 ACCOUNTABLE ENTITY (RAE)

As a statewide health maintenance organization with the backing of a national enterprise, Rocky Mountain Health Plans (RMHP) offers the operational scale, technical resources and competencies required to efficiently fulfill the full spectrum of RAE services and functions.

RMHP also possesses unique organizational skills and a nimble, creative management culture that actively promotes shared learning, community integration and local leadership processes. RMHP has demonstrated its collaborative, community-oriented "DNA" over the course of multiple, large scale Cooperative Agreements, such as the CMS *Accountable Health Communities Model* test, the HHS *Beacon Communities* demonstration, the HB 12-1281 payment reform demonstration ("RMHP Prime") and Phase 1 of the Accountable Care Collaborative (ACC).

INCLUSIVENESS, TRANSPARENCY, CHECKS AND BALANCES

In ACC Phase 2, RMHP and Reunion Health will integrate our significant organizational resources with the expertise of leading provider organizations and local leadership in an authentic community governance process within a Joint Operating Agreement (JOA). The JOA structure creates transparency and a decision-making framework that distributes broad authority to local leaders regarding care model and community integration processes. Consumers, county agencies, community service organizations, network providers as well as the broader Health Neighborhood will have both "*a voice and a vote*" regarding the direction and performance of the RAE.

Likewise, the JOA also creates a separation of duties and authority between provider organizations and the RAE, which will comply at all times with client access, safety, quality improvement and all other federal and state beneficiary protections. RMHP is the single, ultimate point of accountability to the Department, and has the right to act unilaterally within the JOA structure when necessary to ensure that covered benefits are delivered timely and fairly – and that all other contractual obligations to the Department are fulfilled in a manner that exceeds program standards.

HOW IT WORKS

The Partners will form two key leadership committees to oversee and share decision-making regarding the delivery and financing of RAE services. These are the Executive Committee and the Directors Committee, which we describe below.
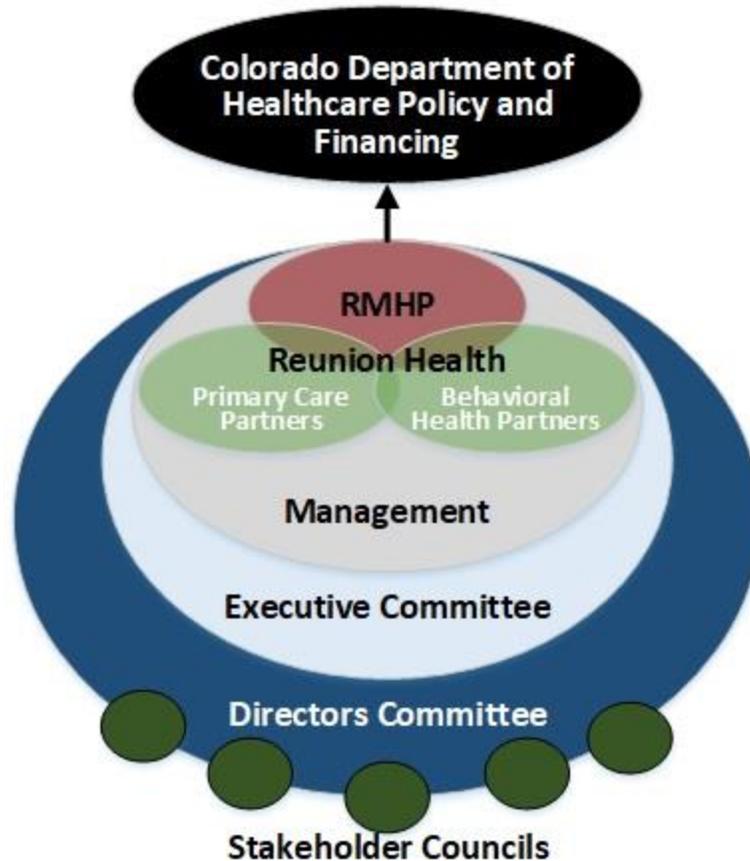
Executive Committee

The Executive Committee is comprised of one chief executive officer representative from RMHP and four chief executive officer representatives appointed by Reunion Health. Each representative will have one vote. The Executive Committee is responsible for decision-making regarding RAE services in the following domains:

- Program budget, financial reporting and performance
- Behavioral health payment models
- Care model design and policy oversight
- Operational policies and procedures
- Performance standards, monitoring and corrective actions
- PCCM and behavioral health provider network participation, tiering criteria, enhanced and alternative payment models
- RAE contract negotiation with the Department
- Compliance and accountability systems

Regular meetings of the Executive Committee shall be held as frequently as necessary and no less than once each quarter. Special meetings may be called by any Executive Committee Member with advance notice.

Members Include:

- Michael Allen, LCSW, CACIII, MBA, SummitStone Health Partners, Chief Executive Officer (CEO)
- Scott Bookman, EMT-Paramedic, Uncompahgre Medical Center, CEO
- Ross Brooks, Mountain Family Health Centers, CEO
- Lisa Brown, NW CO Visiting Nurse Assoc. CHC, CEO
- Jeremy Carroll, River Valley Family Health Center, CEO
- Patrick Gordon, MPA, Rocky Mountain Health Plans, Executive Director
- Mitzi Moran, CEO, Sunrise Community Health
- Sharon Raggio, LPC, LMFT, MBA, Mind Springs Health, President and CEO
- Kay Ramachandran, MA, Marillac Clinic, Executive Director
- Helen Royal, LPC, Summit Community Care Clinic, CEO
- John Santistevan, Salud Family Health Centers, President and CEO
- Lincoln Pehrson, Dove Creek Community Health Clinic, Executive Director
- Shelly Spaulding, The Center for Mental Health, CEO

Directors Committee

The Directors Committee, as well as the corresponding stakeholder Advisory Committees that support it, shall meet at least quarterly, on regularly scheduled dates. The Directors Committee is responsible for decision-making regarding RAE Services in the following domains:

- Population health management plan
- Health and community neighborhood advisory structures and process collaborations, contracts, and data-sharing arrangements
- Integration of other federal, state or foundation grants and model tests awarded to the Partners, as necessary to promote the success of the RAE
- Consumer engagement, consumer network development, design, feedback and process improvement
- Review and approval of prioritized contract deliverables to the Department
- Annual performance plan, quality targets
- Annual report and other public reporting functions

The Directors Committee is comprised of one senior management representative from RMHP and one senior management representative from each of the 11 organizations within Reunion Health. Additional Directors will include one (1) representative appointed by each six (6) stakeholder Advisory Councils, described below:

- **PCMP Council**: This group will include participants from private primary care practices throughout the region, representing multiple specialties and forms of organization (small independent, system-owned, large multispecialty groups, other).

- **Behavioral Health Independent Provider Council**: This group will include participants from independent, non-CMHC behavioral health providers and groups throughout the region.

- **Hospital and Specialty Care Transformation Council**: Hospitals and health systems will participate in this group, as well as specialists from multiple fields. This group will focus upon the design and implementation of transformation and quality improvement projects that expand access, capacity, safety and transitions management for Medicaid enrollees.

- **Performance Improvement Advisory Committee (PIAC):** This group will be convened in accordance with requirements set by the Department, and will participate actively in discussions within both the Directors Committee, as well as in the statewide PIAC convened by the Department.

- **Member and Family Advisory Council:** Consumers and supporting organizations, representing a diverse array of families, children, underserved communities, people living with disabilities and other special needs will participate on this council, to ensure that feedback is conveyed, priorities are set and design improvements are executed throughout the RAE enterprise, Network, Health Neighborhood and Community.

- **Community Leadership Council:** This group will include leaders from the Community Health Alliance movement, Local Public Health, LTSS and other organizations, and will work to so that RAE initiatives and operations are aligned with broader community integration and capacity building initiatives, such as the State Innovation Model Regional Health Connector (RHC) program and the CMS Accountable Health Communities Model (AHCM).

Since there are often multiple entities within the stakeholder group categories represented on the Directors Committee (e.g., multiple hospitals, multiple consumer interests and physician specialties), stakeholder Advisory Councils in each major domain of participation will be convened and staffed by RAE Community Integration personnel to support productive engagement and use of time, and will appoint representatives to the Directors Committee for defined terms of service.

A Directors Committee member must be a director, officer or senior staff member of the appointing organization. This requirement does not apply to Advisory Council Members. Each appointed representative on the directors committee will have one vote.
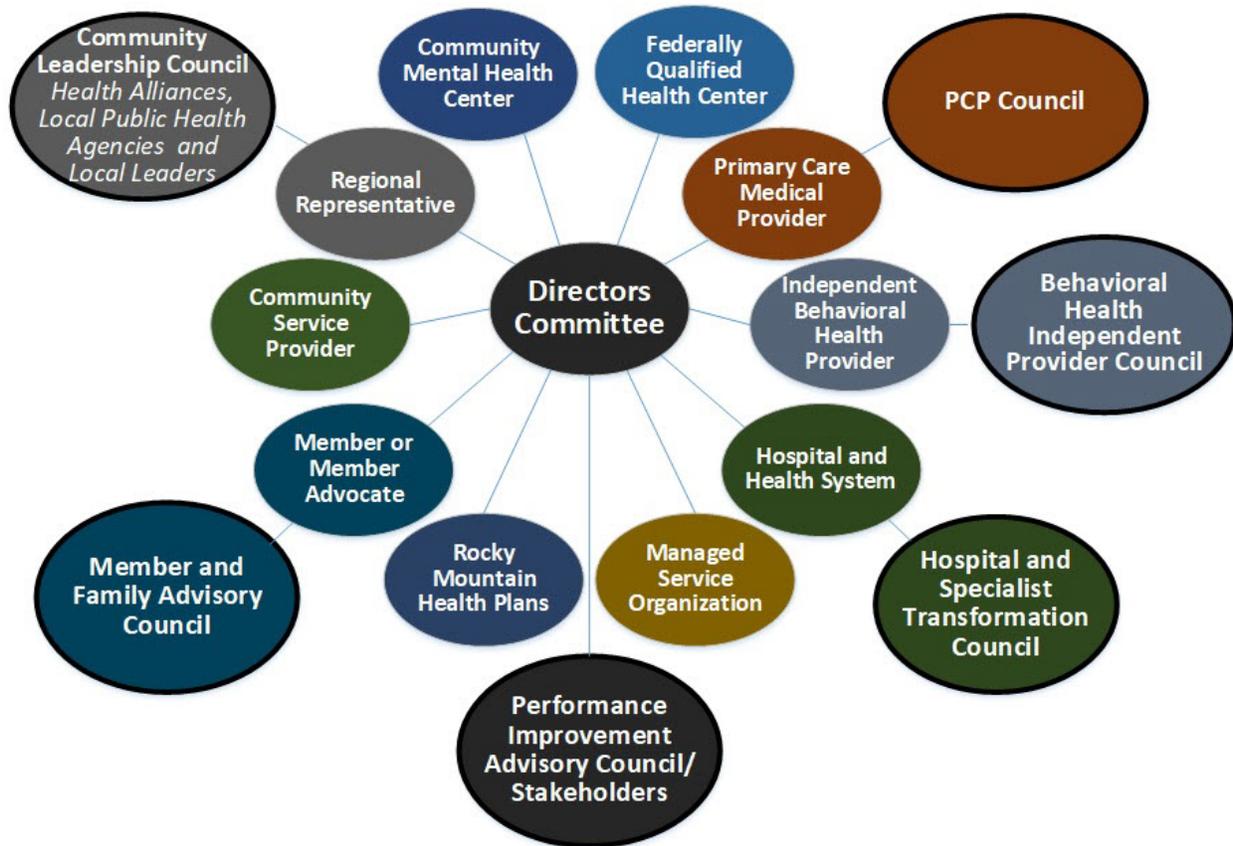
This Directors Committee structure will ensure that RAE operations are tied closely to community needs and priorities. This structure will have the effect of creating a RAE organization that is unique to the Region --- even if similar structures are utilized in other Regions.

ADDRESSING CONFLICTS OF INTEREST

We recognize that conflicts of interest – or the appearance thereof – may arise in the work and day-to-day decision-making of the committees within the RAE structure.

Within the JOA, the Partners are expected to act in the interests of the Membership and State, and to make all operating decisions fairly and objectively, without favor or preference based on personal or respective organizational interests. Accordingly, the Partners will document and publish a Conflicts of Interest Plan, with input from both the Department and the community, which will be applicable to members of our governing committees. Adopting a Conflicts of Interest Plan will not only meet the Department's contractual requirements, but also provide for sound ethics, corporate responsibility, and management practice.

Reporting and Transparency

The elements of our Conflicts of Interest Plan will include components that address misaligned interests at the organizational and operational level, with respect to policies, procedures, approval and participation decisions. It will also address conflicts that may arise for individuals who participate in RAE operations and governance processes. Disclosure, documentation and

reporting processes will be established for the Executive and Directors committees so that any action taken by the Executive Committee to resolve a conflict of interest – whether actual or perceived -- will be documented and reported to the full membership of both committees.

Individual Conflicts

Within the documented Conflict of Interest plan, any governing committee member is required to immediately disclose it to the Executive Committee, where it will be determined how the conflict or apparent conflict is to be resolved. We believe many actual and apparent conflicts of interest can be resolved if the conflict is reported before it creates the appearance or reality of having influenced the judgment of the potentially conflicted individual.

Additionally, any action taken by the Executive Committee to resolve a conflict of interest, whether actual or perceived, will be documented and reported to the full membership of both committees.

Our approach to managing conflicts will include the following steps:

- Duty to Disclose – All governing committee members of the RAE will be required to complete an annual conflict of interest disclosure form. However, this annual disclosure does not relieve these individuals of the responsibility to report actual and apparent conflicts of interest as soon as they become aware of the conflict.

- Evaluation of Conflicts of Interest – The Executive Committee will manage conflicts of interest. After disclosure of the conflict and all material facts, input from legal counsel and any discussion with the person making the disclosure, he or she will leave the committee meeting while the determination of a conflict of interest is discussed and voted upon.

- Procedures Addressing a Conflict – If a conflict is determined to exist, the Executive Committee will decide how it will be addressed. This may include permitting the conflicted individual an opportunity to participate in a discussion of the issue, but not allow them to vote, or excluding them entirely from the discussion as well as the vote.

- Violations of the Conflict of Interest Policy – If a committee member is believed to have failed to disclose a conflict, the member will be afforded an opportunity to explain the alleged failure to disclose. If, after hearing the committee member's response and making such further investigation as may be warranted in the circumstances, the Executive Committee determines that the member has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action up to and including termination of employment and participation in the RAE.

The Partners will submit our Conflicts of Interest Plan to the Department within 30 days of the effective date. It will also be posted on our website. We will update the plan and submit the updated plan to the Department any time the plan is changed or a new conflict of interest is discovered. We also plan to submit our Conflict of Interest Plan to periodic external review or independent audit. Any final report issued by the external reviewer or independent auditor will be posted to our website and submitted to the Department.

SUPPORT FROM OUR COMMUNITY PARTNERS

The following region 1 and statewide organizations are supporting RMHP's ACC Phase 2 proposal and have authorized RMHP to identify them in this RFP response.

Reunion Health Community Mental Health Centers (CMHCs)	Location / Region
Montrose Center for Mental Health	Montrose
Mind Springs Health	Mesa & NW Colorado
SummitStone Health	Larimer County

Reunion Health Federally Qualified Health Centers (FQHCs)	Location / Region
Salud Family Health Centers	Larimer County
Northwest Colorado Health	Steamboat & Craig
Summit County Community Health Center	Summit County
Mountain Family Health Centers	Garfield, Eagle/Pitkin
Marillac Clinic	Mesa County
River Valley Health Centers	Montrose, Delta
Uncompahgre Medical Center	Norwood
Dove Creek Clinic	Dove Creek
Sunrise Community Health	Larimer County

Long Standing Stakeholders	Location / Region
WestPac Physicians Advisory Group	Region 1
Mesa County Physicians IPA	Mesa County
Western Colorado IPA	Montrose County
St. Mary's Hospital and Regional Health Center	Mesa County
Kaiser Permanente	Larimer County
Mesa County Health Leadership Council	Mesa County

Consumers	Location / Region
Colorado Cross-Disability Coalition (CCDC)	Statewide
Member Advisory Committee	Region 1
Center for Independence (CFI)	Mesa County
Deaf Community WorkGroup in Larimer County	Larimer County
Disabled Resource Services	Larimer County
Northwest Colorado Center for Independence (NWCCI)	Steamboat & Craig
Southwest Center for Independence (SWCI)	Durango

Community Health Alliance	Location / Region
West Mountain Regional Health Alliance	Garfield, Eagle/Pitkin
North Colorado Health Alliance	Loveland
Northwest Colorado Community Health Partnership	Rout, Moffat, Jackson
Tri-County Health Network	Ouray, Montrose
Southwest Area Higher Education Council	Durango and Cortez

Public Health, Human and Community Services	Location / Region
Mesa County Public Health Department	Mesa County
Boulder County Department of Housing & Human Services	Boulder County
San Juan Basin Public Health	La Plata County
Health District of Northern Larimer County	Larimer County
Delta County DHS	Delta County
Northwest CO Health	Routt County

Health Information Exchange & Data Management	Location / Region
Quality Health Network	Region 1
Colorado Community Managed Care Network	Statewide

Advanced PCMPs	Location / Region
Pediatric Partners of the Southwest	Durango
Primary Care Partners	Grand Junction
Associates in Family Medicine	Ft. Collins
Foresight Family Practice	Grand Junction
St. Mary's Family Residency / Randall Reitz CO-EARTH	Grand Junction
Roaring Fork Family Practice	Glenwood Springs

Hospitals	Location / Region
West Springs Hospital	Grand Junction
Montrose Memorial Hospital	Montrose
Aspen Valley Hospital	Aspen
Yampa Valley Medical Center	Steamboat
UC Health-Ft Collins Family Medicine Center & Residency Program	Ft. Collins
Rocky Mountain ACO / Western Health Alliance	Montrose
Denver Health and Hospital Authority	Denver, Winter Park

School Based Health Centers	Location / Region
A Kidz Clinic	Montrose
Roaring Fork SBHC	Glenwood
Summit Community Care Clinic SBHC	Summit County
Silverton School Telehealth Clinic	Silverton

Long Term Services and Supports & I/DD Agencies	Location / Region
Hope West Hospice and Palliative Care	Grand Junction
Strive	Grand Junction
Community Options	Montrose, Delta
Community Connections	La Plata, Archuleta
Horizons Specialized Services	Steamboat & Craig

Long Term Services and Supports & I/DD Agencies	Location / Region
Mountain Valley Developmental Services	Garfield, Eagle/Pitkin
Foothills Gateway	Larimer County

Substance Use Disorder Managed Service Organizations (MSOs)	Location / Region
Signal Behavioral Health Network	Larimer County

Other Essential Community Partners	Location / Region
Colorado Community Health Network	Statewide
Ute Mountain Ute Health Center	Montezuma County
Pinon Project – Family Resource Center	Montezuma County

LETTERS OF SUPPORT

Letters of support are included in Appendix B. Excerpts from letters of support received from community partners are included below.

Colorado Cross-Disability Coalition

"RMHP excels at bringing people together. They do this in effective ways with decades of experience. They know how to get the right people to the right tables and are always eager to be a leader or participant (whichever is appropriate) in an effort to solve problems. As our health care system braces for uncertainty and as we as a state stand ready to reject austerity and embrace a strength based, inclusive approach, this organization has the capacity to play an essential role in ACC 2.0. In closing CCDC would strongly endorse RMHP as our first choice in any region in Colorado."

--Julie Reiskin, LCSW, Executive Director

Pediatric Partners of the Southwest

"Our partnership with RMHP has allowed us to create our PPSW Integrated Behavioral Health Program tailored to our rural southwest region. This program has served as a foundation for the development of our pediatric medical home trauma informed practice and a model for team based care including a care coordinator, medical nurse navigator, and Registered Dietitian. These building blocks allowed us to leverage our experiences into our specialty telemedicine partnerships and local school based health efforts. RMHP's attention to local Colorado communities is well-aligned with the Department's vision for Colorado Medicaid, but their ongoing, bold commitment to innovation and improvement in partnership is what sets them markedly apart from other competitors for the RAE regions. There is no other regional organization, with the innovative tools and boots on the ground positive relationships, that is well positioned as RMHP to support the Phase 2 goals of the Accountable Care Collaborative."

-- M. Cecile Fraley MD, CEO

Reunion Health Letter of Support

July 17, 2017

Sarah Miller

Colorado Department of Health Care Policy and Financing
Purchasing and Contracting Services Section
1570 Grant Street
Denver, CO 80203-1818

Re: Letter of Support for Rocky Mountain Health Plans ACC Proposal and RMHP Prime

Reunion Health, LLC is integrated service delivery entity comprised of a comprehensive network of the undersigned Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. Rocky Mountain Health Plans (RMHP) and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. We have found RMHP to be an exceptionally well-qualified partner during Phase 1 of the ACC. We fully support RMHP's proposal to serve as the Regional Accountable Entity during ACC Phase 2. We also support the **RMHP Prime** model that currently operates within six Region 1 counties, in which several Reunion Health organizations currently operate, and advocate continuation of Prime under RMHP's leadership during ACC Phase 2.

On behalf of all twelve Reunion Health, LLC organizations enumerated below, we attest our support.

Sincerely,
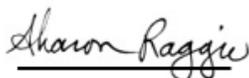
Sharon Raggio, CEO	Shelly Spalding, CEO	Ross A. Brooks, CEO
Mind Springs Health	**Center for Mental Health**	**Mountain Family Health**
Lisa Brown, CEO	Jeremy Carroll, CEO	John Santisteven, CEO
Northwest Colorado Health	**River Valley Health Centers**	**Salud Family Health Centers**
Scott Bookman, CEO	Lincoln Pehrson, CEO	Helen Royal, CEO
Uncompahgre Medical Center	**Dove Creek Clinic**	**Summit Community Care Clinic**
Kay Ramachandran, CEO	Mitzi Moran, CEO	Michael Allen, CEO
Marillac Clinic	**Sunrise Community Health**	**SummitStone Health Partners**

Offeror's Response 9

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

INTRODUCTION

As a group dedicated to improving health care in Colorado, we recognize that our Member engagement activities must be as diverse as our Members. Our Member Engagement objective is to identify how we can best support our Members in achieving their health and well-being goals. We seek to do this by improving:

- **Health literacy**: The ability to make daily life decisions about sleep, diet, exercise, alcohol intake and other lifestyle factors that support health
- **Health*care* literacy**: The ability to navigate various avenues of medical care and understand and follow medical directions
- **Engagement in health system redesign:** The ability to inform the system so that the system adapts to the needs of the Member

We bring accessible, integrated and coordinated care to our Members. We continuously adapt to our Members' needs by asking them how we can serve them better, and improving quality outcomes.

Community Engagement: Leveraging Trusted Partners

To be effective, Member engagement strategies must involve the communities where Members live, work and play, enlisting a variety of trusted partners. We follow the Colorado Department of Public Health & Environment (CDHPE) Office of Health Equity's Community Engagement framework,[6] adapted from the Annie E. Casey Foundation:

- Value and prioritize lived experience and community voice
- Commit to full transparency and accountability
- Acknowledge that there are institutional, systemic and structural barriers that perpetuate inequity, which has silenced the voice of the community over time
- Commit to partnership in the co-creation and co-ownership of solutions

Our vision for Member engagement is shared leadership in all of our communities. Recognizing the historical barriers to optimal health, we seek Members from a variety of cultural groups, abilities and disabilities, and from all levels of engagement to participate in leadership roles.

RMHP is a credible messenger, having provided service to Medicaid clients for over 40 years. More importantly, we communicate messages with individual Members in their desired format and language both directly and through providers, care coordinators and community partners trusted by Members. Using local and familiar messengers who are culturally aligned or aware is often more effective than communications that originate with the RAE organization.

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[6] http://www.colorado.gov/pacific/sites/default/files/Authentic Community Engagement to Advance Equity.pdf

RMHP was honored with recognition by the Colorado Cross-Disability Coalition (CCDC) at their 2015 annual Access Improvement Awards ceremony. In the words of Julie Reiskin, CCDC Executive Director:

"These awards are given to those that go above the letter of the American's with Disabilities Act (ADA) to implement the spirit of the law. The policy goal of the ADA has always been to include people with disabilities into all aspects of American life. Because people with disabilities have historically been so disenfranchised, it is important to take affirmative steps regarding inclusion if inclusion is going to be real and meaningful. As our organizational motto 'nothing about us without us' indicates, involvement in all levels of policy and program development is vitally important to people with disabilities. It also makes sense and the evidence shows that involvement of 'clients' is necessary for strong programs throughout the health and human services industry… We hope by highlighting Rocky's work we can send a message that while Real and Meaningful Engagement does take real work, and real time--it yields real results."

Making it Easy for Members to Receive Useful Information

While delivering the message is the first part of our engagement strategy, we also enable Members to seek accurate information as they need it. Our goal is to make it easy for our Members to engage with us.

Our website is modern and accessible through personal computers and mobile phones, as many of our Members consume information primarily via their phones. However, we also recognize that many of our Members - particularly those in rural and frontier counties - lack access to the Internet and desire health information in other formats. We therefore maintain alternative methods for Members to receive health information:

- Members can call our One-Call center to receive information about health care programs and resources, or to reach their local care coordinator.
- Members can access MyHealthLine, which combines the national Lifeline benefit (free smartphone or bring your own phone) with interactive digital health programs to support and motivate Members.

Health Literacy

According to the National Network of Libraries of Medicine[7], health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Social determinants research indicates that health behaviors are a major factor in health outcomes. Health literacy is a key tool for Members to engage in health-promoting behaviors. We use innovative strategies, such as the *Baby and Me Tobacco Free* incentive structure, to promote self-management and Member engagement in health literacy.

Healthcare Literacy

Health*care* literacy, on the other hand, is the knowledge and skill to successfully navigate the health care system. For this complex topic, our key strategy is to make information

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[7] https://nnlm.gov/professional-development/topics/health-literacy

understandable and the health system more readily accessible to Members. For Members with lower-level reading skills, we use picture-based instructions where possible. For Members who have difficulty remembering instructions, we use teach-back methods to improve retention. Graphs can be an appealing and informative means of communicating health risk information to adults with low numeracy skills.[8] Healthcare literacy is a necessary step toward engaging Members fully in their wellness and treatment plans.

Bi-Directional Communication: Learning from Each Other

When we open the door for Member engagement, we invite bi-directional communication. Every communication with a Member presents an opportunity for feedback so that we can continue to learn and evolve based on Member needs. We have traditional feedback mechanisms such as customer satisfaction surveys and Member Advisory Councils, as well as nontraditional tools such as *Voice of the Consumer*, which uses one-on-one interviews to understand our Members' health and wellness related desires and challenges at a deeper level. We also seek knowledge from external sources, such as the Department's Member Experience Advisory Council. Our goal is to engage Members in a proactive cycle of participation, feedback, and redesign.

PERSON- AND FAMILY-CENTERED APPROACH

"The real meaning of person-centered care is understanding what a person's real goals are, and supporting the Member in achieving those goals."

Member Advisory Council member

Person- and Family-Centered Member Engagement means:

- Providing Members with the information and supports they are seeking, at the time that they need them
- Using a variety of evidence-based communication tools to adapt to different learning styles and preferences
- Seeking continuous Member feedback about our engagement approaches

RMHP listens to and learns from our Members to determine how we can most effectively support them in achieving their personal health and well-being goals. We closely align our Member engagement activities with the Department's person- and family-centered approach. We respond to Member, family, and caregiver needs, using a variety of communication tools to improve health literacy while striving to understand cultural preferences. We currently comply with the requirements listed in Section 5.5.1 of this Request for Proposals (RFP) and will continue to do so as the RAE.

RMHP understands and recognizes that the health of an individual is heavily affected by the health and behaviors of household members – particularly in the case of parent/child dyads.

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[8] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy. Washington, DC.

Because of the interdependent relationship between the health of individuals and the health of the family, consideration of family dynamics and family-level interventions is a key component of our person-and family-centered Member engagement approach.

We also understand the importance of targeting. Tailoring communication to the intended audience allows Member communications to be person- and family-centered, providing Members with information that is most relevant to their needs and priorities. With the Department-implemented Health Needs Survey and region-wide screening efforts, we will have even greater ability to hone our messages and improve self-management and related health outcomes among patients with limited health literacy.

CULTURAL RESPONSIVENESS

The Partners are committed to delivering services in a culturally responsive manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities. RMHP provides services regardless of gender, sexual orientation or gender identity. We currently comply with the requirements listed in Section 5.5.2 of the RFP and will continue to do so as the RAE.

> *"If you have come to help me, you can go home again. But if you see my struggles as a part of your own survival, then perhaps we can work together."*
>
> *- Lila Watson, an Aboriginal Woman from Australia,*
>
> *quoted in RMHP's Bridges out of Poverty training presentation*

In addition to the *Disability Competent Care* and *Bridges out of Poverty* trainings we currently offer, we are developing additional cultural competency training programs for providers and RMHP staff regarding:

- Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services
- The medical risks associated with the Member population's racial, ethnic and socioeconomic conditions

We are aware that in many cases the messenger is as important as the content of our message. No one message or approach can be applied to an entire population. Our Member Advisory Council has stressed to us the importance of offering information in multiple formats and we have followed this advice. Consumers hear messages about their health very differently, and that variation is tied to age, gender, ethnicity, education level and socioeconomic status. Moving from providing medical care to changing health behaviors is a dramatic shift in focus. In order to achieve this objective, we need active partners with a deep social network in every unique community. To this end, we strive for a diverse workforce and support our providers and partners in doing the same.

Our member engagement approach is designed to be responsive to our Members' cultures, languages and modes of communication. On an individual basis, we assess and reassess our Members' cultural norms, practices and needs through the *Communication, Cultural, Language*

and Spiritual Assessment domain of our comprehensive needs assessment, which is detailed in Offeror's Response 16. On a population basis, we use tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which ask consumers and patients to report and evaluate their experiences with health care, including the cultural competence of their providers.

Voice of the Consumer Project: Learning Directly from Members

Through our *Voice of Medicaid* project,[9] we learned that Members generally trust their community service providers and rely on them for health care information. The Medicare-Medicaid Members interviewed specifically focused on financial realities and how they reach out to certain social support networks in times of need. These include churches, food banks, resource centers, the Salvation Army and family, all of which should be considered touchpoints for health information as well as referrals.

Health care navigation, which is even difficult for native English speakers and Members with relatively high socioeconomic status, is particularly challenging for Members who do not speak English as a first language. Participants suggested ways to combat the confusion, including bullet-point lists of covered services; in-person workshops in Spanish and English detailing the Medicaid program; and flyers at bus stops outlining the difference between Medicaid and Medicare. In addition, we have access to language assistance so Members can communicate in their own language.

We are using the rich data collected through this project to develop an interactive journey map that will allow people to "walk in the shoes" of a Medicaid Member, exploring the obstacles on the journey and identifying solutions.

Latino Community

The American Diabetes Association's Latino Initiatives team partnered with us for the *Voice of Medicaid* project to conduct one-on-one interviews with Spanish-speaking individuals, including recent immigrants living in monolingual households. These interviews helped us respond to the needs of this large minority population in several realms, including access to information, social services, and care navigation.

Based on the data, we know that certain populations access information about Medicaid differently. For Latinos, our study indicates information about Medicaid comes primarily by word-of-mouth or from local schools. This underlines the necessity of partnering with community stakeholders to make accurate health information available to improve healthcare literacy, since not all cultural groups access information through traditional channels.

Lesbian, Gay, Bisexual, Transgendered, Queer (LGBTQ) Community

RMHP will develop a health care system that supports and meets the needs of the LGBTQ community. We recognize that the LGBTQ community has been historically marginalized due to a lack of culturally competent providers and a health care system that has not always considered their needs. Research suggests that LGBTQ individuals face health disparities linked

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[9] Rocky Mountain Health Plans, The Voice of Medicaid Report, 2016 3rd and 4th Quarter, Compiled by Sheila Wise, PhD, RMHP Senior Customer Experience Analyst

to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQ persons has been associated with high rates of psychiatric disorders, substance abuse and suicide.[10] These risk factors can result in delayed care for treatable illnesses. LGBTQ individuals have higher rates of several cancers and suffer from common illnesses like heart disease as well. We recognize that while this population is often pigeonholed into a five-letter acronym, there are differences between, for instance, a gay man seeking a "LGBTQ-friendly PCMP" and a transgendered man seeking a provider to manage hormone treatments. Within each of these groups there are a range of individual identities and barriers to care. We strive to understand people both in the context of their gender or sexual identity as well as separately, simply as a person seeking good health.

RMHP will provide training and technical assistance to health care providers, social service partners and front-line staff to better serve the LGBTQ population. Trainings will focus on:

- Trauma Informed Care, an evidence-based practice to elevate understanding of people's life events, histories of discrimination and cultural backgrounds
- How to inquire about a Member's preferred pronoun and what to do if you accidentally use the wrong one
- Changes in health care forms and dialogs to be less hetero-normative (e.g., allowing people to choose *transgender* or *other* when identifying their gender, or always following up the question "are you sexually active?" with the question "with men, women or both?")
- Heightened awareness of health risk factors, since LGBTQ Members have higher rates of depression, anxiety, victimization and suicide
- Processes for having conversations with patients about behaviors and associated risk rather than just identity

In early 2017, this training was provided at Mind Springs Health by Western Colorado Health Network. Members and community advocates have told us that the training has already improved the culture of care for LGBTQ Members. We plan to expand the availability of this training under the RAE.

MEMBER COMMUNICATION

Healthcare literacy is at the core of our Member communication. Medicaid Members, along with many consumers, find the health care system challenging to navigate. Although a problem across all of Colorado, consumers in Region 1 report far more favorable experiences.

In a market research, key informant and focus group study undertaken by RMHP and UnitedHealthcare, 28 percent of Medicaid beneficiaries statewide report that it is difficult to figure out who to call with questions about Medicaid. In Region 1, less than half as many people find that difficult (13 percent). Similarly, 12 percent of all Coloradoans report trouble

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[10] Lesbian, Gay, Bisexual, and Transgender Health, Healthy People 2020, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, accessed July 13, 2017.

understanding their Medicaid benefits. In Region 1, just over half that many (7 percent) report such challenges.[11] While Region 1 appears to be performing somewhat better than the rest of the state, we continue to improve our Members' understanding of health care while simultaneously making the health care system more understandable.

Our goal is to share information with our Members in a way that promotes actionable healthcare literacy. To do this, we must share information in their preferred format and language, using language assistance lines and other services. We present draft versions of new Member materials to our Member Advisory Council for their review, and implement their feedback in the final versions. We also work with our provider network to help them gather Member feedback.

Clear communication enables the Member to understand their benefits, rights and how to access the services they need. We maintain consistent communication, both proactive and responsive, with Members. We attest that we will comply with all requirements, including completion and timely submission of each of the specified deliverables described in Section 5.5.3 of the RFP.

We use a variety of phone, web, and written tools to communicate clearly and concisely with Members, including the following:

- Our Member website will provide access to all information described in Section 5.5.3.8 of the RFP. Our website includes many Member resources such as how to find a provider, how to get care, available services, community resources, and Member handbooks.

- Our website was tested by the Colorado Cross-Disability Coalition (CCDC) for accessibility and usability. Individuals who have low literacy, disabilities, and language assistance requirements tested the website and we made changes to incorporate their recommendations.

- Members can chat in real-time through their computer or mobile device with knowledgeable and personable Customer Service representatives.

- Members can use their computer or smartphone to communicate with their care manager and/or health care provider.

- Members are provided with toll-free numbers with TTY/TDD and interpreter capability. We also train our staff on using Relay Colorado services because our Members have told us that they prefer using video equipment rather than typed text/TTYs.

- Our online provider directory includes functionality that allows Members to post reviews about the providers they have seen regarding ease of scheduling, check-in and wait times and courtesy of reception staff. Because Members can post their views anonymously, they can feel comfortable being honest about their experiences.

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[11] Understanding the Colorado Medicaid Member, UnitedHealthcare and RMHP Outreach Study, May 2017

- We provide information on advance directives, including applicable state law to all Members. Our care coordinators receive training from experts on advance directives. For Members with additional questions, RMHP will contract with experts in this area to answer their questions accurately.

For Members who use the Internet, our website provides tools designed to help them understand their benefits and become active participants in their own health care. Members can access the website at their convenience to find information about community and social services available in their area, Member handbooks, provider directories, information about the Member Advisory Council as well as other helpful links for services such as the Colorado QuitLine.

While we have a robust online presence, many Members want to speak with a live person, primarily in time of need. The One-Call Center is at the core of our communication options for Members. We maintain, staff, and publish the number for a toll-free telephone line that Members can call regarding customer service or care coordination issues. We will assist any Member who contacts us, including Members not in our region who need assistance with contacting a PCMP or RAE.

The OneCall Center will operate all day, every day of the year, and will serve Members and providers. The line will provide easy access to interpreter or bilingual services and include a TTY line. The call tree will be streamlined and well organized, with careful attention paid to minimizing the number of options callers need to listen to, yet covering the primary topics of concern to Members and providers. Callers will be given the option to bypass the call tree and talk with a staff member. OneCall staff will include trauma-informed highly skilled professionals who are provided regular training and in-service support on how to best serve our Members.

As often as possible, we seek to make these calls a "one-stop shop." However, if a Member needs to speak directly to a provider or requires information beyond what our call center can offer, we will do a "warm transfer", with an introductory summary of the call so that the Member does not have to begin the conversation over.

Our technology supports warm transfers to participating providers who are prepared to respond to direct transfers from our call center to schedule appointments or provide other support to a Member. By making the connection with the provider when the Member calls, we become the Member's partner, helping them navigate the system and engaging them in taking the next step in managing the care they need when they need it.

MARKETING

We currently comply with all marketing requirements described in Section 5.5.4 of the RFP and will continue to do so as the RAE. As a health plan operating in Colorado for more than 40 years, and serving Medicaid Members almost since inception, we are well-equipped to understand the complete array of state and federal requirements applicable to marketing activities and will engage only in those that are authorized.

HEALTH NEEDS SURVEY

The Partners are eager to use the Health Needs Survey developed by the Department and completed by Members during or directly after enrollment to comply with Section 5.5.5 of the RFP. We will use the survey results to inform Member outreach, care coordination activities, stratification and predictive modeling. The RAE will develop an automated process to deliver data from the survey to care coordinators, the call center welcome team, and community providers. We currently send real-time alerts using ADT data and will use that same process to efficiently distribute survey information.
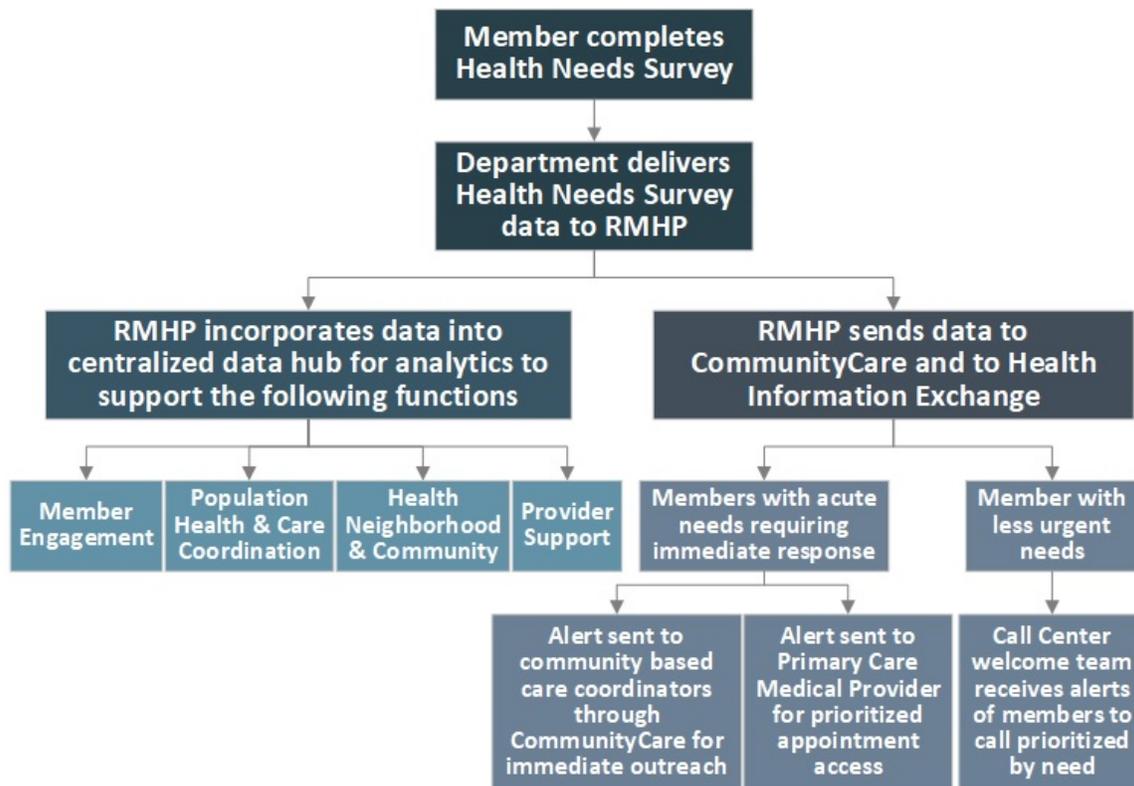
The chart above demonstrates that we will use the Health Needs Survey data to inform overarching activities as well as provide personalized outreach to Members. "High-risk" Members, such as a woman who is pregnant and homeless, will receive care coordination outreach within two business days of the RAE receiving survey data from the Department. In most cases, Members with acute needs will receive priority for outreach.

We are able to be efficient in our outreach because we will use a range of professionals to coordinate care for complex cases. The first person that a Member with complex or acute needs speaks with is also likely to be the care coordinator who will follow the Member in the community.

For Members who only require a referral, we are uniquely equipped to maximize the opportunity that the welcome call is a high-value conversation. Through Healthify and 2-1-1, we will be able to create a summary of referrals for each Member including both clinical and non-

clinical services. This will be available to the call center staff when they call the Member. The call center staff will document the referrals provided, and that information will go to the Social Information Exchange for the participating organizations to see if the Member followed up on their referral. We are then able to strategically prioritize follow-up calls for those Members who did not follow-up on the referral.

In addition to informing initial outreach and care coordination, the Health Needs Survey will inform Partners' stratification and prediction strategies. For instance, question 10 of the survey provides information about a Member's smoking, eating and exercise habits, which will inform our health literacy strategies so that Members receive information relevant to their personal priorities.

MEMBER EDUCATION OF MEDICAID BENEFITS

RMHP will engage in a robust onboarding process to provide Members with the knowledge and tools they require to appropriately access their Medicaid benefits. We often employ innovative face-to-face approaches to onboarding in order to capture populations who are at particularly high risk. For parolees awaiting re-entry into the community, RMHP regularly presents a *Health Literacy 101* presentation and distributes a quick-reference wallet card. We also solicit input from our Member Advisory Council on how to make the onboarding process as effective as possible and act on their recommendations.

Onboarding will be calibrated differently for children and families, who will receive much of their Medicaid onboarding from **Healthy Communities** with RAE partnership and support. We will comply with all requirements in Section 5.5.6 of the RFP, and describe our approach below.

We will continue to collaborate with the Healthy Communities contractors in our region for onboarding children and families to Medicaid and the Healthy Communities program and will continue to share information that supports our collaboration.

We will continue to refer child Members and their families to Healthy Communities for assistance with EPSDT, finding community resources, and navigating child and family services. We will also make referrals for children in care management who may need assistance from waiver programs or respite care. We receive referrals from Healthy Communities when they identify a Member who needs care management assistance. Where appropriate, we will continue to share needs assessments to support the Member and the family without duplicating each other's activities.

Healthy Communities Collaboration and Referrals

As an example of Healthy Communities collaboration and data sharing, RMHP's Northwest Community Partnership community care team is located in the same building as Healthy Communities staff. This close proximity enables coordination, hand-offs and referrals that help Members get what they need without having to figure out which program or person can help. This collaboration also helps provide the appropriate service without duplication and removes administrative barriers.

We are offering the use of RMHP's care management tool to our Healthy Communities partners to support their activities and promote coordinated care for our Members. Our community

partners use this tool for care coordination and outreach activities. Data security is in place that allows our Healthy Communities partners to use this tool for their entire population, not just RMHP Members. The San Juan Basin and Delta, Mesa and Gunnison County Health Departments currently use RMHP's care management tool to support their onboarding and outreach activities.

We will continue to share data with Healthy Communities contractors to facilitate care coordination and other Member interventions. We will partner with Healthy Communities contractors to create an annual plan describing how we will collaborate for the onboarding of children and families. RMHP will orient to the RAE all Members who are not contacted by Healthy Communities. We will continue to use a multi-touch approach including mailings, welcome calls, and care coordination outreach to Members, including those with complex needs. We will provide Members with accessible, easy to understand information about navigating their plan and benefits, particularly screening exams.

Healthy Communities Integration – San Juan Basin Public Health
San Juan Basin Public Health uses the functionality of the shared care management tool to outreach to its new moms. When an RMHP Member is discharged from the hospital after delivery, a community care team coordinator receives an alert. The hospital's discharge notice triggers a workflow in the care management tool that notifies the care coordinator to outreach to the new mother to help connect her to resources she needs. These might include helping her apply for nutrition programs (e.g., WIC, SNAP) or, if she's a first time mother, enrolling her in the Nurse-Family Partnership where a trained nurse will visit the home and provide coaching until the child turns two years old.

One of the important benefits for Members is the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, administered in conjunction with Healthy Communities. Colorado lags well behind the national average on this program's performance measures. Improving EPSDT screenings and working in conjunction with Healthy Communities is a priority for us.

Currently, screening rates differ significantly within Region 1. As reported in the 2015 EPSDT Mapping Outcomes Report, three counties in Region 1 stand out for both their high screening and participant ratios, i.e., Gunnison, Summit, and La Plata counties comprise three of the top six counties in the state.[12] In contrast, neighboring Montrose, Ouray, and Hinsdale Counties all had rates in the bottom six counties statewide.

We are taking a multi-prong approach to actively address EPSDT screening rates. RMHP produces reports that identify EPSDT service gaps, including gaps in well child visits and immunizations. Once we identify these children, we encourage them to get and keep an appointment with a PCMP. We do this through mailings to the family, and by providing each Healthy Communities contractor with a list of the children in their community who have gaps in care for their local targeted outreach activities. At the same time, we provide each PCMP with a

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[12] EPSDT Outcomes Mapping Report, May 2015: https://www.colorado.gov/pacific/sites/default/files/Annex%20C-%20EPSDT%20Outcomes%20Mapping%20Report.pdf

list showing their attributed patients who have gaps in care. As a result, the RAE, Healthy Communities, and PCMPs have a consistent message and focus to resolve the gaps in care.

Healthy Communities Integration – Mesa County Health Department
The Mesa County Health Department is using the integrated care management tool to track activities for their own campaigns based on priorities established locally. For example, they use the tool to track individuals who need assessments and require quarterly follow-up calls, record patient activation measurement, and track letters that have been sent specific to particular outreach efforts. RMHP supports the production of reports that analyze the data available in the tool, and measures the impact of these campaigns on the population as a whole.

As the RAE, we will continue to partner with Healthy Communities contractors on innovative ways to reach families. We will identify community events such as back-to-school nights as opportunities to educate families on the RAE and Healthy Community services and benefits.

RMHP will continue to conduct trainings for Healthy Communities contractors about the ACC and our unique interventions and processes. In addition, we will visit with Family Health Coordinators across Region 1 to discuss local questions and issues, and identify collaborative opportunities.

PROMOTION OF MEMBER HEALTH AND WELLNESS

Health*care* literacy will result in short-run cost savings and better outcomes for areas heavily influenced by health care, whereas health literacy will result in long-term cost savings and better overall health outcomes. Our health literacy strategy prioritizes and uses Colorado State of Health and Winnable Battles goals around prevention and wellness.

The promotion of health literacy is central to our population health strategy and drives our entire RAE vision. Innovative Member engagement on health and wellness encompasses much more than mailings. It must include self-management, skill building, and coaching – and be relevant to the Member population. As we test and evaluate different Member health promotion and activation strategies, we will monitor outcomes and share lessons learned at the Operational Learning Collaborative. We attest that we will comply with the requirements described in Section 5.5.7 of the RFP.

Among our initiatives to improve Member health and wellness are three primary, discrete initiatives—Patient Activation, Motivational Interviewing and the use of text and Web-based health and wellness programs.

Patient Activation is a construct that measures whether patients have the knowledge, skills, and confidence to manage their own health. To make Patient Activation central to our approach, we have purchased a license to the 13-item Patient Activation Measure(PAM). Our practice transformation training covers not only measuring, but also promoting activation. In a February 2013 *Health Affairs* article, the authors found that more activated patients fared better on blood pressure and diabetes control and smoking cessation. Furthermore, they had lower health care costs and higher satisfaction with their medical care.

RMHP provides extensive support to primary care practices in using this tool. It is one of the RMHP Prime quality measures that are tied to shared savings. Currently, 33 of the 38 primary care practices participating in RMHP Prime use PAM within their practice. Our studies have found an inverse relationship between PAM score and ER utilization, potentially indicating that activated Members make better use of preventive care.[13]

©2016 Insignia Health. Patient Activation Measure® (PAM®) Survey Levels. All rights reserved.
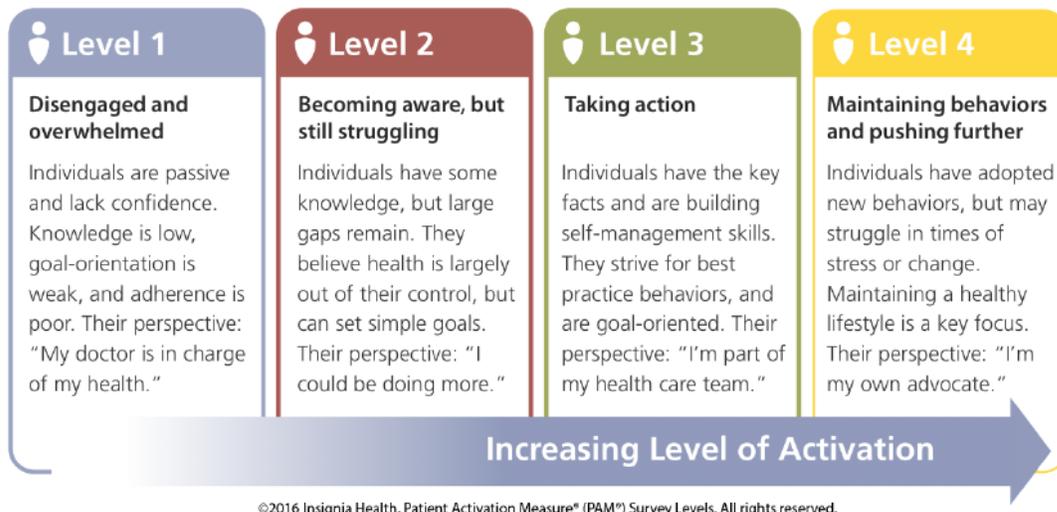
PAM's effectiveness can be demonstrated by a patient interaction with Dr. Lars Stangebye, a family doctor in Montrose. He has used PAM for several years – administering the tool himself instead of delegating the task – as part of his work with Practice Transformation and the RMHP Prime shared savings program. Recently Dr. Stangebye administered PAM to a long-time patient. To his surprise he discovered that the patient had severe alcoholism, which exacerbated his chronic conditions. Dr. Stangebye felt that without PAM he would likely still be unaware of the patient's underlying issues. This knowledge presented the opportunity to set effective treatment goals for the patient.

Motivational Interviewing is another strategy that our network of providers and community based organizations use as an approach to behavior change. It is rooted in an understanding of how hard it is to change learned behaviors. Originally developed for substance abuse, it is now a method providers use to assist Members in behavior change for a range of health conditions. We provide motivational interviewing training for our Provider Network and care coordination staff, ensuring they have a diverse toolkit of skills.

In addition to these two innovations at the provider level, a third way of engaging patients is a new set of text- and Web-based health and wellness programs. These health and wellness programs support Members' health literacy and incentivize behavior change. There is a wealth of data that demonstrate that incentives increase engagement and support behavior change,

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[13] Rocky Mountain Health Plans, Comparison of Prime ER and Inpatient Utilization to Average PAM Scores, April 6, 2016

improving outcomes and reducing costs in the long term.[14] Following the contract award, we will present an incentive plan to the Department for approval. Our plan will describe proposed interventions, target populations, goals and incentives. The approach will comply with all federal guidance and laws concerning Member incentives.

MyHealthLine

With our comprehensive *MyHealthLine* **program and mobile application,** we will conduct targeted text campaigns to support Members in staying on track with their health goals. About 80 percent of our Members use text messages already, and many of those who do not are eligible for free Lifeline smartphones. We will draw upon UnitedHealthcare's experience and effective processes to assist Members to apply for the federal Lifeline benefit – which now includes smartphone support. In other state markets, over 70 percent of Members said MyHealthLine helped them remember something health-related, such as making an appointment. Examples of the texting campaigns we will use include:

- **Text4baby (t4b)**: Timely health tips through pregnancy and baby's first year; includes reminders for prenatal/postpartum appointments and immunizations. *Outcomes include: 35 percent fewer missed appointments, 63 percent participants reported t4b helped remind them of appointments, 65 percent talked to their doctor about a t4b topic*

- **Text4kids (t4k)**: Health tips and reminders for parents of children 1-18 on oral health, nutrition, well-child visits, and developmental milestones

- **Text4health (t4h)**: Health tips and reminders for adults over the age of 18 based upon age and health risk factors

- **Care4life**: Personalized, interactive education and support program that helps individuals better manage their diabetes through medication and appointment reminders, nutrition and exercise education, blood glucose tracking and more; developed in collaboration with the American Diabetes Association. *Outcomes include: 13 percent increase in medication adherence, 14 percent drop in blood glucose levels, and 28 percent increase in number of days exercised*

- **Text2quit**: Innovative program that uses text messaging, email, web, and Quit Pal, combined with evidence-based best practices, to help smokers quit. *Outcomes include: 32 percent quit rate, participants enrolled in text2quit twice as likely to quit vs. control group*

In addition, we offer other disease-specific and wellness apps for Members of all ages. Using this technology solution, we have the ability to build our own texting campaign targeted to the Region's demographics and health needs, e.g. daily medication reminders.

Often a Member's barrier to health is not a lack of knowledge but rather resource constraints. Many Medicaid Members face food insecurity, housing instability and other social circumstances that negatively impact health. Core to health promotion is a strategy to support

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[14] Wojcik, Joanne. (November 2011). Wellness program uses rewards to boost patient health literacy. Business Insurance. Retrieved from http://www.businessinsurance.com/article/20111120/NEWS05/311209974.

Members in identifying and accessing the social resources that they require. Our strategies to approach Social Determinants of Health are detailed in Offeror's Response 14.

Our digital efforts at Member engagement also involve care coordinators. We leverage the local 2-1-1 resource database and our *Healthify* application, to provide a robust, validated taxonomy of social services. A simple search feature allows relevant categories to be sorted by type of service and preferred location. Every resource includes a map, contact information, eligibility requirements, service hours, and other applicable information to facilitate a successful Member referral to needed services.

MEMBER ENGAGEMENT REPORT

In our capacity as the Region 1 RCCO, we have extensive experience with developing Member Engagement reports and will comply with the requirements described in Section 5.5.8 of the RFP.

CONCLUSION

Our Member engagement approach, with open communication lines and Member participation in program design, leads to a stronger and more effective program. Our consumer networks reach out to Members, proactively engaging them in the design of their health plan. Through direct communication with Members, we gain an accurate, actionable understanding of their concerns and can work together to find effective solutions. In addition to addressing the items from the RFP, we go beyond by leveraging our Members' experience and activation.

Our inclusive consumer network deepens our connections to the communities we serve and our ability to continue to learn as a system. We do this by:

- Fostering consumer leadership
- Connecting influential individuals and groups within diverse populations
- Using promotoras and peers as trusted messengers
- Providing shared learning and training
- Using community leaders to make connections
- Partnering with advocacy organizations to facilitate client involvement with policy creation and establishment of local groups to engage in outreach and education

This deep network creates channels for meaningful bi-directional communication between Members and the RAE. RMHP recognizes that Members and their families have great insight about improving Health First Colorado and the ACC. Our Member Advisory Councils provide an effective structure for this important work. The councils involve higher-level program and policy work and act as the eyes and ears for RMHP regarding Member perspective.

We learn by engaging council members' in open and honest feedback. Most of all, we listen to what they have to say. As a result of Member Advisory Council input, we work with providers to help them better serve patients with disabilities and to assess the accessibility of their facilities through a disability competent care training program facilitated by the Colorado Cross-

Disability Coalition (CCDC). We will provide clear training and leadership opportunities for council participants, including conference attendance and trainings.

Council members have expressed interest in the development of a statewide learning collaborative, where client councils from all RAE regions can interact to learn from each other and the efforts of other regions. RMHP is committed to supporting its establishment and ongoing success. We have found similar cross-regional networking activities for providers to be effective and look forward to expanding these efforts with Members.

Council members have expressed to us the importance of recognizing the philosophical tenets of the independent living movement, including consumer control and the right to fail. We recognize that Members have a right to take risks in life, including living in the community if they have disabilities. More importantly, they have the right to decide for themselves the services they want, how they want them delivered, by whom, and in what context. Our role is to listen, learn and offer thoughtful options to help them meet their unique goals.

Quote from RMHP Member Advisory Council Member
"Many of us have personal goals that are different than fixing some problem it looks like we have. Ask people what their real goals are – maybe it's not medical, maybe it's being able to knit, or visit the mountains. I want options and I want to be able to choose without being judged. Peers and thoughtful care coordinators can do this; places like Independent Living Centers can help make the options known. I don't want to be saved. I want options and freedom of choice."

Offeror's Response 10

Describe how the Offeror will handle grievances and appeals.

INTRODUCTION

The Partners believe that all Members, their families and advocates should be encouraged to drive the direction of their health care and receive support when they voice concerns about the care they receive. We believe that reviewing individual Member grievances and appeals provides an opportunity to not only respond to the individual Member, but also assess our responsiveness to Members as an organization. We want to learn from what Members tell us and use their input to make changes and improve the entire organization so that it works for their benefit.

Rocky Mountain Health Plans (RMHP) is an experienced payer with the understanding, infrastructure and skill set necessary to administer a grievance and appeal system that is fully compliant with 42 C.F.R. Part 438, Subpart F. Along with our Partners, we are prepared to handle grievances about any matter related to the Contract. Furthermore, we will assist Members in following the Department's procedures for handling appeals of physical health adverse benefit determinations including assistance in completing forms, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. We will inform our network providers and subcontractors about the Member's rights with respect to appeals, State Fair Hearings, and continuation of benefits during appeal, as well as any rights the Provider has to appeal or challenge our decision not to cover a service. In addition, we will ourselves handle appeals of adverse benefit decisions for the Capitated Health Benefit we will be administering as the RAE, should we be selected for a contract. We are equipped to collect, track and report information to the Department about all grievances and appeals that we handle as well as undertake our own analysis of the data to identify trends and opportunities for improvement. We believe information gleaned from grievances and appeals can provide a valuable source of feedback to support our continuous quality improvement program.

GRIEVANCES

The Partners have experience managing a grievance process that is fully compliant with federal law. We view complaints as opportunities for improvement and encourage Members to bring problems or concerns to our attention as soon as possible, both at the plan and provider level. There is no "wrong door" for a Member to register a complaint or grievance. Our behavioral health and community health center partners are accustomed to handling expressions of dissatisfaction at the point of care. As part of the Regional Accountable Entity (RAE) structure, they will document, track and report their activities to RMHP so that all information can be consolidated at the plan level, including all grievances filed (locally and at the plan level), for reporting to the Department. We will administer this process collaboratively through the RAE Compliance Director working with our behavioral health and community health center partners to assure the process is fair to Members and efficiently executed by the RAE.

We educate Members about the grievance process, including providing instructions about how and where to file a grievance, in the Member handbook. We also inform all network providers

and our subcontractors about the grievance process and the Member's rights within that process.

We accept grievances from Members either orally or in writing at any time and we always acknowledge receiving a grievance within at least two days. Decision makers on grievances are not involved in any previous review of the matter, nor are the decision makers a subordinate of anyone who was. If the grievance involves a clinical issue, we require that an appropriately licensed professional with an unrestricted license and expertise in the Member's condition or disease make the decision regarding the grievance. We make a decision and provide notice to the Member within 15 business days of when the Member filed the grievance. Our notice explains the Member's right to bring an unresolved grievance to the Department and we understand that the Department's decision is final.

We document any problems that a network provider brings to our attention as well as our proposed solutions. We understand that the Department may review any of our documented solutions and direct us to find another solution or follow a specific course of action should the Department find our solution insufficient or otherwise unacceptable. Network provider concerns will be forwarded to appropriate internal entities (e.g., Medical Director, Director of Quality Improvement, Quality Assurance/Utilization Management Committee) within the RAE to look for common quality and performance issues.

Should the Department be contacted by a Member, family member or caregivers of a Member, advocates, the Ombudsman for Medicaid Managed Care or other individuals/entities with a grievance regarding concerns about the care or lack of care a Member is receiving, we will address all issues as soon as possible and will keep the Department informed about our progress on resolving concerns in real time and will advise the Department of final resolution.

NOTICE OF ADVERSE BENEFIT DETERMINATION

When RMHP denies coverage of or payment for a Covered Behavioral Health service, we will send the Member a written notice of adverse benefit determination that complies with all regulatory requirements including:

- A description of the adverse benefit determination
- The reasons for the determination, including the Member's right to be provided (free of charge) with reasonable access to and copies of all documents, records and information relevant to the determination
- The Member's right to appeal, or the Provider's right to appeal when acting on behalf of the Member
- The Member's right to request a state fair hearing
- Instructions on how to appeal or file a grievance
- The circumstances under which an expedited resolution of the appeal are available
- The Member's right to request that benefits continue while the appeal is pending, how to make the request and the circumstances under which the Member will be responsible for repayment of continued benefits

This notice will be provided in an easily understood language and format as well as in alternative formats for persons with special needs, and in state-established prevalent non-English languages in the region.

RMHP will provide notice at least 10 days before the date of action, if the determination is a termination, suspension or reduction of previously authorized Medicaid-covered services. We will comply with all other time frames for notice applicable to the various circumstances set forth in federal regulation, state administrative rule and the RFP.

With respect to standard service authorization decisions that deny or limit services, we will issue decisions as expeditiously as the Member's health condition requires or within 10 calendar days following receipt of the request. If the Member or Provider asks us to extend the timeframe, or if we think an extension of time to submit additional information is in the Member's best interest, we will grant an extension for up to 14 additional days. We will provide the Member with notice about the extension and their right to file a grievance if they disagree with our decision to extend the timeframe.

In those cases where we or a Provider believe that following the standard authorization timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, we will make an expedited decision as soon as possible and no later than 72 hours after receipt of the request for service. If the Member or Provider asks us to extend the expedited timeframe, or if we think an extension of time to submit additional information is in the Member's best interest, we will grant an extension for up to 14 additional days.

We will issue service authorization decisions on the date that the applicable timeframe expires if we are unable to reach a decision for either a standard or expedited request.

HANDLING APPEALS FOR THE CAPITATED BEHAVIORAL HEALTH BENEFIT

RMHP's has over 40 years of experience administering federal health care programs, including managing and implementing a compliant and effective appeals process. RMHP will handle appeals of adverse benefit determinations for the Capitated Behavioral Health Benefit in compliance with requirements set forth at 42 C.F.R. § 438.400.

We will allow Members, and Providers acting on behalf of Members with the Member's written consent, to file appeals within 60 calendar days from the date of our notice of adverse benefit determination. We will accept appeals either orally or in writing, and unless an expedited resolution is requested, we will require an oral filing be followed by a written, signed appeal.

Decision makers who receive and review appeals are not involved in any previous review of the matter. If a grievance involving a denial of an expedited resolution of an appeal or if a Member is appealing a denial based on lack of medical necessity, we will require that an appropriately licensed professional with an unrestricted license and expertise in the Member's condition or disease make the decision. Because appeals will involve the Capitated Behavioral Health Benefit, we will have a psychiatrist on staff available to review these cases when medical necessity is the issue.

We will provide the Member with a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. If the Member has requested an expedited appeal resolution, we will inform the Member of the limited time available to do this. We will also give the Member, the Member's representative, or legal representative of a deceased Member's estate (any of whom will be consider a party to the appeal) an opportunity to examine the Member's case file, including medical records and any other documents and records that are relevant to the decision.

CONTINUATION OF BENEFITS AND SERVICES DURING AN APPEAL

We will continue the Member's benefits while an appeal is in process if the Member files within 10 days of the mailing of the notice or the intended effective date of the proposed adverse benefit determination, whichever is later. To qualify for continuation of benefits, the appeal must involve the termination, suspension or reduction of a previously authorized course of treatment and the services must have been ordered by an authorized provider. Further, the Member must request that benefits be continued and the request must be made before the current authorization expires. The benefits will continue until one of the following occurs:

- The Member withdraws the appeal.
- The Member does not request a State fair hearing with continuation of benefits within 10 days of adverse appeal decision.
- An adverse state fair hearing decision is made.
- The time period or service limits of a previously authorized service have been met.

We may recover the cost of continued services furnished to the Member during the pendency of the appeal if the final resolution is in our favor.

If the services were not continued and if we or the State Hearing Office reverse our decision to deny, limit or delay services, we will authorize or provide the disputed services promptly. This means as expeditiously as the Member's health condition requires but no later than 72 hours from the date of reversal.

We will notify the requesting Provider and give the Member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

RESOLUTION AND NOTIFICATION OF APPEALS

RMHP, as the accountable entity, will make a decision on an appeal and provide notice to the Member within 10 business days of when the Member filed the appeal. If the Member or Provider asks us to extend the timeframe, or if we think an extension of time to submit additional information is in the Member's best interest (and we can demonstrate this to the Department's satisfaction), we will grant an extension for up to 14 additional days. We will provide the Member with written notice within two days about any extension that is not requested by the Member.

In those cases where we or a Provider believe that following the standard appeal resolution timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, we will make an expedited decision as soon as possible and no later than 72 hours after receipt of the request for expedited appeal. If the Member or Provider asks us to extend the expedited timeframe, or if we think an extension of time to submit additional information is in the Member's best interest, we will grant an extension for up to 14 additional days. If we deny a request for expedited resolution of an Appeal, we will transfer the appeal to the standard timeframe for appeal resolution and give the Member prompt oral notice of the denial and written notice within two days of receiving the request for expedited resolution. If we extend the timeframe and the Member did not request the extension, we will provide written notice of the reason for extension within two calendar days. Once an expedited appeal decision is made, we will provide written notice, and make reasonable efforts to provide oral notice of the resolution.

State Fair Hearing

For decisions not wholly in the Member's favor, our notice will explain the Member's right to request a State Fair Hearing and how to make that request. Our notice will also explain the Member's right to continue to receive benefits pending a hearing, including that the Member may be responsible for the cost of any continued benefits if our decision is upheld at the hearing.

If we do not adhere to the notice and timing requirements regarding a Member's appeal, the Member is deemed to have exhausted the appeal process and may request a State Fair Hearing.

We will participate in all State Fair Hearings regarding appeals in accordance with the requirements set forth in the RFP.

OMBUDSMAN FOR MEDICAID MANAGED CARE

Along with its Partners, RMHP will work with Members to assist with problem solving, grievance resolution, in-plan and administrative law judge hearing level appeals and referrals to Community resources. When appropriate to do so, we will refer members to the Ombudsman for Medicaid Managed Care for assistance with these issues when we are unable to help. We will share PHI, with the exception of psychotherapy notes and substance use disorder-related information, with the Ombudsman upon request. We will not require a signed release of information or other permission from the Member unless we have previously obtained written and explicit instructions from the Member not to share information with the Ombudsman. We will develop a policy outlining these requirements and distribute it to network providers, subcontractors, advocates, families and Members so that they are knowledgeable about the Ombudsman for Medicaid Managed Care and understand when and how this resource can be accessed.

GRIEVANCE AND APPEALS REPORTING AND ANALYSIS

RMHP is fully prepared to submit to HCPF a quarterly Grievance and Appeals Report that includes all of the information required by the RFP and applicable federal regulations. Our

Partners will handle grievances at the point of care and they will report their activities to RMHP so that all information can be consolidated by us, including grievances filed at the plan level as well as behavioral health appeals, for reporting to the Department.

The Partners will use all information internally to help us identify and address trends and any areas of concern identified by Members. Appropriate staff and committees will regularly review grievances and appeals data to identify trends and to take action as needed to make improvements in our processes. The RAE will ultimately be accountable for the operation of the grievances and appeals function. The RAE's Compliance Director will review complaint and appeal data and information to verify all processes are followed timely and correctly, elevating issues to RMHP's Executive Director, the RAE Program Director or RAE governing committees, as appropriate. The RAE's Executive Committee will also review complaint and appeal data to identify opportunities for improvement and assist in prioritizing interventions. Quality of care concerns will be shared with the Director of Quality Improvement, the Quality Assurance/Utilization Management Committee and the Partners. Requirements and processes established for investigating quality of care concerns will be followed. This is discussed in more detail in Offeror's Response 23.

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.

INTRODUCTION

As a major payer in Colorado with a strong Medicaid presence, Rocky Mountain Health Plans (RMHP) has a robust network of Primary Care Medical Providers (PCMPs) and behavioral health providers, inclusive of all provider types set forth in Section 5.7 of the RFP. We are committed to providing our Members with timely and convenient access to high quality, culturally responsive physical and behavioral health care services. We are investing in practice transformation, telehealth and innovative transportation solutions to **increase access** and **rethink the delivery of care**.

Our provider network features:

- One of the largest physical and behavioral health networks in Colorado that leverages the experience of the Partners – Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs) -- and RMHP the Region 1 Region Care Collaborative Organization (RCCO).

- A large statewide market share. RMHP and UnitedHealthcare serve over 1.3M Coloradoans in our combined Medicaid, Medicare and commercial health plan offerings through our existing participating provider networks, which gives us the ability to leverage key provider partnerships to better support Medicaid strategies.

- An extensive network of contracted and credentialed primary care medical providers. RMHP's current statewide participating provider network includes 597 of the 636 PCMPs participating in the Accountable Care Collaborative, or 94 percent of all ACC PCMPs statewide.

- A robust network of behavioral health providers, which includes 2,555 contracted, credentialed and Medicaid re-validated mental health providers, statewide. Likewise, RMHP has agreements with 333 psychiatrists or other psychiatric prescribers who are contracted, credentialed and Medicaid re-validated, statewide.

- RMHP's participating provider network also includes 171 contracted, credentialed and Medicaid re-validated Substance Use Disorder (SUD) providers statewide.[15]

- Comprehensive experience and network in network management and maintenance in a diverse array of communities, including frontier, rural and urban areas.

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[15] All behavioral health provider counts in this response have been de-duplicated by National Provider Identifier.

- A nationally-recognized Practice Transformation and Clinical Informaticist (a.k.a. CHITA) workforce to accelerate team-based care, integrated behavioral health and overall capacity expansion in the network.

- Strong partnerships with hospital systems, specialists and other health neighborhood providers.

Our network is more than sufficient to meet the needs of the total RAE Membership both now and in the future.

A. ALLOW FOR ADEQUATE MEMBER FREEDOM OF CHOICE

RMHP has robust, *boots on the ground* staff for provider network recruitment, development and maintenance. Our Provider Network Management (PNM) team works with *all* providers across the region; we will not discriminate against providers for any reason. Our staff provide direct service, contracting, credentialing and quality support for both physical and behavioral health providers, functioning as a "one-stop-shop" to help providers navigate the Medicaid Program and its administrative systems and processes. PNM staff are always available to meet providers face-to-face, and will make special efforts to provide in-person assistance to behavioral health network providers as the RAE is implemented to ensure continuity of care for our Members.

Regional Accountable Entity (RAE) Primary Care Medical Provider Network

We offer a robust RAE PCMP network because we encourage all primary care practices in our region to participate in the Accountable Care Collaborative. Our supportive and responsive team works to make it easy and hassle-free as possible to opt in to the ACC. Whether it's helping PCMPs navigate the interChange and the new Provider Web Portal, answering a question about claims or authorization status, or encouraging them to begin the practice transformation journey, we deliver high-touch provider support with first have knowledge of the community context.

We have been successful at retaining primary care practices by:

- Being a provider partner, not just a payer

- Supporting payment reform through initiatives such as the RMHP Prime in Western Colorado

- Investing in practice transformation and support of patient centered medical home initiatives, such as the Enhanced Primary Care Medical Provider (EPCMP) Program

- Participating in multipayer practice transformation initiatives like the State Innovation Model (SIM) and the Comprehensive Primary Care Plus (CPC+)

We continuously monitor the PCMP network and identify eligible practices that are not yet participating by analyzing claims data, learning directly from our Members, and keeping a close pulse on the community. When an eligible and not yet participating practice is identified, we reach out to the practice to explain the benefits of participation and encourage them to join the program. If a practice is not yet willing or able to participate, we follow-up out on a routine,

periodic basis, as we often find that a change in circumstance or leadership can precipitate a change in direction.

RMHP's philosophy is to contract with all available providers willing to serve Medicaid enrollees who meet our credentialing and quality standards. High provider participation levels result in accessibility and choice for our members. We have expanded primary care choices for Members by leveraging participation in other lines of business. Within the past few years RMHP has also expanded primary care access by providing value-added services for PCMPs, including practice transformation activities and payment reform initiatives that support advanced primary care.

We have streamlined the process for eligible providers to become PCMPs so that Members can be quickly attributed. As the RCCO in Region 1, RMHP has developed the **largest network of Medicaid PCMPs of any current RCCO**, both in total PCMPs (76 percent higher than the average of RCCOs 2-7) and in per capita (almost 50 percent higher than the average of RCCOs 2-7). The graphs below show the Medicaid PCMP network in Region 1 compared to the PCMP network in the other 6 RCCOs.[16]
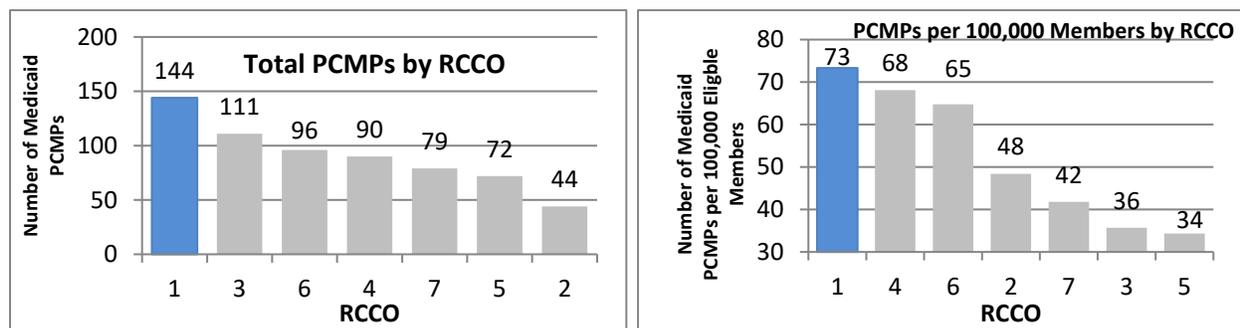
Of the 144 PCMPs in Region 1, only two PCMP Sites have no contract with RMHP. These two sites are Kaiser Permanente clinics in Larimer County. Kaiser Permanente and RMHP have joined a strategic partnership for the purpose of the Regional Accountable Entity program, and have agreed that both of these clinics will be contracted by the time the RAE contracts are executed. This means that all Members attributed to Region 1 PCMP sites can be enrolled in the Region 1 RAE, without interruption, hassle or confusion.

Primary Care Accessibility

The current RMHP network meets and exceeds the Department's access requirements in adult primary care, pediatric primary care and Obstetrics/Gynecology (OB/GYN).

Our network includes 7.0 adult PCMP practitioners per 1,800 eligible adult members based on the enrollment estimates in the RFP, and 8.4 pediatric PCMP practitioners per 1,800 eligible pediatric members. This exceeds the Department's standard of one PCMP practitioner per 1,800 adult or child Members.

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[16] All data presented in responses 11 and 12 reflect available data as of July of 2017 provided by the Department. We believe the data in these sections are a conservative representation of our network's size.

The table below shows the number of RMHP PCMP practitioners, average travel time in minutes and miles to two PCMP sites, and percent of Members with access to care within the Department standards. The average travel time and distance for a Member to reach at least two PCMP Sites in our network is a quarter of the time allowed by Department standards, and nearly 100 percent have geographic access to care within the Department's standards – despite the rural and frontier characteristics of Region 1.

Table: Summary of RMHP's ACC Network in Region 1

	Number of RMHP PCMP Practitioners	Average Minutes to Two PCMP Sites	Average Miles to Two PCMP Sites	Percent of Members with Access (Minutes)	Percent of Members with Access (Miles)
Adult Primary Care	423	3.9	4.0	100.0	100.0
Pediatric Primary Care	414	4.3	4.5	100.0	99.9
Gynecology, OB/GYN	34	7.3	7.6	99.6	99.5

To support the health of Members, the Partners have collaborative agreements, working partnerships, Memoranda of Understanding (MOUs) and contracts with Essential Community Providers throughout Region 1. These partnerships include 10 Federally Qualified Health Clinics (100 percent), five Indian Health Care Providers (100 percent), 15 Rural Health Clinics (100 percent) and 12 School-Based Health Clinics (86 percent). The School Based Health Centers who have not contracted have all expressed interest and we will continue to work with them to complete all of the necessary administrative tasks to join the ACC. Our extensive presence in the region mean that no Member will have to change their provider unless they choose to do so. For members who must be hospitalized, they also have many options. RMHP's network includes with 34 hospital sites in Region 1 and 104 hospital sites statewide.

RMHP's contracted and credentialed health plan network includes 94 percent of the PCMPs participating in the ACC Program statewide. This includes 3,784 pediatric practitioners, 3,251 adult practitioners and 825 of the OB/GYNs – all of which have completed interChange re-validation. RMHP's statewide relationships mean seamless transitions and readily available support for Members who temporarily or permanently seek care outside of the Region 1.

Our PCMP network is open to new members. RMHP's current ACC network has 310 and 308 pediatric and adult primary care providers accepting new Members, which is equivalent to 74.9 and 74.4 percent of all such providers, respectively.

Our network has sufficient capacity to schedule patients within the time standards established for various levels of acuity as defined in 5.7.4.13. Because many of our Members cannot make appointments during normal hours, several FQHCs and private providers see Members outside of the normal daytime hours. Within RMHP's current ACC network, 60.6 percent of all pediatrics and 41.3 percent family & internal medicine providers offer evening and/or weekend appointments.

To demonstrate and monitor our network's adequacy, we will create a yearly report that reports the composition of our provider network, their geographic locations, cultural and language expertise, and accessibility to people with disabilities. RMHP will continue to track on a quarterly basis the PCMPs open to new members and those who offer after-hours access. In ACC Phase 2, we will track primary care practices who offer covered, short-term behavioral health services.

RAE Behavioral Health Network

RMHP's behavioral health network strategy will create broad and inclusive Member choice among behavioral health and substance abuse disorder providers, while ensuring greater value and financial sustainability over the long run. A clear, objective structure for value-based contracting, reimbursement and capacity-building is essential to ensure access to comprehensive behavioral health services for our Members. RMHP, Reunion Health and our community providers will work closely with the Department over the course of ACC Phase II to align payment modeling and rate development for the Capitated Behavioral Health benefit with a comprehensive, value-based contracting and program design.

There are currently 2,555 mental health and 171 substance use disorder providers contracted and credentialed in RMHP's statewide behavioral health network. In addition to the fundamental role played by partnering Community Mental Health Centers, other high-quality providers participating in our network will be afforded an opportunity to serve RAE Members, at the following, objectively assessed, competency-based tiers of participation.

Criteria	Preferred Tier	Comprehensive Tier
Eligible providers	Qualified and licensed behavioral health and substance abuse treatment providers who successfully complete our contracting and credentialing process.	Qualified and licensed behavioral health and substance abuse treatment providers who successfully complete the criteria of our contracting and credentialing process.
Payment	Basic, fee-based reimbursement, with eligibility for a share of BH incentive payments, in alignment with efficient documentation and engagement requirements set forth in the RFP.	Advanced payment models will be available at this level, such as sub-capitation or case rate, with eligibility for a share of BH incentive payments, such as for superior benchmark performance inpatient and/or emergency department utilization by Members served.
Member Volume	No minimum	A minimum of 100 unique Members annually

Criteria	Preferred Tier	Comprehensive Tier
Competencies	The RAE and partnering community mental health centers will fulfill level of care and service delivery coordination functions that fall outside the scope of practice for providers at this level.	• Common service planning • RAE Care Coordination linkages • Participation in the RAE Independent Provider Network advisory council • Participation in the quarterly quality improvement meetings,
Documentation	Providers at this level routinely meet Medicaid assessment and documentation standards set by the Department – with minimal necessary correction, re-work or oversight.	Providers at this level exceed all assessment and documentation requirements, and can fulfill more extensive reporting requirements necessary to support effective administration of the Capitated Behavioral Health Benefit with limited support from the RAE

Single case agreement arrangements, or one-time contracts for service of a single patient, will also be accommodated to the ensure continuity of individual Member-provider relationships, with basic fee-for-service reimbursement. All credentialing and Colorado Medicaid documentation requirements must be met in these cases, as well, in order to qualify for reimbursement.

Members can choose providers in either tier. That said, Members requiring B3 services and extensive care management are likely best served by CMHCs, or programs offered by providers in the Comprehensive Tier. Providers can participate in either tier as long as they meet criteria, pursuant to an objective assessment and transparent process maintained by the RMHP and Reunion Health.

All contracted and credentialed providers – at every level -- will be afforded an opportunity to improve their network status at any time, with practice transformation and collaborative learning support offered by the RAE and leadership presence in the Independent Provider Network advisory and Director's Committee structure.

Behavioral Health Network Size and Accessibility

In Region 1, RMHP's contracted and credentialed behavioral health network includes 472 unduplicated mental health providers, 50 unduplicated SUD providers and 100 unduplicated psychiatrists and other psychiatric prescribers – all of which have completed the Department's re-validation process for Medicaid participation. These providers meet the access standards defined by the Department for 100 percent of Members in Region. The average travel time and distance for a Member to reach at least two providers in our network is less than 35 percent of the maximum time and distance requirements defined by the department.[17] RMHP will also

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[17] Note these calculations assume that all providers in the proposed network serve both adults and children. We do not currently differentiate between behavioral health providers that serve only adults or only children, but will identify these providers in our database prior to the start of the contract.

invite 460 Medicaid-validated mental health providers and 15 SUD providers not currently in RMHP's statewide to provide RAE services, provided they meet contracting, credentialing and documentation requirements.

Table: RMHP's Network of Medicaid Validated Providers

	Number of RAE Contracted Providers (and HCPF Revalidated)	Average Minutes to Two Providers	Average Miles to Two Providers	Percent of Members with Access (Minutes)	Percent of Members with Access (Miles)
Psychiatrists and other psychiatric prescribers	100	9.8	10.4	100.0	100.0
Mental health providers	472	4.2	4.5	100.0	100.0
Substance use disorder provider	50	9.2	9.6	100.0	100.0

The number of mental health providers per 1,800 Members is 4.3, quadruple the minimum requirement.

Statewide, the Partners will provide services to Members regardless of the Region in which they seek care. RMHP is currently contracted with 2,555 unduplicated mental health providers and 171 unduplicated SUD providers who are Medicaid validated and 1,973 mental health and 136 SUD providers who are not currently Medicaid validated.

For those Members who require a higher level of care, there is one inpatient psychiatric hospital in Region 1 operated by Minds Springs Health, a Reunion Health partner. Outside the region, RMHP maintains a robust behavioral health network statewide. We are currently contracted with all inpatient psychiatric facilities in the state, both standalone as well as those that are part of larger hospital systems, including SCL Health, UC Health, Children's Hospital Colorado and HealthOne. Our PNM representatives are currently assigned to manage all facility relationships within geographic areas, including inpatient psychiatric providers.

In addition to geographic accessibility, we promote providers that allow our Members to access services after hours. Our Provider Network includes a behavioral health sites with evening and weekend availability. Mind Springs offers after-hours appointments in Grand Junction three days a week and groups after hours in most locations. Summit Health Partners has after-hours availability in Fort Collins and Loveland four days per week and on Saturdays.

To demonstrate and monitor network adequacy, we will create a routine report that details core capacity statistics for behavioral health and SUD treatment providers, including detail regarding expertise with children and families, sexual assault, eating disorders and other specialty areas. We will evaluate caseload for providers, pursuant to clearly documented standards for appropriateness. Further, we will prospectively address our plans to improve

Network composition and performance over the next year to meet the needs of our Members, including special populations. We will also track timeliness standards, prevalence of single-case agreements used, acceptance of mental health certifications as well as any other information requested by the Department.

Improving Efficiency and Increasing Capacity

RMHP provides *practice-facing* and *patient-facing* human resources to promote team-based, community-connected practices that address health and social determinants in a whole person model of care. One of the most valuable resources we make available to improve efficiency and increase provider capacity is our Practice Transformation program. Likewise, the Community Health Worker and Health Engagement Team model sponsored by RMHP and partnering CMHCs creates greater capacity to accept Members who might otherwise experience difficulty establishing a medical home. The two barriers most commonly cited by providers are no-shows and patients with complex social needs. Additionally, we support the development of on-site care coordination, helping Members to become more activated while freeing providers to work more efficiently. Finally, in our role as a payer within the Medicaid Prime program, we have developed robust, risk-adjusted payment and incentive arrangements that generate additional financial support for PCMPs that serve resource-intensive Members.

B. MEETING THE UNIQUE NEEDS OF THE POPULATIONS

The Region 1 service area encompasses 2 urban, 12 rural, and 8 frontier counties. It is home to varied geographies from plains regions to mountain communities. The Region has diverse community demographics, with people working in a variety of industries. Like many of the state's regions, Region 1 population trends reflect such as increasing average age and a dramatic increase in the Hispanic population. These trends are more prominent in some areas than others; for instance, the ski resort counties of Summit, Eagle, and San Miguel will experience relative increases greater than 8 percent in the over-65 population, while Delta and Dolores are predicted to have negative percentage changes.[18] Eagle and Garfield counties average almost 30 percent Hispanic, while Rio Blanco, Hinsdale, and Ouray average well under 10 percent.[19] Locally-tailored solutions are required to meet the needs of these very different, largely rural, communities.

Our community partnerships, forged over many years, have demonstrated significant success precisely because services are woven into the fabric of each community. A service or program that is appropriate and efficacious in one community may not necessarily be applicable or transferrable to another. We have adopted a multi-faceted approach to addressing this variation in order to meet the needs of every subpopulation in the Region.

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[18] Colorado State Demography Office, "Aging and Poverty in Colorado."
https://www.colorado.gov/pacific/sites/default/files/13EconPov0729- PresentationAging and Poverty in Colorado 2013.pdf

[19] Slate, "Where Hispanics Live."
http://www.slate.com/articles/news_and_politics/map_of_the_week/2012/07/map_of_america_s_hispanic_population_county_by_county.html

Community-Based Services

Embedding healthcare in community-based locations allows Members to obtain care in a setting that is comfortable and accessible to them. Since Members in rural regions may not be able to get to the next town, saving trips by co-locating with other services may reduce significant barriers to access. Co-location additionally provides opportunities for warm hand-offs and streamlined communication among healthcare and social services providers, as well as building awareness of the availability and importance of healthcare services. The Partners currently collaborate with local partners to offer healthcare onsite at many family and community resource centers, schools, homeless shelters and local public health offices throughout Region 1. We have already cited some of these collaborations earlier in our response. Some additional examples include:

- Mind Springs provides therapy, consultation and case management at over 100 schools in 10 counties throughout the Region 1, at school-based health centers and at over 20 preschool/daycare facilities in four counties.

- SummitStone provides day treatment, individual and group therapy, case management and consultation at multiple community based locations in Loveland.

- Mountain Family Health Center provides behavioral health, medical and dental services at school-based clinics in the region and behavioral health at family resource centers.

- Mind Springs provides therapy and case management services at the Pitkin County family resource center.

Individuals Experiencing Transportation Barriers

Because access to reliable transportation can be a barrier to provider access, we offer a variety of transportation solutions to our Members. These services are outlined at greater length in responses 13 and 14 and include:

- Liberty Mobile – An Uber-type model enabling people in rural and frontier to get transportation where there are no taxis or public transportation. RMHP is currently piloting this program in partnership with the Tri County Health Alliance the rural and frontier regions of Montrose, Ouray and San Miguel counties.

- Toyota Lease Model – UnitedHealthcare has established an arrangement with Toyota that affords local plans and community partners access to low-interest financing and fleet lease arrangements. RMHP has funded vehicle fleets to CMHCs and FQHCs to support our CCT, Community Health Worker and Health Engagement Team during Phase 1 of the ACC. The Toyota agreement will enable us to sustain and scale this model significantly during ACC Phase 2.

- Mobility Manager – Efficiently and consistently integrating transportation in care coordination activities requires complex knowledge, focus and sustained relationships. RMHP will dedicate a Mobility Manager to facilitate transportation services and provide training and consultation to care coordinators.

- Crisis Transport – Law enforcement and public safety organizations face constrained budgets, and increasingly decline to transport Members during crisis episodes for assessment or admission. RMHP and Reunion health members will develop solutions,

such as training appropriately suited volunteers, to accompany CMHC professionals during crisis transportation in rural areas.

Tribal Communities

There are two Tribal Health Centers in Region 1: the Southern Ute Health Center in Ignacio, which is currently in the process of becoming a PCMP, and the Ute Mountain Ute Health Center in Towaoc. We are engaged in discussions with the Department's Tribal Liaison and are working out a plan to continue our PCMP contracting dialogue with the Ute Mountain Ute Health Center, as their participation in our PCMP network is a top priority.

In our efforts to support the work of tribal health centers, we have participated in the annual Ute Mountain Ute Health Fairs for the past four years at the invitation of the Tribal Health Center staff. We have also assisted the Health Center's administrative staff with the Department's revalidation and enrollment process.

Creating Telehealth Solutions

Telehealth is an emerging, transformative solution for improving access, experience of care and capacity in rural and frontier areas, helping RMHP meet the unique needs of the population in this region. The rural landscape of Region 1 prevents in-person visits for every Member at all times. In Region 1, 72.6 percent of people live in a rural or frontier classification and public transportation is limited. In the winter, snow blocks roads and creates a hazard even for those with reliable transportation.

One challenge to its widespread use by Medicaid beneficiaries is a lack of access to hardware and data plans. To overcome this barrier, we are pleased to offer MyHealthLine, which connects Members with free smartphones and data plans through the national Lifeline benefit and provide site-based telehealth infrastructure to rural practices.

RMHP has also developed EasyCare Colorado, in partnership with CirrusMD, to support a wide variety of virtual clinic and asynchronous practice models, which include services provided directly by the health plan to Members, as well as those available from FQHCs, private practices and CMHCs. Any of our primary care, behavioral health and community service partners can use the EasyCare CO platform free of charge for virtual visits and secure chats for the populations they serve – without regard to enrollment status in RMHP, the ACC or any other payer coverage. We have also integrated CirrusMD's solution within Quality Health Network (QHN), which enables patient interactions to be documented as brief encounter notes, tagged with general categorizations (e.g., prescription, refer to PCP, refer to ED, refer to care manager) and routed immediately to clinical end users in other organizations that serve the patient.

Telehealth is ideal for behavioral health where in-person interaction is not required. It may also allow Members to discuss issues that might be difficult to discuss in person. Members with social anxiety or concerns about safety can see a physician in a safe location. The EasyCare interface not only allows for face-to-face video visits but also secure text-based communications, ideal for administering talk therapies such as Cognitive Behavioral and Dialectical Behavioral Therapies.

ECHO Use

Project ECHO (Extension for Community Health Outcomes) expands the capacity of primary care providers to serve the needs of patients with complex conditions by providing them with appropriate guidance and training. The Partners support the use of tools like Project ECHO that combine telemedicine, case-based learning, and disease management techniques. Because of severe shortages of specialty providers in rural areas, people with complex conditions such as hepatitis C, opioid use disorder, or rheumatoid arthritis often must travel long distances or wait months to get treatment. Such problems are compounded by the fact that many rural patients are poor. Given these barriers, such patients often forgo treatment or wait until they have severe complications before seeking help.[20] Through the ECHO model, specialty providers help guide rural community providers in applying best practices to manage care, and the community providers build their knowledge of conditions and serve as expert consultants in their regions.

Transitions of Care

While in densely populated areas, transitions of care often occur within a small radius of the Members' home, transitions for Members who reside in rural areas can require travel across the Region or the entire state. The Partners have collaboratively developed programs targeted at transitions of care between settings and levels of care to ensure Members are connected back to their community and to ongoing treatment through a PCMP. We are focusing on two special transitions that are often problematic: discharge from inpatient hospital settings and release from criminal justice settings. The latter individuals have complex medical, behavioral and social needs that must be addressed in a comprehensive way to successful reintegrate the Member into the community. Their discharge needs will be discussed below in special populations.

For other inpatient transitions, the Partners will build upon current collaborations with local hospitals for discharge planning for individuals who need ongoing treatment for a chronic condition or behavioral health diagnosis. Health Information Exchange services provided by QHN and CORHIO create real time intelligence regarding admissions and discharges. We currently receive Admissions, Discharge and Transfer data for our Members from hospitals across the entire state, due to an interface we collaborated with the two HIE organizations to develop. Alerts are routed automatically to RMHP's shared care coordination platform to CCTs throughout Region 1, as well as to PCMP EHRs via QHN's Direct service. ADT alerts and discharge support is available for both primary care needs and behavioral health needs. We currently provide practice transformation to assist practices in developing the technological capacity in their home electronic medical records to receive ADT data and enhance care coordination with local hospitals.

C. SERVING DIVERSE MEMBERS WITH COMPLEX AND SPECIAL NEEDS

A key strategy for maximizing provider capacity to serve Members with complex and special needs is our team-based approach to care. During ACC Phase 1, RMHP established and supported transdisciplinary community based care teams (CCTs) that built on and enhanced the

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[20] Hostetter, Martha. Case Study: Project ECHO Expands Access to Specialty Care for Rural Patients. Quality Matters (Commonwealth Fund). November/December 2009.

individual community's leadership, strengths and resources to support care coordination. CCTs serve as the local experts and as capacity builders for the local PCMPs, hospitals and behavioral health providers by acting as practice extenders, supporting individuals with complex medical, behavioral and social needs. During Phase 2, RMHP and Reunion Health CMHCs will more closely integrate intensive care management services for special populations within the comprehensive RAE program structure established by the Department.

Programming includes prevention programs and services for individuals involved in criminal justice and other special populations, as well as supporting access to care for members living in isolated communities or experiencing other barriers to care using telemedicine, mobile services and community-based integration. All services align with our Population Health Management Strategy.

The Partners are also adopting CommunityCare, a HIPAA-compliant care coordination platform to align and monitor services for Members with unique needs. CommunityCare integrates evidence-based medicine, gaps in care and hospital admission, discharge and transfer (ADT) messaging. It includes a Member's acute care, preventive care, chronic disease management, medical, and behavioral health records as well as social and long-term care services. The dynamic, person-centered electronic record houses the person-centered care plan and provides Community Care Teams (CCTs) with real-time online access to view, update and communicate about each Member's medical information 24 hours a day, seven days a week.

Targeted Efforts to Address Socio-Economic Barriers to Care

Because many of our Members face cultural and structural barriers to receiving care through traditional healthcare systems, the Partners provide direct outreach and use co-location strategies to improve access. We will develop, promote and scale programs targeting access to services that meet the unique needs of the populations in our region, including:

- Individuals at every life stage
- Individuals involved in the criminal justice system
- Children and families involved with child welfare
- Individuals with intellectual or developmental disabilities (I/DD) in need of behavioral health services
- Individuals with limited English proficiency (LEP)
- Deaf and hard of hearing population
- Individuals experiencing housing insecurity
- Individuals experiencing transportation barriers
- Tribal communities
- Individuals who identify as LGBTQ

Supporting Individuals at Every Life Stage

The Partners currently provide a spectrum of services tailored to specific needs at each life stage. As discussed above, the age distribution of Region 1 varies dramatically from county to county. Services align with the life stages endorsed by the Colorado Opportunity Framework,

including family formation, childhood (early and middle), adolescence, adult (transition, early, independent, and assisted), end-of-life, and members living with disabilities.

We will use publicly available, local data to assess the life stages of Members and match those data—as well as demographic projections of life stages—to expertise and capacity within Network. For instance, areas with elderly populations need more primary care providers as well as more specialists; areas with more women of child-bearing age need more obstetricians as well as behavioral health providers that can provide counseling and groups for new mothers. If there are local but uncontracted providers that meet these needs, we can increase our outreach efforts. If there are no local providers of these services, we can look at improving capacity among existing providers or utilizing services like telemedicine. We are committed to maintaining a network that is responsive to our Members' needs.

Individuals Involved in the Criminal Justice System

Access to behavioral health evaluation and treatment services is a particular need for individuals involved in the criminal justice system. Individuals with mental health needs are disproportionately represented in the criminal justice system, which is not an appropriate or effective setting to provide the help they need to achieve recovery and become thriving members of their communities.

In Region 1, there is great variation in the prevalence of criminal justice involvement. While Pitkin, Jackson, and Ouray counties have some of the lowest arrest rates in the state, Mesa County has one of the highest rates. The arrest rate in Mesa County is primarily driven by juvenile arrests, indicating that this population may be amenable to intervention.[21]

Over a period of years, the Partner CMHCs and RMHP have developed effective collaborations with local jails, prisons, and detention facilities. For example, the CMHC Partners provide an array of behavioral health services, medication management and case management in jails throughout the region. The Partners' service planning policy specifically addresses care coordination for individuals leaving the criminal justice system, and includes the following basic elements:

- Members released from criminal justice facilities have access to services with the identical standards that are afforded other Members for routine, urgent, and emergent care, including the same access to outpatient appointments and prescribers. As appropriate, Members may be directly transferred from jail to the mental health center, a prescriber appointment, or an emergency crisis evaluation.

- Members involved with the criminal justice system are provided with a referral to a PCMP if they do not have one established.

- Members involved with the criminal justice system are assisted in accessing physical health, specialty care and/or community resources.

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[21] Colorado Division of Criminal Justice, "Crime Statistics." https://www.colorado.gov/pacific/dcj-ors/ors-crimestats

Co-responder, specialty courts and continuity of behavioral health services for these individuals are discussed in Offeror's Response 14.

Families Involved with Child Welfare Services

Child Welfare is a critical entry point to identify children and families in need of healthcare services and connect them to treatment. Research demonstrates that the child welfare and foster care population have high health needs: 25 percent of children entering foster care have three or more chronic conditions[22] and nearly 50 percent of children entering foster care have significant emotional and behavioral health concerns.[23] Healthcare system capability to appropriately identify children with needs, stratify to intervention by risk, and successfully connect to treatment interventions is "fundamentally reliant on partnerships with child welfare agencies."[24]

We are committed to contracting with primary care and behavioral health providers who can provide services to children and families involved in the child welfare system. We will build upon the Partners' work with county departments of human services' (DHS) child welfare systems to support evidence-informed approaches to improve the system. DHS can identify the providers they have built successful relationships with so that we can reach out to and engage these providers in the network. We facilitate regularly scheduled complex care coordination meetings in partnership with county DHS to review the needs of Members involved in the child welfare system, who are often in need of more intensive behavioral health services. The Reunion Health CMHCs currently provide behavioral health and comprehensive trauma assessment and facilitated connection to treatment for children and families involved in child welfare, and can support expanding this capacity to additional behavioral health providers throughout the network.

Active collaboration with DHS and routine evaluation of the success of this collaboration is essential to meet the complex needs of these children and families. In some cases, medical and behavioral services are already co-located. For example, Marillac Clinic in Grand Junction has a location inside Mesa County Department of Health. In addition to identifying opportunities to expand our network in partnership with DHS, we also will administer annual surveys to DHS staff to obtain feedback on their ability to access healthcare services for children and families. Meetings with each county to address identified needs and improve coordination with network providers and other Health Neighborhood organizations will follow these surveys.

Individuals with Intellectual and Developmental Disabilities (I/DD)

Coordination of care and access to treatment for individuals with a dual I/DD and behavioral health diagnosis is currently fragmented due to distinct billing systems and scopes of work. We

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[22] L.K. Leslie, M.S. Hurlburt, J. Landsverk, K. Kelleher et al. "Comprehensive Assessments for Children Entering Foster Care: A National Perspective." Pediatrics, July 2003.

[23] B.J. Burns, S.D. Phillips, R. Wagner, R.P. Barth, D.J. Kolko, Y. Campbell, et al. "Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey." Journal of the American Academy of Child and Adolescent Psychiatry, v43, n8, August 2004.

[24] Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit. Kamala D. Allen, Sheilf A Pires, Roopa Mahadevan. Center for Health Care Strategies, Inc. February 2012

will seek to expand access to care by developing I/DD treatment capacity among behavioral health providers.

In 2016, the Department awarded RMHP the **Cross-System Response for Behavioral Health Crisis Pilot Project**, in Delta, Garfield, Larimer, Mesa and Montrose Counties. RMHP, partnering Community Centered Boards (CCBs) and CMHCs are working together to assess clients in crisis for an I/DD, manage the crisis, and create follow up plans. Additionally, the partners collaborate in professional learning communities that teach them how to manage crises for clients with I/DD and track and share data on the clients. Through weekly operations meetings, the partners discuss cases and work to improve processes and communication.

Following the crisis, the CCBs and CMHC providers create follow up plans to support patients and their families with managing symptoms and adhering to treatment through continued 30, 60 and 90 day follow-up. The providers work with the individuals and their families to teach them life skills to improve their quality of life and functional status and work towards achieving better day to day management and reduce future crisis episodes. The community providers work together to access and use health, social and alternative services, LTSS, intensive case management, housing support, and medication management to wrap around an individual to support them living in the community. At least 137 individuals have received crisis services in the first nine months of the pilot.

Individuals with Limited English Proficiency

> *"If I didn't have a translator, I'd be desperate."*
> *– Monolingual Hispanic parent of a child who receives Medicaid[25]*

All Region 1 RAE Members will have access to linguistically appropriate support services that reflect their needs. Specifically:

- **Healthcare services in their preferred language**: We will provide infrastructure and availability of 24/7 medical interpretation available for the complete set of threshold languages for residents of Region 1, including American Sign Language. We will identify health care providers who speak languages other than English, including American Sign Language, in the Provider Directory and on our website.

- **Educational materials in their preferred language**: All Member information and education materials will be available in Spanish, and translations will be made available in other languages, including braille or audio recording.

- **Educational materials in the appropriate literacy level**: All materials are written at or below a 6th grade reading level to increase comprehension for Members with limited literacy skills.

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[25] Understanding the Colorado Medicaid Member, UnitedHealthcare and RMHP Outreach Study, May 2017

In an effort to meet the Member's needs, and make interactions with providers more efficient, RMHP proactively identifies health care providers who speak languages other than English. Our physical health network currently includes 67 unduplicated providers in Region 1 who speak at least one language other than English. When direct interaction with a bilingual health care provider is not possible, RMHP makes interpretation services available. RMHP also provides funding for a Spanish-speaking interpreter in Summit County who supports clinics and local social service organizations, and is available via phone and in person to all individuals living in Summit County in need of the service. We are also funding a full-time American Sign Language interpreter for Mesa County. We look forward to exploring additional opportunities to provide this additional support during ACC Phase 2.

Deaf and Hard of Hearing Populations

RMHP and local disability advocacy partners facilitated a community town hall and provider learning collaborative in Fort Collins in November 2016. The event featured an introduction to deaf culture provided by a deaf individual as well as an explanation of Video Remote Interpreting and information about RMHP care coordination resources. Participants left the event with a toolkit of information that they can immediately implement within their organization to help them better serve deaf and hard of hearing populations. We plan to continue this work as the RAE and expand it to the entire region.

Individuals Experiencing Housing Insecurity

Access to care remains a prevailing issue for a population of individuals experiencing homelessness or who are at risk of becoming homeless. We understand the scope of the problem and have developed approaches to supporting our Members who are dealing with it.

In a 2017 survey, there were 4,019 homeless women, men and children counted in Region 1 vicinities. Of the Region 1 counties surveyed, there were 2 chronically homeless individuals in Eagle County, 29 in Garfield County, 10 in La Plata County, 118 in Larimer County, 154 in Mesa County, 27 in Montezuma County, and 7 in Pitkin County. Chronic homelessness is highly associated with serious mental illness, substance use disorder, and physical disability, highlighting the need for primary care physicians to ask about and address this risk factor.[26]

We believe that the best way to serve members experiencing housing insecurity is to "meet them where they are" – literally and figuratively. Reunion Health members serve individuals experiencing housing insecurity through primary care medicine integrated with behavioral health and social services. For example, SummitStone Health Partners currently integrates behavioral health services for individuals in permanent supportive housing, in libraries and at community service provider locations. When Members enjoy housing stability, they have better health and access to supportive services.

Another partner, Marillac Health, has co-located primary care providers to provide medical services at Homeward Bound homeless shelter and the homeless day shelter in Grand Junction. We will continue to explore opportunities to provide services to Members in locations that are convenient for them.

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[26] Colorado Coalition for the Homeless 2017 Homeless Point in Time Study Sheltered and Unsheltered Count: A Snapshot of Homelessness in the Colorado Balance of State Continuum of Care

Individuals who identify as LGBTQ

To support Members of the LGBTQ community, the Partners will assist interested practices in becoming practice allies. Such practices can choose to post small rainbows in waiting rooms, change intake forms to use non-binary and non-heteronormative language and ask Members their preferred pronoun at appointments. The Partners will actively recruit LGBTQ-friendly specialists that can address the unique needs of Members seeking gender transition--such as an endocrinologist to monitor hormone treatment--and provide training to practices to know and understand the heightened risks for Members who identify as a part of the LGBTQ community, risks like suicide, mental illness, bullying or sexual violence.

There are currently several providers in the RMHP statewide network who self-identify with experience in LGBTQ care and counseling:

- 1090 MSW Providers
- 311 PhD Providers
- 84 MD Providers
- 34 RN Providers
- 1,519 Total LGBTQ-Experienced Providers

The Partners will support sufficient network ability to meet the complex behavioral, physical and social needs of Members by increasing capacity to deliver the full continuum of services covered under the Medicaid benefit and facilitating coordinated transitions from acute and inpatient care. We will focus on network capacity for specialty care, behavioral health and care transition services to compliment services available through the Member's medical home.

D. SUPPORT THE PARTICIPATION OF SMALLER PRACTICES IN ITS NETWORK, PARTICULARLY IN RURAL AND FRONTIER AREAS

Small practices are essential participants in the Network and Health Neighborhood, and often serve as providers of choice for many Medicaid Members – particularly in rural areas. The personal connection between the Member, the provider, and the community is a key component of person-centered health. The Partners will utilize a structured and inclusive network development approach to encourage participation of practices of all sizes and levels. RMHP has extensive experience working with small practices – 91 of our PCMPs have less than 400 attributed Members, and only 21 PCMPs have 1,000 or more attributed Members (as shown in the graph below).

Number of PCMPs by Attribution Volume
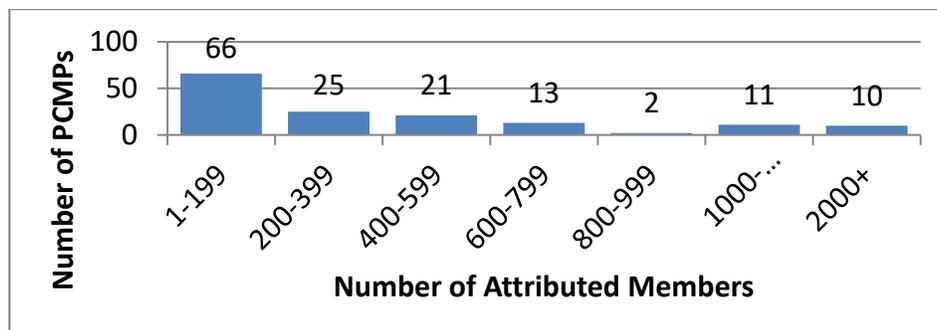
Structure

Our structured network strategy targets resources to the providers who assume the greatest proportionate responsibility for Medicaid Members and achieve the greatest degrees of transformation and performance, ensuring they have the support they need to be successful and create value. Payment is based on interest of the provider and evidence of efficacy. This means that small practices will not be disadvantaged in our PCMP network strategy.

RMHP recruitment efforts will clearly communicate opportunities for RAE-level supports, as well as practice transformation to build capacity within the practice to encourage small practice participation. Our approach will provide a single point of contact for practices for streamlined access to our full spectrum of innovative practice transformation and care coordination services. RMHP will collaborate with individual PCMP practices to provide data, tools and learning opportunities to build capacity for future health care reforms.

Inclusive

In many communities, and particularly in rural and frontier areas, RMHP's philosophy is to contract with all available physicians, pharmacies, Essential Community Providers and hospitals that meet RMHP's credentialing and quality standards. This inclusive concept results in high provider participation levels from small practices, which creates a plentiful provider base that affords accessibility and a range of services for all our Members.

We value and consider diversity to be a key part of a comprehensive Provider Network. We will have dedicated resources for provider network recruitment, development and maintenance. Small practices will have a single point of contact with RMHP during the recruitment and contracting process to streamline communication, and will receive information about available practice transformation and provider supports targeted to the practice's structure, Member population and geographic location. We believe that it should be simple for patients to choose their provider and that attribution should be time limited so the program is organized around active, current relationships.

Supports for Small Practices

We recognize that small practices can make a significant impact on the community in rural and frontier areas. Since Region 1 consists mainly of rural and frontier counties, these small practices are the front-line providers for most of our Members.

Smaller practices will have access to the same supports, trainings and opportunities as larger practices. Because they often are working with limited resources, we make investments in them through practice transformation support and global payments so that they have the ability to expand capacity and access through improved workflow and team-based care. RMHP will tailor content to fit within the scope of a smaller practice and promote those supports which will best enhance service delivery and extend provider reach. Additional examples of supports we expect to deploy in rural and frontier areas include:

- RMHP will support some PCMP functions on behalf of small practices that do not have the internal capacity for requirements that are accessible to larger practice. Community Care Teams often fulfill this role in Region 1, at the present time.

- Telehealth can be used for virtual colocation of behavioral health providers to increase access to integrated behavioral health and physical health services. Tri-County Health Network in Montrose, Ouray and San Miguel has adopted EasyCare for this purpose.

- The Colorado ECHO project provides targeted training to practitioners at small practices in within-scope case-based learning and disease management techniques specific to the needs of their Members. The provider will be able to build their knowledge of conditions with a high incidence among their patients.

- Learning collaboratives enable more relevant peer-to-peer learning and sharing of best practices that are successful across care settings. Learning collaboratives can bring together practices from diverse rural and frontier communities to develop big-picture strategies, as well as bring together practices from the same geographic region to address locally identified needs and barriers to care.

- Member access to primary care and behavioral health is dependent not just on the availability of services, but also on the member's ability to get to those appointments. We are reducing these barriers in two ways: Mobility Manager (discussed in more detail in Offeror's Response 13) and Telehealth (addressed above).

Foresight Family Practice illustrates how our approach to support works. Foresight is a small two-person practice that takes high-need patients. By providing them with team-based training and other practice transformation curricula and support, these two physicians served more patients with higher complexity while reducing their total cost of care. With an integrated behavioral health funded by RMHP, they had support within the practice that could help with things like motivational interviewing and patient activation. This resulted in more engaged, healthier patients who interacted positively with medical staff. By providing support where practices need it, we help providers reduce and manage many of barriers to accepting Medicaid Members. We are not just a payer, but rather a valuable community partner for providers.

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 Partners have adopted a network management strategy that reflects the needs and preferences of the enrolled population. Members will be able to choose from a broad network of appropriately contracted and credentialed providers. We will frequently review attribution – in bilateral communication with providers – so that accurately identified, active provider-Member relationships are the basis of care coordination, measurement and payment.

To serve the needs of our Members, the Partners will maintain a robust network of Primary Care Medical Providers (PCMPs) and behavioral health providers. Our overall strategy in this area is straightforward:

- We will manage the provider network using a structured, inclusive approach, which allows the broadest possible participation by appropriately contracted, Medicaid enrolled and credentialed providers.

- We will utilize our considerable practice transformation and network management infrastructure to conduct objective, ongoing, transparent assessments of PCMP and behavioral health provider skills and performance.

- Resources and reimbursement levels will be aligned with PCMP and behavioral health provider competencies in care coordination, data-driven quality improvement, documentation, Member volume and complexity.

- We will offer both PCMPs and behavioral health providers the opportunity to assume greater responsibility in value-based, Medicaid service delivery, at commensurately higher levels of network status, with the support of aligned leadership and collaborative learning structures.

A. CERTIFY PROVIDERS AS MEETING THE ACC CRITERIA

Objective and Transparent Criteria

In our capacity as the Regional Care Collaborative Organization (RCCO) for Region 1, Rocky Mountain Health Plans (RMHP) has completed over two hundred Practice Site certifications for PCMP status. RMHP's dedicated and highly knowledgeable Credentialing and Re-credentialing team within the Quality Improvement department manages the certification process, in close collaboration with our Provider Network and Community Integration teams.

The Partners will identify potential additional PCMPs through Department-provided data and information obtained from our Members through interaction with our Customer Service and Care Management teams. Local Provider Relations staff will contact these providers to explain the benefits of Accountable Care Collaborative (ACC) participation and offer assistance with

completing the contracting process. Our goal is to make onboarding with the second phase of the ACC as simple and hassle-free as possible throughout the Health Neighborhood. We will build upon materials and processes that RMHP has developed as both an RCCO and a statewide health plan to guide providers through the contracting process. Further, RMHP's locally-based Provider Relations staff frequently travel throughout the region, including remote Rural and Frontier communities, to provide in-person assistance with Department forms and systems.

B. CREDENTIAL PROVIDERS

Credentialing is a core component of RMHP's quality improvement program. RMHP has established policies and procedures for credentialing and re-credentialing its provider network, including physical and behavioral health providers.

As a comprehensive health plan with full Medicaid accreditation from the National Committee for Quality Assurance (NCQA), RMHP is responsible for maintaining both a physical and behavioral health network for the delivery of Child Health Plan Plus (CHP+) benefits in twenty-two counties. In 2015 the Department's third-party auditor, Health Services Advisory Group, evaluated RMHP's CHP+ plan for compliance with credentialing and re-credentialing requirements, including its behavioral health network. This audit found that RMHP met 46 of 46 applicable elements – a perfect score of "100 percent met". The credentialing and re-credentialing record review conducted at the same time evaluated 83 applicable credentialing elements and 90 applicable re-credentialing elements. Similar perfect scores were recorded for RMHP's Prime credentialing policies, procedures, and records for Medicaid providers. RMHP's written policies and procedures describe the process used to collect and verify information within the required time frames, criteria required for acceptance, the role of the credentialing committees and medical director, and a well-defined appeal process.

Independent behavioral health providers in Region 1 have expressed frustration with the time frame required by the current Behavioral Health Organization to complete credentialing – sometimes several months after required documentation is submitted. RMHP's policies and standards will be easily accessible to providers who wish to understand the process for credentialing, re-credentialing and required turnaround times. The current average credentialing turnaround time by RMHP – from application to notice of completion – is approximately six weeks.

RAE Behavioral Health Provider Credentialing and Re-credentialing

RMHP uses tools and standards that support administrative simplification for providers. Accordingly, we use the Council for Affordable Quality Healthcare's (CAQH) *Proview* tool, which is available to providers at no cost. CAQH ProView streamlines provider data collection by allowing providers to update their current information and supporting documents online at any time. We will make this information available to the credentialing team via a simple provider approval process. The use of CAQH ProView eliminates the need for providers to print and mail credentialing applications, greatly reducing the turnaround time. Occasionally, a provider may express their preference for submitting a paper application. In such cases our Credentialing and Provider Relations representatives will work directly with the provider to assist in mailing or faxing their application and supplemental documents to us.

In accordance with NCQA accreditation requirements, RMHP's Credentialing team investigates any previous malpractice claims, disciplinary actions or other pertinent information. Upon completion of all primary source verification and applicable investigations, the clinician's file is presented to the credentialing committee, which comprises both staff and network clinicians. The credentialing committee reviews any practitioner file that does not meet criteria. Using all of the information collected during the credentialing process, the committee approves or denies the clinician's application to join the network.

Upon decision by the credentialing committee, the clinician will be sent a decision notification letter. Clinicians that do not pass credentialing will receive information about what is necessary to correct the application. Clinicians that are accepted to the network will receive a Network Manual, which serves as a reference guide to our policies and procedures; approach to treatment; and administrative protocols for certification, claims submission and appeals. The manual also details expectations for the provision of services and covers regulatory standards.

Re-credentialing: The re-credentialing process is required at least every three years, and follows the same steps as the initial credentialing process. Re-credentialing begins six months prior to the three-year anniversary of the provider's initial credentialing or last re-credentialing date, allowing time for the provider to update their CAQH ProView profile and application.

Credentialing Delegation: For approved practices that have the resources and processes to comprehensively review and credential their own providers, we offer delegation of credentialing functions. As a benefit of delegation, practices need only submit a roster of approved provider additions, terms, and changes on a monthly basis to make updates to our claims system and directory.

Provider Agency Credentialing: In addition to credentialing individuals, we are experienced at credentialing at a provider agency level. Agency credentialing can be implemented when the entity is licensed by the state, and this credentialing method is frequently used for our behavioral health and substance use disorder providers. In addition, this method relies on the simple roster management of independently licensed staff employed at the agency. Contracted agencies that meet credentialing delegation requirements can update their staff rosters using the secure provider portal, or they can send their rosters to the assigned Network Manager for completion.

C. Notify Providers regarding selection and retention

Clear, objective and timely feedback regarding provider applications for credentialing and network participation is essential to RMHP's network improvement and maintenance strategy. All network credentialing and tiering assessments will be made available to providers in a timely manner, no more than 90 days from the date of application. The assessments and network status decisions will be documented in an objective manner and indicate the basis of the decision, and will be reported transparently to the members of the Director's Committee in the RAE governance structure. They will also be made available to any other interested party, including the Department, upon request.

More importantly, providers who fail to meet criteria for admission to the network, or participation at a higher tier will be afforded support from RMHP's Credentialing, Provider Relations and Practice Transformation teams, so that they can take concrete action to close gaps and reapply for admission or a new tier stratification status as quickly as possible. Finally, the community governance model and an opportunity for recourse to representative leaders appointed to the Director's committee will keep the RAE accountable in this critical dimension of performance, and "keep the door wide and open" for any provider that seeks to assume greater responsibility for serving Medicaid members.

D. MONITOR AND ENSURE COMPLIANCE WITH ACCESS STANDARDS

The Partners are committed to providing access to care as a means to optimize Member experience. Lack of access for a Member represents a missed opportunity to impact the Member's health and provide a positive direction for their health outcomes. Our network's diverse provider composition and combination of clinic- and community-based service locations and partnerships with local hospitals will support compliance with these standards as well as Member choice, ease of access, and engagement in care.

RMHP maintains comprehensive quality standards to identify, evaluate, and remedy problems relating to access of care. For the geographic area served, RMHP regularly reviews access to care by Members, considering the relative availability of providers in the area based on location, number and type of providers, and the usual travel patterns in the community. All complaints are investigated promptly, and staff periodically conduct "secret shopper" or "open shopper" tests as necessary to assess and resolve apparent compliance problems.

The Partners will build upon RMHP's experience and activities to identify, evaluate, and remedy access problems. The RAE Directors Committee will continually monitor adequacy and capacity, identify any potential network issues and make recommendations or suggestions for resolution to the Executive Committee. Recommendations may include contracting with certain providers where practicable, encouraging providers to travel to certain areas, providing transportation alternatives to Members and expansion of telehealth solutions. The issues identified and their resolution will be reported to RMHP's Compliance Officer so they are prioritized for ongoing auditing and monitoring.

We will base the need for additional access on the following factors:

- Responsiveness to a specific need identified by the quality improvement team
- Results of Member surveys measuring wait times for appointments
- Responsiveness to Member requests and feedback
- Expansion of the RAE network service area
- RAE network analytics that illustrate the need for more providers – based upon enrolled membership and projected enrollment – to provide adequate access to care in compliance with contract requirements.

The Partners will apply the Department's established physical and behavioral access standards, which adopt varying distance and travel time criteria according to Urban, Rural and Frontier

geographic designations. RMHP produces Geo-Access maps and reports that show time and distance standards for its Medicaid, CHP+ and other lines of business. These reports present the following information for each zip code in the region:

- The number of Members
- The percentage of Members in that zip code that have or do not have access following the Department's time/distance standards
- The average time to travel to one PCMP, and the average time to travel to two PCMPs

The Partners will leverage RMHP's experience with preparing and submitting network adequacy reports to the Department that provide:

- An up-to-date picture of the total number of providers by type and county, including but not limited to PCMPs, specialists and hospitals, and the ratio of Members to providers
- A current count of the number of providers accepting new patients and offering appointments outside of typical workday hours, Monday – Friday, 7:30 a.m. – 5:30 p.m.
- A description of how the network of providers meets the needs of RMHP's Member population, including Members in special populations

RMHP is also able to produce information on provider cultural and language expertise. For example, the number of PCMPs by language spoken are: Spanish (63), German (1), Korean (1), Portuguese (1), and Multilingual – unspecified (2).

RMHP will produce similar data for its behavioral health network, including:

- Provider caseload data
- Number of providers able to accept mental health certifications
- Number of co-located services that support the needs of special populations in Region 1
- Percentage of Members that receive services within timeliness standards
- Number of behavioral health provider single-case agreements used
- Number of new providers contracted in the quarter
- Number of providers that left the network in the quarter

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.

Western Colorado is approximately 40,000 square miles, with vast geographic, economic, demographic and community diversity. Due to the size of the region, we have identified six distinct Region 1 Communities and Health Neighborhoods. Health Neighborhoods are primarily made up of the medical resources serving a member; Communities include the Health Neighborhood <u>and</u> the non-medical resources that serve a member. We will support these Communities through region-wide infrastructure, resources, national expertise and tools from the Partners. While many resources will support the entire region, processes and relationships will be developed locally.
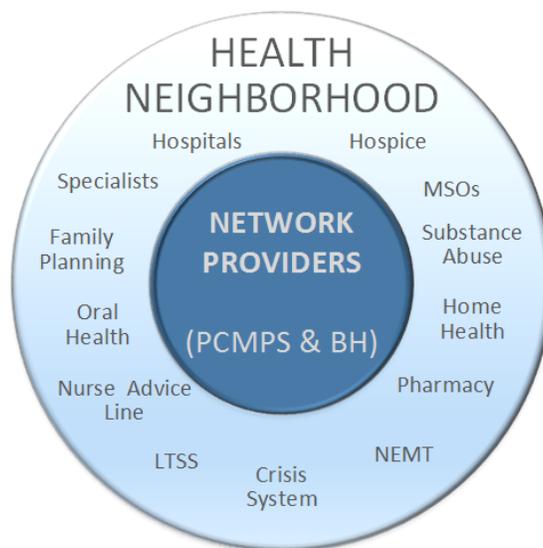
Integration across the neighborhood is supported at both the local and regional levels. At the regional level, our community governance structure includes members from across the health neighborhood, establishing a forum that will focus on furthering the goals of better integration and enhanced coordination. At the local level, the six Communities will be led by an *anchor organization*. Anchors are committed to the ACC, and play a leadership role in health systems reform in their community. Anchor organizations may be a hospitals, Federally Qualified Health Centers (FQHC), Local Public Health Agencies (LPHA), community Health Alliances, or providers of "specialized expertise" such as mental health, public health, or primary care. RMHP will build upon leadership wherever it exists regardless of organization type.

The six communities are defined by naturally occurring patterns of care, geography and the presence of local leaders or infrastructure. Fort Collins, Steamboat Springs, Glenwood Springs, Grand Junction, Montrose and Durango all have clinical leaders, health alliances and community infrastructure that allow them to promote community integration. These regions align well with the major FQHCs, Community Mental Health Centers (CMHCs), and hospitals in the region. A high-functioning and nimble RMHP Community Integration Team has supported

these local organizations during the first phase of the ACC, and looks forward to expanding and accelerating our engagement as the RAE in Phase 2.
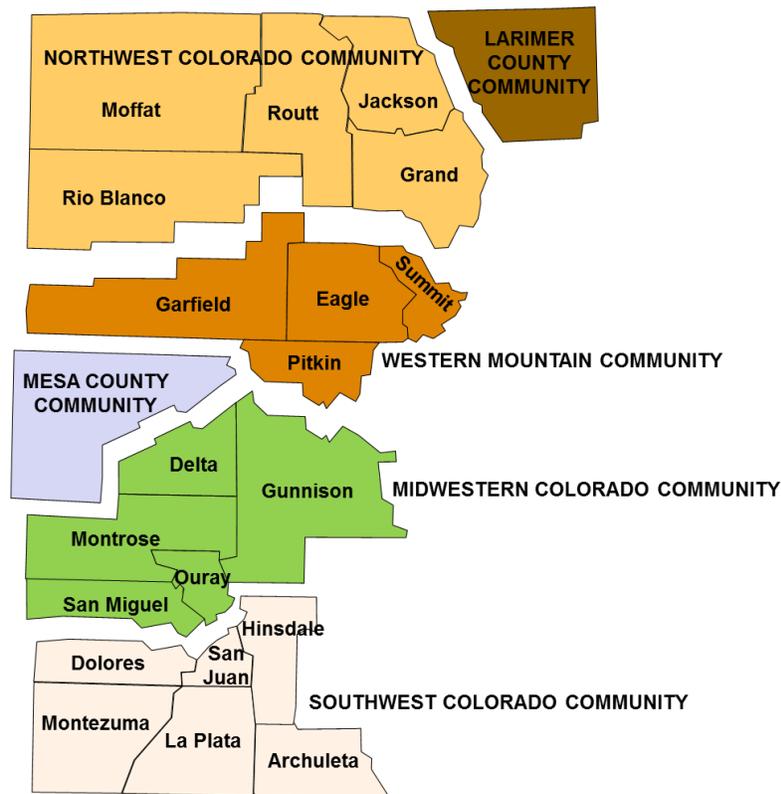
Our commitment to develop high functioning Communities and Health Neighborhoods entails flexibility to effectively align Medicaid-related activities with broader capacity building opportunities. Our investments in social information exchange (SIE), health information exchange (HIE), telehealth, CommunityCare and other community resources can and will be leveraged to benefit all Medicaid members in the RAE. It is our policy to offer tools that providers can use with all of their patients, regardless of enrollment in RMHP. An example of this is EasyCare CO, a telehealth tool currently provided by RMHP at no cost. We are also committed to directly supporting all Colorado Medicaid Members, regardless of RAE assignment. For example, our existing call center is open to any Medicaid Member who needs it, and support is not limited to referrals within Region 1.

ENGAGING HEALTH NEIGHBORHOOD PROVIDERS AND FOSTERING COLLABORATION

We will foster collaboration through a community convening process that ensures specialists, hospitals and other Health Neighborhood members build relationships with primary care providers and other individuals and organization that interact with the same cohort of patients. The more these organizations work together to address the common challenges they observe and must overcome to support their clients, the stronger the Health Neighborhood will become. The most effective way to support this capacity building is to leverage pre-existing

forums, bring additional parties to the table as necessary, and provide the group with the tools and support that will accelerate progress on agreed priorities.
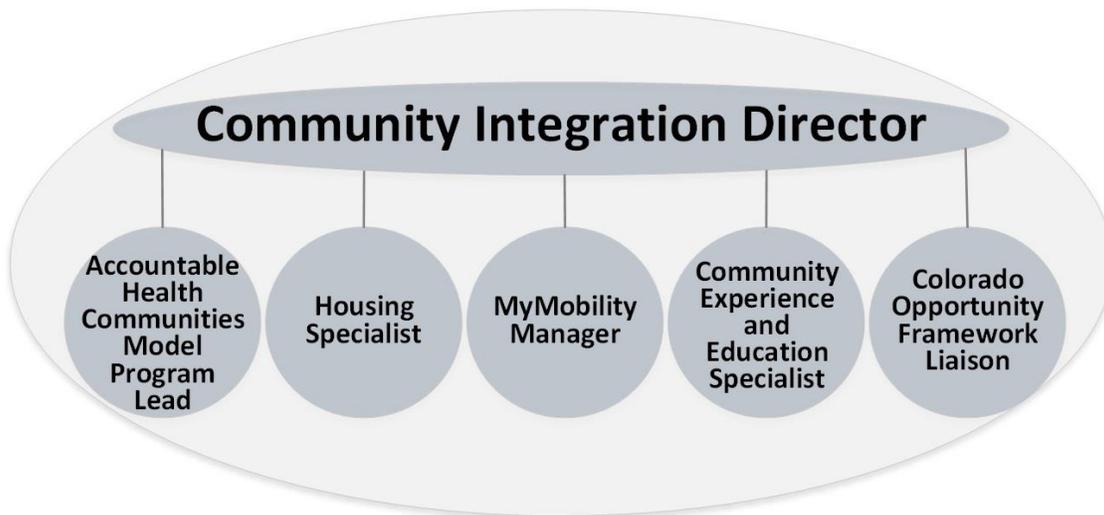
To support these efforts, RMHP's Community Integration Team will provide resources, tools, expertise, cross-region learning, and other assets as needed by the Community. The Community Integration Team will include an Accountable Health Communities Model Program Lead, a Housing Specialist, a MyMobility Manager, a Community Experience and Education Specialist, and a Colorado Opportunity Framework Liaison. This local team will also leverage the national experience of UnitedHealthcare. UnitedHealthcare has demonstrated commitment to innovation by bringing leading thought leaders into the organization. An example of this is the recent hiring of Jeff Brenner, a MacArthur Fellowship ("genius" grant) winner, formerly the Executive Director of Camden Coalition. Dr. Brenner is nationally recognized for creating better models of care for the sickest patients, and will use his expertise to benefit Colorado.

Partnering with the Health Neighborhood in Meaningful Conversations about Quality, Utilization and Cost

We will engage our partners in systems-level change and collaboration using robust data and analytics, and leveraging advanced analytics, including our *Impact Pro* platform. Using Impact Pro, we will analyze integrated medical, behavioral and pharmacy claims as well as lab test results to identify patterns of care at the practice, hospital and regional level. This powerful tool allows us to understand the pattern of care in each Health Neighborhood. For example, we can identify, by location, whether certain medications or procedures have higher rates of use.

We will continue to share these analyses with our Network of providers and community partners to support continuous quality improvement activities and efforts. We will also increase our use of this data to identify issues that appear across the community and assess the effectiveness of the various approaches to resolution.

For example, we used advanced analytics to produce and display differential rates of Emergency Room (ER) use in north and South Larimer County. We produced heat maps showing ER utilization rates by zip code and shared these with Network partners. This data

presented an opportunity for both northern and southern parts of the county to have meaningful conversations and take action geared toward improvement in the system.

The North Larimer County Community Care Team adjusted their target population based on the data and analysis, and as they dug deeper, found that people with Substance Use Disorder (SUD) significantly impacted ER utilization. As a direct response to this finding, they created an opioid oversight program with the goal of standardizing opioid prescribing and monitoring all patients on chronic opioids. In addition, a North Larimer Community Care Team member now participates in the Opioid Education Group that teaches various coping skills, opioid safety and alternative pain management techniques to patients with chronic opioid use. This team member also provides one-on-one care management for group members.

The South Larimer County Community Care Team developed a multi-pronged response tied to the wide range of drivers of ER use in their region. They distributed a handbook to parents with information on how they could treat the symptoms of their children's minor illnesses at home and when it is appropriate to go to the ER. They also held focus groups and key informant interviews, and based on information gained, expanded same-day appointments and added a triage nurse to their workflow to assess patients' immediate needs. The triage nurse can treat many minor conditions or provide a warm hand-off to an available provider.

In addition to supporting community-level conversations, we will also use claims data to identify practices and practitioners that might benefit by altering their prescribing practices. Impact Pro can identify gaps in evidence-based care, which can be used to design and implement effective case management and provider engagement strategies. Understanding what services are provided and how they are delivered is the first step to reducing the duplication of services and providing more effective care for Members.

Specialty Care

Access to specialty care is one of the more significant challenges in the current Medicaid structure. The demand for specialty care among the Medicaid population greatly exceeds the supply of specialists who will see Medicaid patients, especially in the rural and frontier areas of Western Colorado. In our online survey (part of our *Understanding the Colorado Medicaid Member* outreach in May 2017), Region 1 Members were less likely to report difficulty accessing specialty care (54 percent) compared to the statewide average (63 percent). This may be due, in part, to the fact that where RMHP is the Medicaid payer, RMHP can use its influence to support provider participation across all lines of business.

RMHP will make every effort to identify geographic areas where more specialists are needed and to incentivize specialists to see Medicaid patients. While we will work on providing all needed specialty services to Medicaid Members, we will focus first on those specialties identified by Members and providers as the most difficult to access. Second, we will focus on those identified by the Colorado Health Institute: pain management, endocrinology and ophthalmology.[27] We will support expansion of access to specialty care in two ways: 1)

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[27] http://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2010_SpecialtyCare.pdf

recruiting specialists to join the network; and 2) improving the efficiency and capacity of specialists who serve Medicaid.

A study conducted by the Colorado Medical Society reported that specialists' main barriers to seeing Medicaid patients, or to seeing more Medicaid patients, are the prevalence of no-shows, tardiness, low reimbursement, and the high social complexity of Medicaid patients. Effectively addressing these issues is important work, and success in this area can make a significant difference in the quality of care provided by the RAE to Medicaid Members. RMHP has a multi-pronged approach, described below, to address identified barriers and encourage specialty providers to accept Medicaid patients in greater numbers.

Reduce No Shows and Address Social Barriers

RMHP will work to reduce no-shows and social barriers by offering Members **MyHealthLine** text reminders and by offering a care coordinator to individuals requiring more support. MyHealthLine sends text appointment reminders to patients and, with 71 percent of enrollees saying it helped them to remember an appointment, has demonstrated a positive impact. Ninety-six percent of patients enrolled in the program stay enrolled, and 85 percent of members would recommend the program to a friend. In addition, Members will also have access to the CommunityCare portal where they can access their care plan, track appointments and medications, and securely email their care coordinator.

For Members who face more significant challenges in making scheduled specialty visits, **Health Engagement Team (HET) workers** will be assigned. HET workers are non-traditional community health workers who are embedded in Primary Care Practices and receive training from a Community Mental Health Center. Because HET workers are embedded, patients are often able to meet their HET worker while they are in the office seeing their PCMP.

HET workers have access to leased vehicles and are able to provide **transportation** and drive Members to their specialist appointments, and to support them in identifying solutions to other social needs that might impact the Member's ability to meet with the specialist as scheduled. HET workers often accompany Members on appointments with specialists, and help the Member prepare for the appointment and understand the role of the specialist. The support of these non-traditional health workers allows specialists to focus on providing clinical care.

Provide Practice Transformation Support to Increase Capacity

RMHP also increases specialist capacity by offering an innovative **Practice Transformation opportunity geared specifically to specialists.** Specialists can participate in an RMHP-offered Specialty Practice Foundations course, in which participants learn basic QI skills that include Plan, Do, Study, Act (PDSA) cycles, process mapping, and basic data use to develop and implement practice improvements. Specialty practices also learn about infrastructure they can use to enhance coordination between themselves and primary care. Specialists participating in the Specialty Foundations program receive a minimum $5,000 incentive payment. Although this program is relatively new, practices in multiple specialty categories have enrolled, and the first practice is ready to graduate soon.

RMHP also serves as a resource to practices that participate in learning tracks that promote practice transformation and collaboration between specialists and primary care providers. For

those seeking Patient-Centered Specialty Practice (PCSP) Recognition, an NCQA medical home concept extended to specialists, RMHP provides Quality Improvement Advisor Support, Clinical Informaticist support, various other tools and resources, learning collaboratives and targeted training programs, all free of charge.

RMHP also serves as one of the Practice Transformation Organizations that provide on the ground support and education to practices enrolled in the Transforming Clinical Practices initiative (TCPi) through the Colorado Practice Transformation Network (PTN). The majority of TCPi practices are specialty providers, who are working to improve patient outcomes and reduce unnecessary care (testing, procedures and admissions) by enhancing patient-centered care and team care, using data to drive change and implementing the medical neighbor-High Value Care Coordination model. The latter includes development of care coordination agreements as using pre-consultation/pre-visit review, referral guidelines and referral tracking to improve the referral process.

Provide Telehealth Tools to Improve Access to Specialty Care

Studies have shown that **telehealth** has the potential to reduce costs for all parties, increase access to specialty care, improve quality of life, and minimize disruptions for patients without sacrificing quality of care.[28] [29] [30] As specialists transform their practices, telehealth has great potential to be a cornerstone of clinical care. RMHP has contracted with CirrusMD to support virtual clinic and asynchronous practice models. **EasyCare CO**, a CirrusMD platform, is available free of charge to network providers, for use with all of their patients, not just RMHP Members. EasyCare CO allows providers and patients to have video or chat interactions in a HIPAA-secure environment. For specialties like dermatology, a brief video chat can eliminate the need for an in-person visit. In addition, EasyCare CO is connected to Quality Health Network (QHN), the health information exchange; QHN can support the transfer of EasyCare information from one provider to another.

We recognize that operational, financial and cultural barriers to adoption of telehealth must be addressed. RMHP has invested significant time and effort in identifying and addressing the barriers to provider and Member adoption of telehealth by creating a telehealth learning collaborative of providers willing to "pave the way." Mountain Family Health Centers, Primary Care Partners, Northwest Colorado Health and Northern Colorado Health Alliance have been meeting with RMHP representatives weekly, and as a group on a monthly basis, to collaboratively modify EasyCare for use throughout the region, and to develop policies and procedures for implementation. With RMHP's assistance, the Colorado Health Foundation awarded a grant to this cohort of providers to accelerate the learning process. For example, we

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[28] Flodgren, G., Rachas, A., Farmer, A., Intizari, M., Shepperd, S. Interactive telemedicine: effects on professional practice and healthcare outcomes. Cochrane Effective Practice and Organisation of Care Group, 2013. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002098.pub2/abstract

[29] Hofstetter, PJ, Kokesh, J., Ferguson, AS, Hood, LJ. The Impact of telehealth on wait time for ENT specialty care. Telemedicine Journal E Health, 2010
Health http://www.ncbi.nlm.nih.gov/pubmed/20575722

[30] Shah, MC, McDermott, R., Gillsespie, SM, Phillibrick, EB, Nelson, D. Potential of telemedicine to provide acute medical care for adults in senior living communities. Academy of Emergency Medicine. 2013. http://www.ncbi.nlm.nih.gov/pubmed/23406075

have found that patient enrollment is often quite challenging, and telehealth onboarding is more successful if it occurs during a face-to-face session in the clinic. We have also discovered that while the video is an appealing feature, the chat function is particularly popular.

EasyCare has the potential for significant benefit in rural areas, where the distance between patient and provider can present a challenge to accessing care. EasyCare also provides a way to address the transportation challenge faced by many Medicaid patients. In addition, through UnitedHealthcare's MyHealthLine program, RMHP will work to connect Medicaid enrollees with federally subsidized Lifeline phones to maximize the number of Medicaid enrollees who have the smart phone and data plan resources necessary to use telehealth.

Pediatric Partners of the Southwest (PPSW) in Durango provides an example of how telehealth can be leveraged to connect Medicaid patients to care. Durango is three and a half hours from the closest urban area, Grand Junction. For many children, the only subspecialists who serve their specific condition are located in Denver -- six hours away. PPSW employs a mix of outreach clinics (to which providers travel) and telemedicine to support client access to care. These specialty outreach clinics meet every two to six months. They are supplemented by telehealth where PPSW acts as the "originating site" for the call. The nurse on site will perform any necessary physical services such as taking vital signs, and the patient visits with the specialist via video link. The telemedicine clinics include diabetes, pulmonary and sleep medicine, endocrinology, down syndrome, behavioral health, and cystic fibrosis. Telehealth has dramatically reduced barriers to accessing specialty care as well as costs for patients' families. Prior to the use of telemedicine, the average round trip time was 840 minutes or 1.68 days. The average cost of a trip to Denver was $570 for overnight lodging, food, fuel and wage offset for the caregiver. Trips to the PPSW clinic averaged just 70 minutes.

Establish and improve referral processes

Improving the process by which patients are referred to specialists is a critical component in increasing Medicaid Member access to needed specialty care. At a high level, this can be accomplished by ensuring that referrals are made only for those patients that actually require specialty care and that the patient understands the role of the specialist. This requires enhanced communication between PCMPs and specialists, additional support for patients, and tools that facilitate the referral process. Below we discuss how the Partners will work to improve specialist referrals in four specific ways: 1) by promoting the Primary Care Compact; 2) by using e-consults; 3) by employing innovative tracking methods for specialist availability; and 4) by supporting Project ECHO. RMHP knows, based on its years of working with Western Slope practitioners on practice transformation, QI and care coordination initiatives that both primary care and specialty practices are eager to take on these advanced referral processes.

Primary Care Compact

RMHP has supported communication between primary care and specialty practices by assisting practices in using the Colorado Medical Society's Patient Centered Medical Home (PCMH) Primary Care-Specialty Care Compact. This structured referral process helps improve referrals for the patient, referring physician and specialist, resulting in a more efficient, patient-centered process.

The Compact emphasizes a pre-referral consultation between clinicians, which addresses the appropriateness of the referral and permits information sharing around the referral condition. Pre-consultation allows referrals to be directed to the most appropriate specialty and allows the specialist to communicate back to the PCMP if further evaluation or treatment is not indicated. This can increase access to specialty care by allowing specialists to focus on those cases appropriate for their expertise.[31] In addition, during the pre-consultation, needed information, such as core patient medical data, the requested role of the specialist and the suggested urgency can be solicited and shared, maximizing the use of time during the consultation with the patient, and reducing the number of follow-up appointments. Pre-referral processes can be streamlined through an electronic system. All Reunion Health members will adopt CommunityCare, which supports this referral process.

Defining and clarifying the role of the specialist during the referral process benefits all parties. For a cognitive or procedural consultation, typically the specialist will not assume a long-term management role but will assess the patient or perform a needed procedure, provide a referral response note and recommendations, and return the patient to the requesting practice for ongoing care. In a co-management role, the specialist will have ongoing involvement in the patient's care with both the specialist and referring clinician agreeing to maintain standards in four domains of the referral process: transition of care, access, collaborative care management, and patient communication. These domains are carefully managed to avoid duplication of services and to maximize the care provided by the primary physician.

E-consults

Virtual consultations ("e-consults") can be used to answer simple questions and provide recommendations from one clinician to another without the need for a face-to-face appointment with the patient. Observational studies suggest the potential for e-consultations to reduce not only waiting times for specialty care[32] but also the need for face-to-face consultations.[33] [34] The combination of a pre-referral consultation to reduce unnecessary or inappropriate referrals and e-consultations to answer a simple question that does not require a face-to-face visit can do much to reduce the volume of patients seeing a specialist. E-consults also reduce the need for patients to take time off from work, to travel or to incur transportation costs.

While virtual consultations can occur by phone, use of video communication is preferable. RMHP is well-prepared to support the Department's emerging e-consult strategy by integrating e-consultation into our existing and planned suite of digital health tools.

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[31] "Coordinating Care in the medical neighborhood; critical components and available mechanisms". AHRQ Publication NO. 11-0064. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 540 Gaither Road, Rockville, MD 20850. June 2011

[32] Chen AH, Murphy EJ, Yee HF Jr. eReferral—a new model for integrated care. N Engl J Med.2013;368(26):2450–53

[33] Horner K, Wagner E, Tufano J. Electronic consultations between primary and specialty care clinicians: early insights. Issue Brief (Commonw Fund). 2011;23:1–14.

[34] Palen TE, Price D, Shetterly S, Wallace KB. Comparing virtual consults to traditional consults using an electronic health record: an observational case-control study. BMC Med Inform Decis Mak. 2012;12(1):65

Tracking Specialist Availability

In order to support Members in gaining rapid access to specialty care, RMHP will track specialists who will see Medicaid Members and whether there are any additional requirements for the appointment such as labs or records. RMHP will begin by tracking those specialists for whom members report the most difficulty accessing.

Specialist tracking will be managed by staff reporting to the Chief Network Officer. Information about specialist access, including provider types or geographic areas with identified access challenges will be shared with the RAE Governance Committees. This topic will be discussed in depth at the Hospital and Specialist Transformation Council, and recommendations will be brought to the Director's Committee. Sharing this information will allow the RAE to be responsive to changes in the specialist network and specialist availability. We will actively seek participation of specialists in the Hospital and Specialist Transformation Council, asking them to engage in problem solving activities.

All parties need to coordinate their efforts for the referral process to work efficiently and successfully. The role of the RAE is to understand the availability of specialty care and to give providers the tools and information needed to prepare the Member for a successful referral. This includes providers establishing pre-referral processes on what information to exchange as part of the referral, and expected communications during the referral. Finally, the Health Engagement Team arranges transportation to the appointment, and provides Member education so that the process is understood.

Project ECHO

The Partners support the use of tools like Project ECHO (Extension for Community Health Outcomes) that combine telemedicine, case-based learning, and disease management techniques to expand access to care for patients with chronic, complex conditions. Because of severe shortages of specialty providers in rural areas, people with complex conditions such as hepatitis C or rheumatoid arthritis often must travel long distances or wait months to get treatment. Such problems are compounded by the fact that many rural patients are poor and/or uninsured. Given these barriers, such patients often forgo treatment or wait until they have severe complications before seeking help.[35] Through the ECHO model, specialty providers help guide rural community providers in applying best practices to manage care, and the community providers build knowledge and serve as expert consultants in their regions.

Promote Awareness of the Availability of Crisis Services

As part of our strategy to improve mental health care for Members, the Partners actively work to increase Member awareness of the wide array of available crises services. Information concerning the state Mental Health Crisis Line is included in print materials provided by the CMHCs and is included on Partner materials made available to Members such as brochures and websites. In addition, we will provide our network Primary Care Providers with patient handouts that specifically address how to access existing crises services.

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[35] Hostetter, Martha. Case Study: Project ECHO Expands Access to Specialty Care for Rural Patients. Quality Matters (Commonwealth Fund). November/December 2009.

We publicize hotlines and walk-ins for Colorado Crisis Services locations in Fort Collins and Grand Junction as well as CMHC crisis services locations. We also coordinate with Members who present to other crisis services locations. There is an established protocol for the state hotline and each MHC: When an individual calls the state hotline and needs local face-to-face assessment or care, a warm handoff is made and pertinent information is shared. There is typically a phone call between state and local crisis clinicians, which may or may not include the Member. Any Member who contacts the crisis line will be offered care coordination.

If a client requires hospitalization, the Partners are uniquely equipped to support a seamless transition into hospital-level care. There are two psychiatric hospitals within Region 1 – in Mesa County and in Larimer County – and both have established processes with the CMHCs and other providers. Because the Mesa County hospital serves a large geographic area, the Partners are developing a pilot program that will provide funding to assist individuals who need safe and secure transportation to a psychiatric facility. We recognize this as a cost effective and humane alternative to an ambulance or to involving law enforcement in a non-criminal situation.

Coordination with Managed Service Organizations

As many as 20 percent, or more, of adults in several Western Colorado counties self-report binge or heavy drinking.[36] In the resort communities, clinicians have observed "overdose seasons" during the fall and spring when many seasonal workers are not working and substance abuse increases. Rural opiate addiction rates across the country exceed those of urban areas, and 17 counties in Region 1 report suicide as a leading cause of death in their county.

Strategic partnerships between Managed Services Organizations (MSOs) and providers are necessary to develop a strategy to address both the individuals who require intervention and the cultural norms that lead to these patterns. The Partners are honored to serve as the Managed Service Organization (MSO) in Region 1, a good first step to making this coordination happen. MSOs, working through the Colorado Division of Behavioral Health, are responsible for service delivery, oversight, quality assurance, and contract compliance of funded substance abuse treatment facilities. We will work with MSO providers so that they can be credentialed and become part of our network. In addition to these institutional linkages, we will establish person-to-person contacts with MSOs in this region as well as other MSOs that our Members utilize. This will ease transitions between different levels of care and allow seamless coordination of services.

For example, a Member may receive outpatient services covered by Medicaid, but require a residential stay that is not covered. Although Medicaid itself does not cover residential services, we still have an obligation to ensure that necessary coordination activities are performed on behalf of the Member. We will work with providers to coordinate activities that cross payers, and make sure the MSO adequately prepares for the discharge of the Member to outpatient care covered by Medicaid.

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[36] County Health Rankings and Roadmaps, Colorado 2017. Retrieved from
http://www.countyhealthrankings.org/app/colorado/2017/measure/factors/49/data?sort=desc-1

This will be particularly important when transitioning from inpatient care to intensive outpatient groups or medication-assisted therapy for opioid or alcohol dependence. RMHP has given special attention to care coordination and transitions in these settings due to the substance abuse epidemic. The integration of behavioral health and medical care in the RAE provides an unprecedented opportunity for RMHP to assist Members in recovery.

Focus on Substance Use Disorders: Hub-and-Spoke Model

Due to our existing emphasis on care transitions, RMHP has already begun to implement a plan to better address opioid use disorder. While opioid overdoses and use rates are lower in Region 1 than other parts of Colorado, treatment providers report a need for additional support in this area, and Medicaid patients are often unable to find Medication-Assisted Treatment, or MAT.

RMHP is developing a hub-and-spoke model of MAT treatment utilizing claims data to find areas with high rates of opioid withdrawal and overdose to target MAT offerings and direct Members to the appropriate level of care. The hub-and-spoke model provides high-level care for complex and acute patients by a specialist (the "Hub"). When patients are stabilized, they transition to a nearby "Spoke" for maintenance therapy. Due to regular referral patterns, coordinators and providers become experts at coordinating care with one another. Other states with this program report the effective bidirectional transfer of patients between hubs and spokes based on clinical need.

Vermont, which first implemented the Hub-and Spoke model, now has the highest capacity for treating opioid use disorder in the United States. There has been a 64 percent increase in physicians waivered to prescribe buprenorphine and a 50 percent increase in patients served per waivered physician.[37]

Hospital Strategy

RMHP has a long history of working closely with hospitals to improve patient care and care transitions. This collaboration, and work related to coordination of care transition, relies heavily on hospital engagement with Quality Health Network (QHN) the Health Information Exchange entity in Western Colorado. Currently, hospital admission/discharge/transfer (ADT) data is sent by 16 hospitals to QHN and is sent by QHN to care coordination teams across the state (through the CommunityCare platform), to PCMPs (either via secure email or through a batch process), and, for RMHP members, to RMHP. Reunion Health partner, Mind Springs Health, is also pioneering CMCH use of Health Information Exchange. The few hospitals not currently sharing real time data with QHN share data directly with RMHP through RMHP's Census Coordinator, who is a member of the care coordination team. Through partnerships with community hospitals and receipt of real time ADT alerts, we have been successful in improving care transitions between inpatient hospitals, outpatient providers, Long Term Services and Supports providers (LTSS), and other community partners.

The availability of ADT data is not limited to hospitals that send ADT data directly to QHN. With support from RMHP, QHN and CORHIO have established a reciprocal data sharing relationship that provides for the sharing of ADT messages between the HIEs. This means that ADT alerts

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[37] Brooklyn, J. R., & Sigmon, S. C. (2017). Vermont Hub-and-Spoke Model of Care For Opioid Use Disorder: Development, Implementation, and Impact. Journal of Addiction Medicine.

from Mercy hospital in Durango, which is not connected to QHN but does provide ADT data to CORHIO, is available to RMHP and Community Care Teams through QHN.

RMHP has developed a number of strategies to address Members with frequent inpatient stays and ER visits utilizing ADT data. In one strategy, RMHP partnered with the UC Health hospital system to sponsor a Medicaid Accountable Care Collaborative (MACC) Team. The MACC team has become an essential part of the care coordination infrastructure in Region 1. The MACC team has access to the EHR (Epic) for two UC Health acute care facilities, the Poudre Valley Health System and the Medical Center of the Rockies. Access to Epic provides the MACC Team with assessments, care coordination information and ADT data, which allows the MACC team to better coordinate with the health care system in this community.

West Springs Hospital is the first inpatient psychiatric unit to navigate behavior health data rules to share behavioral health information with its network of partners through QHN. Sharing behavioral health information with other providers is an essential part of integrating physical and mental health. For instance, knowing that a Member was recently seen at an inpatient mental health facility for severe anxiety could preempt an unnecessary workup for chest pain at another hospital or, may support an effective referral to a behavioral health provider.

Collaborate on the Hospital Transformation Program

The RAE will support the Colorado Hospital Transformation Project, the goal of which is the development of a shared Community vision. An existing alignment between RMHP and the Western Healthcare Alliance, the organization responsible for the two Medicare Accountable Care Organizations (ACOs) in Western Colorado, is already helping to develop a region-wide vision for hospitals to provide better care while reducing administrative burdens. To further support intentional and strategic hospital engagement, the governance structure of the RAE includes a hospital subcommittee that will focus on hospital alignment and hospital integration.

RMHP and the Partners are working on additional ways to involve hospitals in developing a more efficient community-based care model. Community-based care seeks to leverage hospital expertise for upstream interventions, population health and other more efficient types of care. An example of this effort is the Accountable Health Communities Model (AHCM). As part of its AHCM application, RMHP received Memorandums of Understanding (MOUs) from 11 hospitals in which the hospitals committed to conducting social needs screenings related to transportation, housing, utilities and interpersonal violence in their Emergency Room, Labor and Delivery, and Psychiatric Units. The hospitals will provide patients with referrals and connect them with a community navigator if they have a social need identified during the screening and more than two ER visits in one year.

Additionally, RMHP is working with St Mary's Family Medicine Residency on the CO-EARTH Project. *Colorado is Expanding Access to Rural Team-based Healthcare* (CO-EARTH) is a collaborative effort between St. Mary's Family Medicine Residency, RMHP, the Caring for Colorado Foundation, and the University of Colorado Department of Family Medicine. CO-EARTH focuses on supporting smaller or rural clinics in outpatient behavioral health integration. This is an excellent example of how hospital infrastructure and expertise can be leveraged to support system-level improvements.

Collaborate with LTSS providers

RMHP has a long and successful history of collaboration with LTSS providers, and plans on continuing and improving upon this in the future. During the planning phase of the ACC Medicare-Medicaid Program, RMHP developed protocols with LTSS organizations that addressed three major activities: 1) identification of Members engaged in both systems of care; 2) care coordination of shared Members; and 3) other support functions that enhance quality of life or Member outcomes and use care management resources effectively. We continued to refine the protocols as we implemented the multiple phases of the program. The ability for care coordinators to access the LTSS data management system, the Benefits Utilization System (BUS), has proven valuable, as care coordinators and LTSS caseworkers are now using a shared system.

Another example of collaboration is the Cross-System Response for Behavioral Health Crisis Pilot Project, currently operating in Delta, Garfield, Larimer, Mesa and Montrose Counties. In this pilot RMHP and its partners, including local Community Centered Boards (CCBs) and CMHCs, work together to integrate behavioral health and intellectual/developmental disabilities (I/DD) systems to serve people in crisis who too often lack access to necessary mental health services. The partners in the pilot assess clients who are in crisis, manage the crisis, and create follow-up plans. Follow up plans help patients and their families manage symptoms and adhere to treatment through follow-up at 30, 60 and 90 days. Providers work with individuals and their families to teach life skills to improve quality of life and functional status, achieve better day-to-day management and reduce future crisis episodes.

When an individual with I/DD is in crisis, the community providers work together to access a wide range of health, social and alternative services, including LTSS, intensive case management, housing support, and medication management. The partners collaborate in professional learning communities where they learn how to manage crisis for clients with I/DD and track and share data on clients. Through weekly operations meetings, the partners discuss cases and work to improve processes and communication.

RMHP also partners with the Area Agencies on Aging (AAA) and Aging and Disability Resource Centers (ADRCs) throughout our region. The AAA promotes the health and well-being of older adults (60+) by building on individual, family and community strengths. The AAA plan, develop, fund, coordinate, advocate for, and evaluate services for older adults and care-giving families including those living in the community and in skilled nursing facilities. They also provide technical assistance and training to their grantees, aging services providers, and local communities. ADRCs provide a single-entry point into LTSS for older adults, people with disabilities, caregivers, veterans and families. We intend to continue to deepen our collaboration with the AAAs and ADRCs in order to serve individual members and create better systems of care for older adults and people with disabilities.

Another opportunity for collaboration with LTSS providers is the No Wrong Door pilot program, the goal of which is to ensure comprehensive access points for Coloradans seeking long-term services and supports regardless of age, disability, or payer source and improve information about service options for individuals seeking services and their caregivers. As part of the pilot RMHP is collaborating with LTSS providers and care coordinators/case managers, No Wrong

Door Entities, AAAs, and ADRCs to develop holistic approaches to assisting LTSS Members to achieve health and wellness goals.

Two of the four regional pilot sites selected by the Department are in Region 1: Larimer County Department of Human Services and San Juan Basin AAA. We will continue to work with and support the pilot sites in our region as they develop and execute their plan, which will include the following six criteria:

- Information, Referral and Awareness
- Person-Centered Counseling
- Streamlined Eligibility
- Person-Centered Transition Support
- Individual Populations, Partnerships and Stakeholder Involvement
- Quality Assurance and Continuous Improvement

Facilitate health data sharing

RMHP has invested heavily in the development of Quality Health Network, the community HIE on the Western slope. Our investments are predicated on an understanding that improving the health care system is dependent on shared data across the community in a secure, timely, and effective manner. RMHP and QHN have worked closely over the years on numerous important and innovative initiatives. Our collaboration provides the foundation for our work using data exchange, management and analysis to support whole person care.

As of June 2017, Quality Health Network is connected or soon to be connected to:
- *16 hospitals*
- *5 labs*
- *39 long-term care sites*
- *17 behavioral health clinics/community service organizations*
- *2 EMS organizations*
- *Approximately 1,139 licensed providers*
- *2 Health Plans: Rocky Mountain Health Plans and Humana*
- *Mesa County Health Department*
- *Department of Human Services*

164 organizations representing 28 different EHR vendors interface with QHN. More than 94 percent of providers in the QHN service area participate in QHN.

QHN has a reciprocal data-sharing relationship with the Colorado Regional Health Information Organization (CORHIO), a community HIE operating in the Denver-metro and eastern regions of Colorado. QHN also shares data with UHIN, the HIE in Utah, and AzHec, the HIE in Arizona. QHN currently has data on over 740,000 unique patients.

QHN continues to grow and evolve. Over the past year, QHN has implemented a transformative solution for real-time ADT alerts. Providers can limit the alerts they receive (e.g. only inpatient discharges and not ER visits) and the patients for whom they receive alerts (e.g. only high ER

utilizers or patients receiving care coordination support). This allows the providers, and RMHP, to closely monitor complex patients and their use of health care services. QHN has focused on mechanisms for consent to support data sharing in general but especially behavioral health data sharing. All data is also incorporated into the HIE longitudinal record, making it query-accessible, by authorized providers for the timeframe specified in the consent. The behavioral health data maintains a notice of re-disclosure and is in compliance with 42 CFR Part 2.

An (HIE) strives to collect and share health care data; a Social Information Exchange (SIE) seeks to collect and communicate information concerning social determinants of health (SDOH) to complete the picture that drives health. The Partners, supported by QHN, will promote the gathering and sharing of clinical and non-clinical data through the SIE.

This SIE innovation presents the first real opportunity to accurately identify clients at risk and address root causes of health disparities. The SIE will support HIPAA-secure, roles-based access to high-level Member information as well as messaging across systems to other members of the care team. The system will support tracking and managing of referrals to medical, behavioral health and community based providers, as well as providers of housing, food, transportation and other social supports. This new solution will be active in September 2017 and will allow further broadening of the SIE to LPHAs, Healthy Communities, Independent Living Centers (ILCs), and additional community providers to comprehensively serve Members. The vendor selected for this effort, VisionLink, also provides database support to the 2-1-1 resource directory, creating new opportunities for leveraging the functionality of the resource database.

The benefits of SIE are numerous. At the individual level, health care providers often do not think to ask about housing status, and thus may not realize a client is marginally housed and unable to care properly for an injury or rest during an illness. As a result of the SIE, providers will get a fuller picture without having to obtain a complete social history during each visit.

At the population level, RMHP and the Partners can stratify clients based not only on their medical presentation but also on social risk factors, providing the opportunity to greatly improve the health of Medicaid Members by understanding and addressing the range of factors that impact Members' lives. We will be able to know where patients are struggling to get the services they need.

The ability to simultaneous account for health and social factors into account has special relevance to the development of a more proactive strategy for behavioral health care. We know that social factors often have immediate and clear impacts on mental health. Understanding the depth of these impacts allows behavioral health providers to explore new ways to support Members in the community. In addition, the SIE can support intervening with whole families rather than just an individual Member.

Being able to understand the needs of the community based on the needs of individual clients will support robust and data-driven quality improvement activities and lead to more meaningful and beneficial community solutions. For example, these data will present new opportunities to discuss and begin to address, at a community level, the health impacts of inadequate housing. While this issue has been studied at a national level, local data is necessary to build a clear

business case for innovative local solutions. The six communities in Western Colorado will spearhead this exciting approach to problem solving.

An example of SIE efficacy at the local level occurred during RMHP's multi-year pilot of SIE in Mesa County. The Community Resource Network convened a group of engaged PCMPs, CMHCs, SEPs, CCBs, LPHAs, hospitals, county human services agencies and community services providers to discuss how to better coordinate care, especially during times of transition. RMHP found that in some cases, Members could have up to seven different coordinators attempting to coordinate services. Clinical participants noted that while they may have complete medical information, they often were missing critical information regarding social aspects of the Member's needs.

The Mesa County Human Services Department, home health agencies, hospital discharge planners, the Health Engagement Team (HET) and primary care providers came together to test a solution for secure transmission of ADT data and high-level messaging, similar to the traditional phone call method for communication between care coordinators and case managers on shared clients. Once the client's care team is identified, instead of making several phone calls, a member of the team can enter a message such as, "Opal fell and she is now in the ER," and send it securely to the whole care team. This pilot led RMHP to move forward with procuring Western Colorado's SIE solution.

Progress on implementation of the SIE will be accelerated by the Center for Medicare and Medicaid Innovation (CMMI) AHCM grant awarded to RMHP in May of 2017. In 2018, the AHCM grant will require capturing social needs screening data for all Medicaid enrollees on a range of factors, including interpersonal violence, food, housing, transportation and utilities. Data will be collected at clinical sites that include primary care, behavioral health and hospitals. This data, as well as data from the care navigation component of the AHCM contract, will be maintained in QHN. If executed successfully, in two years, RMHP and the Partners will know how many Medicaid enrollees in Western Colorado had an identified social need, and how many of those social needs were addressed.

Establish communication channels and additional alternatives related to Non Emergent Medical Transportation (NEMT)

Availability of reliable transportation is a key factor in access to healthcare. RMHP has employed creative and multi-faceted approaches to address transportation challenges since the vast majority of Region 1 lies outside the area served by the State's contracted NEMT vendor. RMHP has established strong working relationships with transportation networks within individual counties in order to support Members access to this important benefit. RMHP actively participates in the NEMT workgroup of the Provider and Community Issues Subcommittee. We have also assisted several NEMT providers with the Medicaid and revalidation process, increasing the number of providers available in the region, and developed a strong working relationship with Department staff also working to improve transportation services.

Instructions for requesting NEMT or urgent transportation are provided in our Member Handbook. During the new Member welcome call, care coordinators discuss transportation

options with Members or their caregivers and recommend the safest, most appropriate transportation methods based on current level of functioning, waiver program and preference. RHMP Member Service representatives have the training and resources to assist members who need transportation.

Mobility Manager Position

To further improve access to needed transportation, the Partners created a Mobility Manager position to focus specifically and exclusively on the transportation needs of Members. The Mobility Manager will ensure that care coordinators and staff have the most up to date information, resources and options for transportation. The Mobility Manager will:

- Assess the Member's trip needs, develop an individualized trip plan and coordinate transportation that contributes to the Member's well-being
- Develop a plain language travel training program that teach Members about the NEMT benefit and provide information about transportation alternatives
- Coordinate with the NEMT vendor and/or county to request and schedule rides for eligible Members
- Coordinate services with public transit agencies and human service agencies
- Develop community partnerships and leverage existing transportation options to address the lack of transportation
- Provide personalized transportation education and trip planning services

Ride Sharing Program

The Partners will work to develop transportation solutions in addition to those offered through the NEMT system. One alternative solution under development is a ride-sharing model that gives partner organizations the opportunity to provide Members with additional transportation options. We are currently working with local organizations in piloting a rideshare concept in Montrose, San Miguel and Ouray Counties.

The ridesharing model uses local volunteers as drivers, is confidential, has service guarantees, and offers the opportunity to build local transportation capacity in rural areas not served by NEMT, taxis or public transportation. The vendor supporting this service is Liberty Mobile, which is similar in concept to Uber and Lyft, but involves more intensive driver screening and training. Members can use Liberty Mobile as a transportation option to access health care, as well as a way to get to other essential locations such as grocery stores, human service agencies or employment agencies. As part of this initiative, Members will receive a rate discount when using the service to get to medical appointments. Based on the success of the pilot, the Partners are planning to expand this initiative to other areas of Region 1.

Establish communication channels and options for dental services Health

RMHP has established a collaborative relationship with the State's current dental benefit managed care vendor, DentaQuest, through connections with their Outreach and Education Coordinator and representatives who serve our region. We provide support for their initiatives such as their ER diversion program and "Take 5" program that provides incentive payments to

dentists who see Medicaid Members. We coordinate with DentaQuest to educate Members on the availability of the dental benefit and on how to find participating dental providers.

We recently supported the DentaQuest outreach team in their efforts to increase Medicaid dental utilization rates for preventive services among children, particularly dental sealants. If children are receiving sealants, they are likely receiving other preventive care, such as exams, cleanings, and fluoride varnish. We contacted pediatric providers in our region, using a list of targeted zip codes that the DentaQuest Outreach and Education Representatives identified, and made introductions between the practices and the representatives. This campaign was very successful, with the majority of practices agreeing to post DentaQuest dental sealants flyers in their treatment rooms or waiting areas. Under the RAE, we will continue to meet regularly with DentaQuest and identify ways we can collaborate.

For Members who require services beyond what is offered by DentaQuest, we have developed a partnership with the Dental Lifeline Network, a national non-profit organization that provides access to dental care for people with disabilities who cannot afford it, people over 65, and people with complex conditions. Through their flagship program, Donated Dental Services (DDS), dental care is provided through a national network of volunteer dentists and volunteer laboratories. The Dental Lifeline Network has served as a valuable resource for our Members who need dental treatment that cannot be obtained through the Medicaid adult dental benefit.

The Partners will seek opportunities to expand access to dental care through tele-dentistry and dental vans. For example, Mountain Family Health Center (MFHC), one of the Partners, has pursued both tele-dentistry and dental vans and can support partners in other areas of the region seeking to implement similar models. The MFHC dental van, partially funded by RMHP, transports dental hygienists and equipment to provide basic dental services across the rural and mountain region. In addition, they use tele-dentistry at a number of local schools. In this model, dental hygienists provide dental exams, cleanings, x-rays and fluoride applications. A remote MFHC dentist reviews the x-rays and through telehealth and creates the dental plan. The hygienist can then apply sealants or small fillings.

Collaborate with Local Public Health Agencies

In Western Colorado, there are 18 Local Public Health Agencies (LPHAs) ranging significantly in size and scope. The Partners value the important role played by LPHA's and engage with LPHAs in several ways. First, we connect with LPHAs directly. In addition to professional relationships established over our many years serving this region, we involve LPHAs in information transfer through HIEs and SIEs, which allow for rapid communication between health care organizations, health plans, and LPHAs. RMHP has also entered into Community Integration Agreements with a number of LPHAs, providing targeted financial support for work that is aligned with ACC Member needs.

Additionally, we connect with LPHAs through the Western Colorado Public Health Directors Association, which meets quarterly to share information and identify ways to support each other. The Partners are committed to supporting LPHAs through this useful forum as they adopt strategies to combat the leading causes of morbidity and mortality. In addition, The Western Colorado Public Health Directors Association will be asked to participate in the annual

Population Health Summit where the population health strategies funded by the RAE for the upcoming year will be determined, giving this organization direct input into our priorities.

Finally, the Partners connect local public health with healthcare providers. The Partners will accomplish this, in part, through the convenings required by the AHCM grant. In two areas of Western Colorado, the convenings are led by LPHAs and in all other regions, LPHAs play a core role.

Through these multiple points of contact with LPHAs, RMHP and our partners are in constant communication about the public health needs of Members in the region. We already share funding with multiple public health agencies and have developed and continue to work on new and collaborative approaches to addressing the needs of the population.

Offeror's Response 14

Describe the Offeror's plan to support and build Communities in the region to address social determinants of health, including how the Offeror will define Community and address requirements in Sections 5.8.3 and 5.8.4.

COMMUNITY AND THE SOCIAL DETERMINANTS OF HEALTH

The Partners understand that social risk factors in several domains, such as **housing, food, personal safety, utilities, transportation** and **social isolation** often have a greater impact on health than medical care. People with Medicaid coverage are often disproportionately affected by these risk factors, which are highly correlated with poverty The Partners are committed to using their influence at multiple levels–as community members, as employers and as the RAE–to address the Social Determinants of Health (SDoH) that affect the well-being and resilience of our Members. We define the Community as all of the systems that serve Medicaid enrollees, as illustrated in the graphic below.

Rocky Mountain Health Plans and the organizations within Reunion Health have decades of experience working within Region 1 to reduce the health disparities associated with differences in opportunity, education and income. Our organizations were founded to create equitable access to high quality clinical services many years ago, and have worked continuously to improve "upstream" social and behavioral drivers that affect Member outcomes. As leaders within the communities in which we live and work, we have deep local insights, as well as the professional expertise necessary to improve the health of the people we serve. As partners with a national enterprise, UnitedHealthcare, we have access to the sophisticated tools, investment capital and thought leadership necessary to effect community- driven sweeping, sustainable

change in Region 1. Our planned approach toward *community integration* within the RAE includes strategic and tactical elements in four key areas:

- **Leadership:** We will foster region-wide alignment to set priorities, concentrate resources and generate collective impact upon SDoH challenges and opportunities. Chief executives and other senior leaders from several organizations, including local public health agencies (LPHAs), community Health Alliances, Independent Living Centers and sovereign tribal nations will participate in our Stakeholder Advisory Councils and nominate voting members to our Director's Committee. Our community governance structure will align and build upon related community integration resources within the Statewide Health Infrastructure, such as the State Innovation Model (SIM) Regional Health Connector (RHC) initiative, the Comprehensive Primary Care Plus model (CPC+) and the Center for Medicare and Medicaid Innovation Accountable Health Communities Model (AHCM) Cooperative Agreement awarded to RMHP for Region 1. Our efforts will be driven by community priorities because local anchor organizations with capacity and local standing will play a leadership role in health-related efforts in the community.

- **Analysis & planning:** We will utilize a social information exchange and regional data management architecture grounded in SDoH use cases (as described in Offeror's Response 21) to collect information on risk factors across the entire RAE Membership, identify gaps in services and prioritize community capacity building initiatives. We will provide leadership and align organizational resources to accelerate progress on an agreed SDoH agenda.

- **Resource coordination:** We will engage more than community services providers across Region 1 with expertise in food, housing, utilities, social isolation, safety and transportation. Many of these organizations have already executed Memoranda of Understanding (MOU) with RMHP, as part of their commitment to improving coordination with partners in the health care sector. We will make resources and reporting tools available to community services providers and identify opportunities to reduce redundancies and other inefficiencies in care coordination. We will integrate data from 2-1-1, Colorado's resource referral service, and other existing resources and create actionable workflows through our integrated community service coordination solution, *Healthify.*

- **Community connected care:** RMHP will continue to invest in comprehensive, community-connected models of care, as an aligned payer in CPC+ and SIM, as well as a Practice Transformation service provider and "Bridge Organization" convener within our Accountable Health Communities Model (AHCM). As part of AHCM, participants will develop efficient processes for social risk factor screenings, which will happen at Primary Care Medical Providers (PCMP), Community Mental Health Clinics (CMHC) and hospital clinical sites. AHCM is prompting RMHP and participants across the region to develop and scale new skills and tools for making referrals to community services providers, with Practice Transformation and technology supports provided by the RAE.

- **Staff support:** RMHP and Reunion Health will provide adequate resources so that the leaders serving on the Stakeholder Advisory Councils and Directors Committee are

positioned to achieve ACC objectives. RMHP and Reunion will make adequate staffing, funding, data and operational support available to create a solid "backbone" for the ACC Community, as opposed to a "back pocket" operation by a group of busy, distracted leaders. A Community Integration Team within the RAE management structure will be staffed for this purpose, and led by a Director with deep experience in social determinants of health and human centered design. The Community Integration team will also include an AHCM Program Lead, a Housing Specialist a *MyMobility* Transportation Manager, a Community Experience and Education Specialist and a Colorado Opportunity Framework Liaison.

An Accountable Health Community

Our ACC Community strategy is grounded in the ACHM work we have done over the course of 2016 and 2017. The AHCM is a CMS Innovation Center Cooperative Agreement awarded to RMHP, which went into effect in May 2017. AHCM is a five-year test to determine whether screening for social needs (food, housing, transportation, utilities, personal safety and social isolation) in clinical sites (primary care, behavioral health, hospital ER, labor and delivery and psychiatric units), will lower healthcare costs and improve health outcomes. RMHP and our partners selected an AHCM program track that requires convening leaders to identify gaps in social resources, prioritizing gaps and implementing plans to increase local capacity.

As we moved forward with our application for AHCM, we found widespread interest in participating existed across the Region. In a two-month period, we received 111 MOUs from community-based organizations and clinical partners. There was such significant enthusiasm that leaders involved in the AHCM application convened and unanimously decided to pursue the vision articulated in our AHCM application, regardless of whether the grant was awarded.

Upon announcement of the award, an AHCM Steering Committee was formed to administer the project and design a broad vision for community integration. The Steering Committee includes a county human services director, a hospital chief medical officer, a Community Mental Health Center chief executive officer, two Local Public Health Agency directors, and a chief executive director of a Federally Qualified Health Center. This senior team of community leaders is heavily represented in Reunion Health, and will "hit the ground running" with implementation of ACC Phase 2. Specifically, this leadership team will shape:

- Our process for understanding the needs of individual Medicaid Members as well as the systemic health disparities present in Region 1.

- Our approach to developing relationships and communication channels across a broad network of community organizations, and our processes for linking Members to services.

- Our continuing goal to align our work with resources present in the statewide health infrastructure.

HEALTH DISPARITIES IN WESTERN COLORADO

Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people."[38] Eliminating disparities entails a clear, strategic focus and a multi-year timeline. RMHP and Reunion Health have adopted the following priorities in our comprehensive health equity strategy for ACC Phase 2. These points are set forth below, and are adapted from the Surgeon General's recommendations for eliminating health disparities.[39]

Ensure a strategic focus on communities at greatest risk.

According to the Colorado Department of Public Health and Environment Office of Health Equity,[40] rural counties are disproportionately affected by health disparities. The 2016 annual County Health Rankings[41] show that rural counties have seen an increase in premature deaths over the past decade due to factors such as high rates of smoking, obesity and poverty. A major component of the rankings is *years lost to premature death*, defined as *dying before 75 years of age.*

Region 1 consists entirely of rural and frontier counties, with the exception of Larimer and Mesa counties. Significant health disparities are evident in the data – especially within the counties that border Utah. For instance, people in Delta and Dolores counties are more than twice as likely to die early as people in Pitkin and Summit counties.[42]

Minority populations are also disproportionately impacted by health disparities. Latinos experience diabetes, obesity, and HIV at rates far higher than non-Latino whites.[43] Cultural awareness can help alleviate these disparities through the redesign of systems and outreach processes that may discourage use of available services. RMHP has developed well-established processes for cultural awareness training, which include an organizational self-assessment for Culturally and Linguistically Appropriate Services (CLAS), and best-practices materials for our provider Network.

Reduce disparities in access to quality health care

Access to healthcare is influenced by many factors, including provider-oriented elements (e.g., ease of scheduling and availability of providers in the area) and patient barriers (e.g. transportation and child care). Reducing disparities entails a root cause analysis at both the community level and the clinic level. For example, Northwest Colorado Health, a Partner in Reunion Health, conducted a study which found that the poor outcomes of certain diabetic patients were highly correlated with three distinct demographic factors: Medicaid eligibility, geographic location and ethnicity. This variation is now the focus of a root cause analysis with a goal of identifying opportunities for process improvements or community service interventions

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[38] https://www.healthypeople.gov/
[39] Department of Health and Human Services, SurgeonGeneral.gov: https://www.surgeongeneral.gov/priorities/prevention/strategy/elimination-of-health-disparities.html
[40] https://www.colorado.gov/pacific/cdphe/ohe
[41] http://www.countyhealthrankings.org/
[42] County Health Rankings & Roadmaps, Robert Wood Johnson Foundation, 2017.
[43] Epidemiologic Reviews, Volume 31, Issue 1: Health Disparities in the Latino Population, Published August 27, 2009: https://academic.oup.com/epirev/article/doi/10.1093/epirev/mxp008/469470/Health-Disparities-in-the-Latino-Population

that will reduce the identified disparities. RMHP and Reunion Health will support and scale data-driven, root-cause analyses to reveal health disparities that otherwise may be missed.

Increase the capacity of the prevention workforce to address disparities

The prevention workforce in our region includes the staff of local public health agencies, primary care providers, behavioral health providers, and human service agencies. RMHP will increase their ability to identify and address disparities by sharing data and tools and targeted funding, setting priorities and evaluation plans within our stakeholder Advisory Councils and Directors Committee processes. These include improving access to community resource directory data, developing inter-organizational systems for sending alerts with the support of social information exchange services, and lending expertise to the design and execution of evaluation processes for community interventions.

Support research to identify strategies to eliminate health disparities

The Partners will leverage UnitedHealthcare's robust systems and infrastructure to address social determinants of health, as well as their experience with population-based health, including:

- Participation in the National Health Plan Collaborative and Commission to End Health Care Disparities

- Convening of the UnitedHealthcare Group Health Disparities Council, in which internal stakeholders develop internal solutions

- Optum Labs, a group within UnitedHealthcare that partners with the Mayo Clinic and the United States Department of Health and Human Services to research health disparities

We will use their cutting-edge research on health equity to evaluate apropriate interventions for use in Region 1 in order to address the health conditions and social determinants of health specific to Western Colorado.

Standardize and collect data to better identify and address disparities

The Health Information Exchange (HIE) allows sorting and analysis of health conditions and outcomes by a number of demographic and health variables. The upcoming SIE will make an entirely new level of data analysis possible, by allowing the RAE to integrate social variables that previously have not been included. For instance, we will be able to analyze outcomes for diabetic patients not only by zip code, gender, or race but also by smoking status, access to food, housing status, foster care status, or involvement with the criminal justice system.

We understand that there are many dimensions of disparity and thus will devote dedicated resources, including a Senior Community Research Analyst, to analyze all data with a disparities lens to better understand how disparities impact specific populations. In every report we produce, we will address health disparities or address why the data would not allow us to evaluate health disparities.

DEVELOP PLANS TO OPTIMIZE HEALTH OF MEMBERS

Solving the complex problems inherent in reducing social risk factors requires inter-organizational teamwork. RMHP will convene and support six community-based forums to develop local plans for optimizing the health of Members. This approach differs from that of traditional managed and accountable care strategies where the ACO or MCO typically functions as a hub with direct, individualized links to social, education, justice, recreational and other community service providers. Instead, RMHP and Reunion have adopted a more innovative approach, one focused on strengthening the fabric of the system with investments in durable and resilient relationships *among* our clinical and community partners across the region. In other words, we are working to develop a *distributed network* rather than a *centralized network* and empower organizations of all types and sizes across the community.

The size and rural nature of Region 1 means that there are multiple distinct Health Neighborhoods within the Region, as described in Offeror's Response 13. We will leverage existing leadership, patterns of care and local resources to advance our ACC Community strategy. Specifically, each of the six distinct health communities across Region 1 will be supported by an *anchor organization*. Anchor organizations can play a variety of roles such as:

- Implementing local community-based population health initiatives
- Sponsoring community collaboration to improve the health of Medicaid enrollees
- Hosting care coordination teams that work across clinical sites
- Conveying information to the broader community about RAE activities and resources
- Providing a feedback loop to the RAE

As shown below, the anchor organizations we have planned for the first year of the RAE contract include several community Health Alliances and LPHA organizations. The anchor organizations and counties of the six regions are, from north to south:

- **Health District of Northern Larimer County**: Larimer County
- **Northwest Colorado Community Health Partnership**: Grand, Jackson, Moffat, Rio Blanco, Routt Counties
- **West Mountain Regional Health Alliance**: Pitkin, Garfield, Eagle, Summit Counties
- **Grand Mesa County Public Health**: Mesa County
- **Tri-County Health Network**: San Miguel, Montrose, Ouray, Gunnison, Delta Counties
- **Southwest Area Health Education Center** and **San Juan Basin Health Department**: Dolores, Montezuma, La Plata, San Juan, Hinsdale, Archuleta Counties

These organizations are currently the same organizations that have been awarded Regional Health Connector (RHC) funds for the State Innovation Model (SIM) and Community Lead funds for the AHCM. For those receiving AHCM funding, RMHP will require the entity to perform open and inclusive convening services, identify gaps in resources, prioritize focus areas and share data. Each entity will produce an annual plan describing their process, their findings, and the plan for addressing community priorities and identified gaps.

In some cases, simply creating the space for regular, multi-sector conversations will build relationships and improve communication in a way that yields tangible improvements to existing community systems. As an example, we learned from a Region 1 community partner who works in transportation in a rural county that the way providers were scheduling transport appointments reduced his organization's ability to meet client demand. The transportation provider was eager to develop a scheduling solution in partnership with providers to support better access to transportation and thus better access to medical care. Conversation between transportation and health officials was all it took to realize tangible progress. Anchor organizations and their local partners will also have to address more challenging problems, like how to address gaps in housing or housing safety. Communities will drive the process and set their own priorities. Below is a list of supports that RMHP and Reunion will sustain:

- RMHP staff to run meetings, maintain minutes, support coordination with statewide or region-wide efforts
- Software and other tools to manage community services
- Assistance engaging clinical providers
- Funding for training or high-value programs

We will specifically target support in ways that will enhance the capacity of the anchor organizations to address health disparities by:

- Providing each region with an annual health disparities report specific to the region
- Providing or financing training on health equity
- Acting as thought partners

RMHP and the Partners commit to actively engaging in these community processes, to seek community input on RAE activities through these forums and support the ongoing process of community integration.

ESTABLISH RELATIONSHIPS AND COMMUNICATION CHANNELS
Food

Some parts of Region 1 have inadequate access to high-quality, affordable food; seven counties on the Western Slope do not have a grocery store.[44] Over 13 percent of children residing in Mesa, Delta, Gunnison, Montrose, Montezuma, Dolores and San Juan Counties were food insecure in 2015, and that number was no lower than 10 percent in the rest of the region.[45]

To address food insecurity, RMHP will focus on two areas at the outset of the contract: 1) meals for individuals who are transitioning from hospital to home and 2) maximizing enrollment in federal food assistance programs. We will partner with a Colorado-based nonprofit, Project Angel Heart, to offer Meals for Care Transitions. Through this program, patients leaving the

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[44] U.S. Department of Agriculture. Food Environment Atlas. (2012). U.S. Department of Agriculture Economic Research Service. Retrieved from http://ers.usda.gov/data-products/food-environment-atlas.aspx.
[45] Feeding America, Map the Meal Gap 2015: Child Food Insecurity in Colorado by County, 2015: http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2013/CO_AllCounties_CDs_CFI_2013.pdf

hospital will receive nutritious, medically tailored meals through the mail. We will offer to match local hospital investments in a pilot program to provide 30 to 60 days of meals to patient populations with conditions that often lead to readmissions, like congestive heart failure.

More broadly, the Partners will focus on increasing Member engagement in other federal and state services as well as by connecting Members to food pantries and other local resources. Hunger Free Colorado estimates that only 60 percent of Coloradans eligible to receive Supplemental Nutrition Assistance Program (SNAP) benefits are enrolled in the program.[46] In some parts of Western Colorado, that number is even lower. For example, in the 2016 Food Stamps Impact Report,[47] Hunger Free Colorado reported that only 22 percent of eligible Summit County residents were enrolled in SNAP.

We will also focus on increasing the number of eligible individuals enrolled in SNAP, WIC, school meals, and Meals on Wheels by: 1) screening all Medicaid enrollees for food insecurity when they go to a primary care or behavioral health office; and 2) working with schools and local SNAP and WIC coordinators to break down barriers to enrollment. We will obtain the list of Medicaid Members who are SNAP eligible but not enrolled, allowing us to do targeted and thus more effective outreach.

One of the barriers to SNAP enrollment is an in-person interview requirement.[48] In Delta and Montrose Counties, Tri-County Health Network has worked with the counties to develop a process to conduct SNAP interviews as part of their care coordination activities. RMHP will offer each county the services of our care coordinators in order to take on this function. RMHP has also made the EasyCare telehealth platform available to Tri-County as a way of helping these counties identify innovative ways to increase enrollment in SNAP and WIC.

Housing

Members in western Colorado are disproportionately burdened by the cost of housing; nearly half of renters in Mesa County spend more than 35 percent of household income on rent,[49] and during the 2015-16 school year, 1,382 students in the region had unstable housing or were homeless.[50] Medicaid Members who are homeless are more than ten times more likely to have high behavioral health needs, and spend six times as much on inpatient health care compared to housed Members.[51]

Supportive housing programs have been shown to improve the health of Members. For

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[46] The Facts: Hunger in Colorado, Hunger Free Colorado, https://www.hungerfreecolorado.org/hungerfacts/

[47] https://www.hungerfreecolorado.org/impact-reports/ `

[48] Rowe, Gretchen, Andrew Gothro, Elizabeth Brown, Lisa Dragoset, and Megan Eguchi. Assessment of the Contributions of an Interview to SNAP Eligibility and Benefit Determinations: Final Report. Prepared by Mathematica Policy Research for the U.S. Department of Agriculture, Food and Nutrition Service, May 2015. https://fns-prod.azureedge.net/sites/default/files/ops/SNAPInterview.pdf

[49] Source: https://www.colorado.gov/pacific/sites/default/files/OPP_Mesa-County-report-2015.pdf

[50] Colorado Homeless Education Data (based on data collected by the US Department of Education for Title X of No Child Left Behind), 2015-2016. Colorado Department of Education McKinney-Vento Homeless Education. Accessed at https://www.cde.state.co.us/dropoutprevention/homeless_data.

[51] Data taken from RMHP's stratification and population health dashboard that merges healthcare data with social determents of health data (in this case homeless indicators from ICD-10 z-codes).

example, a supportive housing program in Massachusetts reduced annual per capita healthcare costs of Medicaid Members participating in the program from $26,124 to $8,949.[52] The Partners will work with local housing organizations and coalitions that are committed to developing supportive housing. The Partners participate in community planning efforts, help local agencies secure funding, help develop service integration models, provide robust program evaluation, and work to connect Members to community housing resources. Like any other intervention, RMHP's comprehensive, multi-faceted housing strategy spans an entire arc, from defining populations of focus to measuring outcomes. Major elements of the strategy include:

- Planning
- Funding
- Service integration
- Program evaluation

A Housing Specialist with experience in housing policy, program requirements, innovations and challenges, will be part of the Community Integration Team. This skilled professional will develop relationships with local housing agencies, participate in local housing development and service integration initiatives, and act as the RAE's expert on community housing resources. The Housing Specialist will facilitate services for Members by providing consultation to care

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[52] Corporation for Supportive Housing. (2011, June 9). Supportive Housing Reducing Medicaid Costs and Improving Health Outcomes: A Review and Update of the Evidence [Webinar]. Retrieved from http://www.csh.org/wpcontent/uploads/2011/12/6_9Presentation.pdf

managers when they encounter barriers, educate staff about community resources, coordinate difficult placements, and conduct supportive housing assessments and evaluations.

The Housing Specialist will also provide coordination and leadership with outside housing organizations, identify new trends, projects and opportunities, and represent RAE members at meetings with the Colorado Balance of State Continuum of Care (CoC) and Communities developing comprehensive housing strategies. CoC is the organizing group for all HUD-funded housing projects in western Colorado, and covers the 56 non-metro and rural counties in the state, not including metro Denver and Colorado Springs/El Paso County. They also organize most non-HUD housing projects in this region. CoC provides a high-level forum for the Partners to work on integrating care with community-wide housing strategies.

Over the past two months, RMHP's Colorado Opportunity Framework Liaison in the Southwest corner of Colorado has brought together 10 community organizations through the Balance of State to explore "One Roof," an evidence-based housing strategy that provides permanent supportive housing to families to prevent children from being placed into DHS custody. The group is currently engaged in a four-week technical assistance project with the Corporation of Supportive Housing to develop a strategy for how "One Roof" can be used in southwest Colorado.

With the support of the Housing Specialist, the RAE will partner with the CoC to work with local and national experts to develop a toolkit and provide technical assistance to agencies applying for Department of Local Affairs (DOLA) project-based vouchers,[53] which are allocated to organizations to provide housing and integrated supportive services to specific sub-populations. We will create this toolkit and work with local agencies to pursue Low-Income Housing Tax Credits (LIHTC), which provide direct funding for the construction of housing dedicated to low-income households. The Housing Specialist will use data to identify sub-populations that have disproportionate rates of homelessness and correspondingly high health and social service utilization to support program design and to provide agencies with data to support housing vouchers or tax credits applications. Data on Members who are homeless or are receiving multiple forms of government assistance will be provided through existing statewide data-sharing agreements between RMHP and Mesa County, Boulder County and a growing number of other Colorado counties with accessible statewide data.

Project-based vouchers and tax credits are allocated to organizations that demonstrate a robust service integration strategy. RMHP and Mind Springs Health are developing a service integration model where community mental health workers will meet with program participants in their homes and support Members with their landlord relationships, employment goals, access to health care resources, life skills and transportation challenges. This "shovel-ready" model will be offered to organizations applying for DOLA or LIHTC funding. RMHP and Mind Springs Health have agreed to deploy the model as part of Karis Inc.'s (a Mesa County non-profit) August 2017 application for DOLA project-based vouchers for run away and

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[53] The number of housing vouchers available has recently increased partially due to large streams of Marijuana Tax revenue.

homeless youth. As part of this effort, the Partners have committed a 0.75 FTE Community Health Worker to provide integrated supportive services, and Juniper Family Practice has signed an MOU with Karis, Inc. guaranteeing PCMP relationships to 16 runaway and homeless youth.

> *SummitStone Health Partners provides supportive services to 60 residents in Permanent Supportive Housing in Larimer County and operate an evidence-based intervention called PATH that provides services to people who are homeless or at imminent risk of homelessness. The program serves over 400 individuals a year by providing behavioral health services to individuals in permanent supportive housing, in libraries and at social service organizations.*

RMHP will leverage the financial resources and extensive expertise of UnitedHealthcare in our housing strategy. Since 2011, UnitedHealthcare has invested $350 million to build 56 new community developments throughout the United States, creating over 2,700 new homes for people with the greatest needs. By investing in local housing initiatives, UnitedHealthcare puts capital to productive use through the LIHTC program. UnitedHealthcare recently sponsored the Corporation of Supportive Housing's (CSH) Summit in Denver to provide a forum for the exchange of leading national housing models and evidence based practices. The Partners will leverage the expertise of UnitedHealthcare and its partnership with CSH to develop our DOLA/LIHTC toolkit and to identify best practices (such as One Roof).

The RAE will create data sharing agreements with local supportive housing programs to compare cost and utilization patterns of Members who receive housing support on a pre/post basis, with the goal of developing an evidence base for successful programs and identifying ways programs can be improved to better serve communities.

Energy Assistance

In addition to housing costs, utility costs in Colorado's harsh winter climate can be significant. Unlike urban areas, where many low-income people live in congregate housing of some sort, many people in Western Colorado live in isolated locations in housing that may even rely on alternative sources of heat such as wood. Last year, Energy Outreach Colorado, a statewide, non-profit organization that raises funds and administers energy assistance, **spent $174,450 on firewood** for Colorado homes that rely upon wood for heat. Most of these homes are in the rural parts of Colorado.[54] Poor families often spend an exorbitant percentage of their income on energy. In three adjacent southwest Colorado counties, San Juan, Hinsdale, and Mineral, very poor families spent over 35 percent of their income on energy.[55] High housing and utility costs erode economic self-sufficiency, which has a direct impact on health outcomes and status.

Energy Outreach Colorado (EOC) signed an MOU with RMHP for the AHCM, and is eager to expand the scope of our engagement. EOC shared with us that the biggest issue they face statewide is the lack of outreach and a resulting lack of knowledge about energy assistance programs. Studies have shown that the perception of limited available assistance in the state means that fewer eligible households, approximately 20-30 percent of those who are eligible,

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[55] Chandler, A. "Where the Poor Spend More Than 10 Percent of their Income on Energy". The Atlantic June 8th, 2016. https://www.theatlantic.com/business/archive/2016/06/energy-poverty-low-income-households/486197/

apply for benefits.[56] In addition, EOC reports that the federally funded, county administered Low-Income Energy Assistance Program (LEAP) is not well connected to other public benefit programs. In an effort to help bridge these gaps, we will proactively share information about energy assistance with Members by:

- Conducting a targeted campaign to encourage Members to apply for LEAP
- Training all of our care coordinators and call-center staff in EOC resources so that they can respond accurately and completely to questions about energy assistance
- Confirm that Members who have identified difficulty paying for energy costs on our clinic-based social needs survey apply for and actually receive services
- Offer to support EOC in any way we are able to share their vision to bring all of the various energy assistance programs–LEAP, EOC funds and weatherization–together under one entity so that families have one point of entry to access multiple programs.

Childcare

Families seeking childcare often have concerns about affordability, availability and quality. These concerns are particularly acute for low-income working families, whose choices may be limited by their economic circumstances and lack of workplace flexibility. Families with a child with special needs may face even more severe challenges finding and keeping childcare.

According to a 2015 market study conducted by the Colorado Office of Early Childhood, across types of care and age groups, low-income families do not fare well. Across age groups, no more than 25 percent of all counties with available data meet the federal benchmark of equal access to childcare in Colorado. Overall, family homes provide slightly greater access to childcare than do childcare centers. For both types of care, low-income families have less access to infant care than they do to school-age care. [57]

RMHP and Reunion Health will work to identify childcare resources across the region and share this information with care coordinators and others who work with Members who are in need of childcare support. The Community Integration Team will also coordinate with other state resources, such as the Colorado Child Care Assistance Program (CCCAP), to help parents identify available resources. In addition, care coordinators will work to maximize support for children with special needs by arranging appropriate therapies and respite care that children are qualified to receive.

Employment

The RAE strategy for supporting Members in employment has multiple components:

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[56] https://aspe.hhs.gov/basic-report/approaches-low-income-energy-assistance-funding-selected-states

[57] Moldow, E., Velez, C., O'Brien, T., Walters, B., Krebill-Prather, R., and Carlson, B.L. (2015). 2015 Colorado Child Care Market Rate Study. University of Colorado Denver: The Evaluation Center, School of Education and Human Development available at http://www.the-evaluation-center.org/wp-content/uploads/2016/01/FINAL-CCCAP-REPORT.pdf

- Leverage our own hiring ability and engage healthcare providers as employers of opportunity to hire low-income individuals
- Provide workforce training
- Provide supportive employment opportunities to Members who require supportive employment

Healthcare organizations are often the largest employers in a community, particularly in rural areas. RMHP and Reunion partners have developed strategies to hire individuals at livable wages from the low-income communities they serve. The Partners will share their models for hiring with other healthcare organizations and will provide technical assistance to those interested in adopting these hiring practices.

Northwest Colorado Health, a Community Health Center in Craig and Steamboat Springs, has been a leader in this arena. They have altered organizational structures that previously hampered diversity. Their wage policy assures that even the lowest wages provide a sustainable income. Despite the high cost of living in the region, their employees earn enough so that they are not eligible for the organization's own sliding fee schedule for low-income community members. They have also changed their hiring systems to hire monolingual Spanish speakers for jobs that require Spanish. Northwest Colorado Health has moved to a bilingual human resources strategy and created career ladders that allow for growth from entry-level positions.

Mind Springs Health and the Center for Mental Health both hire over 10 percent of their workforce from people with lived experience with mental illness or substance use. These peers run community groups, serve as Community Mental Health Workers, and provide intake support at crisis units. SummitStone provides employment opportunities to current Members in their medical records department.

For individuals with disabilities, we will offer Project SEARCH employment training. UnitedHealthcare, our parent company, has nationwide experience collaborating with Project SEARCH, a unique, business-led, one-year school-to-work program that takes place entirely at the workplace. Project SEARCH helps persons with disabilities get the training and skills needed to successfully find and keep jobs in the community. UnitedHealthcare has developed and implemented an email mentorship program, matching UnitedHealthcare employees with a Project SEARCH intern for a weekly educational and motivational email exchange. At the end of the internship, many interns are offered full-time UnitedHealthcare positions.

For individuals who require supportive employment, the Partners currently run three separate Individualized Placement and Support (IPS) programs. IPS is an evidenced-based program in which Members with behavioral health needs are competitively employed[58] in the community

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[58] "Competitive employment is defined as a job that any person can apply for (not a job designated for people who have disabilities). These positions are full or part time. The worker is paid minimum wage or the same wages as her co-worker if that is more than minimum wage. The duration of the job is not determined by the employment program." – Dartmouth Psychiatric Research Center. "IPS Supported Employment: The Evidence Based Practice. March 2014.

with support of program staff. Employees are provided training and technical assistance and receive individualized support from program case workers. If an employee does not show for their shift, IPS guarantees coverage and provides another qualified person in the employee's place. IPS's evidence base shows that program participants often find jobs independently after participating in the program.

The Community Integration Team will continue to build out the strategy for workforce training and employment opportunities for Members and will discuss this strategy with the RAE governance on an annual basis.

Schools

The Partners will collaborate with schools to:

- **Increase awareness about Medicaid and Medicaid Resources:** Often schools are the most efficient and effective way to communicate with whole families. We will provide all of the school districts in the region with information and materials about Health First Colorado and the RAE, including available services and benefits. Teachers are often the first to know when a child requires services, so making teachers aware of available resources can make a dramatic difference in connecting a child with needed care.

- **Provide teacher or student trainings about relevant health and mental health topics**: Training teachers in Mental Health First Aid (MHFA) and relevant health topics can equip teachers to address issues important to a student's overall health. Several CMHCs already offer MHFA to teachers. We will also provide training on issues like lice removal or other topics they encounter frequently. Northwest Colorado Health is running a positive psychology course in schools and the Partners will extend that across the region in the RAE.

- **Support School Health Centers:** We will tailor our provider support services to school-based clinics, recognizing that they might require different types of training, tools and resource to best serve their pediatric population.

- **Partner on the needs of children requiring Individualized Education Plans (IEP**): Every child requiring an IEP can request a care coordinator through the RAE, and be connected with a RAE coordinator with expertise in child related care coordination. In some areas we will support whole classes of high need students. In Larimer County, a SummitStone LCSW supports a class for students with high needs.

- **Encourage schools to emphasize participation in federally-funded school meal programs** and to consider ways to increase participation, such as breakfast in the classroom, and decrease the paperwork burden on families, such as community eligibility and direct certification.

- **Support school-based efforts to build knowledge of nutrition, healthy eating habits, and agriculture,** such as cooking classes and school-gardens.

In addition to supporting general coordination with schools, we will leverage UnitedHealthcare's experience in implementing health interventions in schools. UnitedHealthcare pioneered a program to increase students' levels of physical activity through

video games, partnering with video game maker Konami. They introduced *Dance Dance Revolution! Classroom Edition* in three states, engaging children in activity from an early age. They found that this introduced children to the idea that exercise could be fun, thus reducing their long-term risk of obesity. RMHP will leverage UnitedHealthcare's partnerships with national and international entities to improve health outcomes far beyond the clinic.

RMHP also finances and promotes education initiatives that prepare youth for school. Reach Out and Read provides children with books when they come to their doctor appointments. Many children of families on Medicaid are not in daycare, so supporting early education through the doctor's office can be especially beneficial. Reach Out and Read reaches over 11,000 Medicaid children annually. RMHP will help Reach Out and Read recruit additional providers to participate and assist with other aspects of Reach Out and Read program development.

Criminal Justice

The Community Integration Team will work closely with the Care Coordination Team to develop a broad strategy related to the intersection of health and the criminal justice system. The goal will be to divert Medicaid enrollees from courts and jails in Western Colorado.[59] In developing this strategy, the Data Driven Justice Initiative housed at the National Association of Counties will serve as a guide. Several Partners have begun this work in their community or with their patient population; the RAE will build on those efforts to develop a region-wide strategy.

To date, the Partners have established "co-responder" programs, where master's level therapists are embedded with local police departments and respond with law enforcement to 9-1-1 dispatch calls. As a first responder, therapists can identify cases where behavioral health interventions can prevent unnecessary use of force and can provide immediate support to Members in crisis.

The Partners provide court-mandated services as part of "specialty courts," which are family, drug and wellness oriented processes that divert certain offenders traditional criminal justice system. In these courts, CMHCs provide intensive rehabilitation and skill building as an alternative to incarceration or removal of children by protective services. Services include group therapy, individual therapy, psychoeducation classes, psychotropic medication administration, and weekly case worker meetings, and usually last 18 months. The Partners also provide

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[59] http://www.naco.org/resources/programs-and-services/data-driven-justice

support to juvenile drug courts for youth with substance use disorders. Juvenile drug courts provide an evidence-based, treatment-focused approach that prioritizes family engagement, and addresses the substance use and co-occurring mental health disorders experienced by youth.

The Partners also work closely with detention facilities to provide services to Members during incarceration and to continue services after Members are released. By holding contracts for the provision of behavioral health services in detention facilities, the Partners are able to provide continuity of care. For instance, the Partners offer the same psychiatrist to Members during incarceration and after release. RMHP care coordinators also work with parole officers to engage Members before release, initiate case planning and provide post release support.

Transportation

With the exception of a few resort towns, rural communities in Western Colorado lack access to basic public transportation. Even Mesa County, the sole urban county, has no substantial public transportation system in place. To address Member's transportation needs, the RAE will have a dedicated Mobility Manager. This person will interface with community organizations and clinical providers serving individual Members to support them in developing better solutions for transportation. Specifically, they will support development of innovative solutions, such as Liberty Mobile, and the effective deployment of RMHP resources.

Liberty Mobile is a rideshare concept pilot in Montrose, San Miguel and Ouray Counties. Liberty Mobile uses local volunteers, is confidential, has service guarantees, and offers the opportunity to build local transportation capacity in rural areas where there are neither taxis nor public transportation. Members can use Liberty Mobile to access traditional healthcare providers, as well as grocery stores, human service agencies, employment agencies, etc. Members will receive a discount for using Liberty Mobile to access medical appointments and discounts will be provided to Members of lower socioeconomic status.

Additionally, RMHP, now has access to a UnitedHealthcare contract with Toyota to provide low-interest loans and leases on vehicle to any community partner or organization. This expands access to high mileage, low maintenance vehicles to expand for transportation options. RMHP and the Partners can extend this opportunity to community partners such as homeless shelters and clinical partners, as well as our existing Community Health Worker programs. This creates a sustainable solution and fulfills an acute need in rural and frontier areas.

Recreation

Recreation centers can be key community hubs for distributing information, serve as the linchpin for members "active living" and provide a good way to reduce social isolation. RMHP will create MOUs with at least one recreation site in each Community to provide free or reduced price memberships (funded by the RAE) to obese Medicaid Members who have created a weight loss plan with their provider that requires enhanced physical activity. In addition, RMHP will refer members experiencing social isolation to recreation centers as one way to become engaged in the community and make social connections.

One example of a community partnership related to physical activity that we have developed as the RCCO in Region 1 involves our partner, the American Diabetes Association Latino Initiatives. We support them in providing dance fitness classes at no cost to the community. Zumba boot camp classes will be offered at the Montrose Recreation Center, scheduled to begin in Fall 2017. The classes will be marketed to the Latino population, but will be open to everyone. Childcare will be provided during the classes. As the RAE, we will continue to work with ADA-Colorado, as well as other community organizations, to support similar programs for our Members.

CREATE ACCESS TO A CENTRALIZED REGIONAL RESOURCE DIRECTORY

We will provide all community partners (clinical and non-clinical) with access to a centralized regional resource directory through our web-based Healthify application. Healthify is an enterprise and mobile application that allows for interactive web-based searches of community resources; it will integrate community resource data collected and validated in the existing Colorado 2-1-1 database. Colorado 2-1-1 is an information referral system funded by United Way, local government and others. The 2-1-1 database lists over 13,000 low- and no-cost resources. Although the phone number is statewide, the call centers and data management activities are locally administered. The Community Resource Inventory will include the entire list of community resources identified by 2-1-1.

In Western Colorado, 2-1-1 is administered by three separate organizations. Most of Region 1 is administered by Western Colorado 2-1-1, housed at Mesa County Health and Human Services. This system is highly regarded in the community and is a trusted source of information for clinics. Larimer United Way administers the northwest region of Colorado, and Mile High United Way administers Summit County. These regional administrators know the resources available in their areas well and have many personal connections with people in social service organizations.

Healthify will access 2-1-1's data to allow for online referrals, secure communication via text message, and referral data analysis. Healthify integrates seamlessly with CommunityCare, our shared care coordination platform. In addition, Healthify allows users to provide feedback on community resources. This will create a real-time feedback loop that will inform our understanding of what changes need to be made to better meet Member needs.

PROMISING INITIATIVES ADDRESSING SOCIAL DETERMINANTS

Increasing evidence shows that disparities in health outcomes are far better predicted by SDoH than health care itself. We align our SDoH strategy with the Colorado Opportunity Project, Winnable Battles and Local Public Health Agency needs assessments. While we plan to have a broad strategy for addressing social determinants, we will prioritize promotion of promising practices in the following domains:

- Obesity: Food insecurity is a key driver of obesity
- Unintended Pregnancy: Unintended pregnancy has a significant impact on economic self-sufficiency

- Housing: Housing is a social determinant with clear ties to health, including substance abuse and behavioral health

RMHP also adopts evidence-based programs and participates in nationwide partnerships. For example, we participate in the Root Cause Coalition, a nationwide group of diverse stakeholders, which hosts the annual National Summit on the Social Determinants of Health. This collaborative promotes evidence-based strategies to address social risk factors.

REMOVE ROADBLOCKS TO MEMBER ACCESS TO PROGRAMS AND INITIATIVES

Just as the healthcare system has moved to co-locate or integrate physical and behavioral health, many clinics are identifying opportunities to co-locate or integrate with the social resources most frequently used by their patient population. Most commonly, community services co-locate in health care provider locations, such as a food pantry located at a clinic. The innovative ideas in this arena abound. One model has *promotoras*, community health workers recruited from the community, teaching families how to grow gardens, eat healthfully, and live actively. As the RAE evolves over the course of Phase 2, RMHP and the Partners will seek opportunities to financially support socially integrated solutions. RMHP and the Partners will identify where to invest in these resources based on data around client gaps in social services that will be available from the SIE and HIE and from Healthify.

Several of our Partner organizations already offer such services. Both River Valley Family Health Center in Olathe and Yampa Valley Medical Associates in Steamboat Springs offer cooking classes. The latter class is aimed at patients with diabetes and is open to the community. In another very rural community, Naturita, the cost of water is so high that very few houses have a lawn. Basin Clinic thus started a community garden outside of their office, paying the water bill for the garden so the community could grow fresh fruits and vegetables.

Alternatively, health services can be provided outside of the clinic setting in social service or community locations, such as wound care clinics at syringe access programs. One example of this arrangement is SummitStone's PATH model, described previously, in which mental health clinicians provide services at libraries or other partner locations. We will include our strategies for social service colocation in our Community Strategies report to the Department.

In addition to co-location, we will promote cross-training of staff and through our community hubs will support forums where cross-agency relationships can be developed.

STRENGTHENING THE COMMUNITY INFRASTRUCTURE: SHARING INFORMATION, ENGAGING LPHA NEEDS ASSESSMENTS, AND EXPANDING COMMUNITY RESOURCES

In a large and diverse geographic region, the RAE find creative ways to extend resources that improve impact. RMHP has proven experience strengthening community infrastructure and expanding community resources through flexible strategies and tactics. This includes fostering anchor organizations and developing Community Care Teams. We also close gaps in targeted areas, such as sponsoring a mobile dental van to expand access to oral health care in mountain communities and schools.

Building on the groundwork that was laid developing the Region 1 AHCM application and the resulting award, the Partners are bringing additional organization and governance to this process. Community leads in each ACC neighborhood will assess current resources, identify and prioritize gaps and develop a plan for addressing those gaps. Identifying community needs will build on the Local Public Health Agency (LPHA) Needs Assessment and the Hospital Community Needs Assessments. Two of the Communities are led by LPHAs, while others have close partnerships, making the LPHA Needs Assessment an important input to the process.

These Community leads will support the planning process by identifying and prioritizing the needs. The RAE will enable us to support the planning and design of community solutions.

STATEWIDE HEALTH INFRASTRUCTURE

Managed Service Organizations and the Colorado Crisis System

Alignment with the Managed Service Organizations (MSOs) and the Colorado Crisis System - previously detailed in Offeror's Response 13 - includes timely information exchange between providers and social services organizations. Our efforts to integrate HIE and SIE support and onboard all organizations in the Health Neighborhood will prevent duplication of resources and promote optimal care for Members, resulting in improved services for other residents of the Neighborhood. This will also inform the efforts of community groups and help identify opportunities to address health and human service gaps in the system of care.

State Innovation Model (SIM)

RMHP and Reunion Health are deeply committed to sustaining SIM efforts. Colorado's SIM plan, "The Colorado Framework," creates a system of clinic-based and public health supports to spur innovation. It includes the following components:

- Providing access to integrated primary care and behavioral health services in coordinated community systems
- Applying value-based payment structures
- Expanding information technology efforts, including telehealth
- Finalizing a statewide plan to improve population health

SIM funding is being used to assist Colorado integrate physical and behavioral health care in more than 400 primary care practices and community mental health centers, and includes the involvement of approximately 1,600 primary care providers. In addition, the State is working to establish a partnership between their public health, behavioral health and primary care sectors.

We are especially committed to aligning with the Regional Health Connectors (RHCs), a SIM-funded workforce that is promoting coordination between clinics and local resources. RMHP is currently serving as a fiscal co-sponsor for RHC deployments in Mesa, Montrose, Delta and Gunnison counties, under an agreement with the Colorado Foundation for Public Health & Environment. RHCs are residents of the community who work full-time to improve the coordination of systems, build and strengthen networks of primary care, public health, human services, and community organizations working to improve health. RHC organizations also serve as Community Leads for the AHCM and anchor organizations for the RAE, which will promote

alignment and sustainability of both efforts. RHCs focus on making connections between clinical and social resources, and as AHCM leads they develop community plans to address gaps in social resources. Doing both simultaneously will improve the value of both efforts.

We have surveyed the region's RHCs to affirm that our goals align as the RHC prioritization process advances. In the Western Mountain Regional Health Alliance, there are three main priorities: 1) access to care for chronic issues; 2) affordable, integrated behavioral and physical health care; and 3) awareness, early identification and response to behavioral health needs. Mesa County emphasizes three different priorities: 1) physical activity and access to exercise; 2) early childhood, social and emotional wellbeing; and 3) cross-organization service, support, and information coordination.

The Partners used these RHC goals to develop strategies for population health, which addresses the common concerns about obesity and lack of physical activity. Our efforts at care coordination and access to behavioral health address these counties' shared concerns about addressing behavioral health needs. Finally, our community engagement strategy addresses cross-organization service, support, and information coordination.

Colorado Opportunity Framework

The Colorado Opportunity Framework developed by the Department is embedded in RMHP's Region 1 strategies for Member engagement, population health and this section, building the Community. RMHP currently staffs and intends to continue to fund a Colorado Opportunity Framework liaison position that will lead regional activities to support Colorado Opportunity Framework goals. Our Liaison will work to support the creation of measurable, integration and referral processes for evidence-based programs within the life stages framework established for the program. This staff member will also be responsible for continuing to partner with the State so that RMHP activities continue to align with the State vision.

One example of our Colorado Opportunity Framework activities to date is the expansion of the B4 Babies initiative as a way to improve maternal and infant health. B4 Babies is an evidence-based program that includes a home visit during the first week of life to support the mother in connecting to healthcare and other services that will improve her health.

The Colorado Opportunity Framework Liaison began by assessing community needs. She identified an opportunity in Montezuma County to use the Pregnancy Risk Assessment Monitoring System (PRAMS) and claims data to identify prenatal women to recruit and enroll in B4 Babies. The Liaison identified Piñon Project Family Resource Center as an organization with a robust referral structure. To support Piñon Project in successful implementation, she worked to modify the care coordination tool they use so that it prompts the user to ask about evidence-based practices and provide high-quality service delivery. The Liaison will continue to provide technical support for Piñon Project as they continue to grow B4-Babies. She will meet with them quarterly to provide ongoing program support and monitoring

The Healthy Communities staff at San Juan Basin Health also now use RMHP's enhanced care coordination tool database to track the pre- and post-natal population and use the same assessments as the Piñon Project. We are seeking to replicate this work within other family

resources region-wide. Over the course of the seven-year contract, RMHP will implement evidence based Colorado Opportunity Framework strategies for each life-stage.

Comprehensive Primary Care Plus (CPC+)

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. The RMHP Practice Transformation Team was awarded a contract to serve as Regional Faculty for the administration of this program to approximately 35 participating practices located on the Western Slope of Colorado.

Comprehensiveness in the primary care setting refers to the aim of practices meeting the majority of its patient population's medical, behavioral, and health-related social needs. Comprehensiveness is associated with lower overall utilization and costs, less fragmented care, and better health outcomes. Participating practices systematically assess patients' social needs using evidence-based tools and conduct an inventory of resources and supports available to meet those needs, making referrals where appropriate.[60]

RMHP and Network PCMPs are already on their way to meeting many of the CPC+ objectives, including those in the domains of Member engagement, care coordination, care management and population health.

CLAG, BENEFITS COLLABORATIVE, AND PHARMACY AND THERAPEUTICS COMMITTEE AND DUR BOARD

The Partners support the Department in the ongoing development of programs by recruiting providers and other stakeholders to engage in advisory groups, incorporating the recommendations of Departmental advisory groups into RAE activities, and educating providers and Members about any changes. The Community Integration Team staff will be involved in Departmental efforts to the extent it is helpful and appropriate. Specifically, the Partners will continue to support the following departmental initiatives:

- Community Living Advisory Group (CLAG)
- Benefits Collaborative
- Pharmacy and Therapeutics Committee and Drug Utilization Review (DUR) Board

Given RMHP's role as a major payer in several Colorado communities, and sponsor of the Payment Reform Initiative for Medicaid Enrollees (RMHP Prime) established pursuant to HB 12-1281 as a fully functioning Medicaid Managed Care Organization (MCO), we are exceptionally well positioned to consult and collaborate with Department workgroups on benefits and value-based insurance design, as well as pharmacy coverage and DUR policies. RMHP maintains a community-based, Pharmacy & Therapeutics committee, led by physicians, pharmacists and research analysts in Western Colorado, which will align and collaborate with the Department's staff and DUR Board to maximize the health impact and value of the Colorado Medicaid drug benefit.

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[60] CPC+ Practice Care Delivery Requirements, CMS Innovation Center, available at
https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf

UTILIZATION MANAGEMENT VENDOR

RMHP partners with the Department's Utilization Management (UM) Vendor on the use of the Nurse Advice Line (NAL) and the Client Overutilization Program (COUP) data. We will designate our ACC Clinical Manager as a single point of contact, with the UM vendor to ease communications. We will analyze the daily data feeds from the UM vendor to see which Members are using the NAL and will conduct outreach to make sure that they are appropriately connected to primary care.

We also promote the NAL in our Member materials, including our post-ER care management outreach campaign. We regularly assess the COUP data provided by the UM vendor and report back on Members engaged in care coordination services with RMHP.

HEALTH NEIGHBORHOOD AND COMMUNITY REPORT

RMHP's Community Integration team will prepare the biannual report on our activities and accomplishments related to engaging and building the Health Neighborhood and Community. This biannual report will contain the following information:

- Participation in Community efforts
- Creation of new Health Neighborhood and Community forums
- Collaboration with hospitals
- Efforts to utilize admit/discharge/transfer data to improve transitions of care and results of those efforts
- Activities to engage Long Term Services and Supports (LTSS) providers
- Activities to increase regional provider enrollment in Medicaid
- Activities to increase regional provider Medicaid Member panels
- Recruitment efforts and training for utilization of electronic consultation

The Partners view the report as not only a method to document our successes in building the Health Neighborhood and Community, but also a vital opportunity to reflect on areas that may require further attention.

Offeror's Response 15

Describe in detail the Offeror's proposed population health management strategy and document the specific major interventions the Offeror will implement using the forms in Appendix I Population Health Management Plan. Describe how the Offeror will monitor and track the delivery of interventions defined in the Offeror's Population Health Management Plan.

The Partners have the infrastructure and skill set necessary to meet the requirements of section 5.9 of this Request for Proposal, and will build on our existing resources for health promotion and population health management to assess, track and manage the health needs and outcomes of all Members.

OUR VISION

We recognize that population health management requires a detailed understanding of the distribution of **health conditions** and **health-related behaviors**, and is further strengthened by consideration of the **social determinants of health (SDoH).** We define population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" and recognize that "in addition, many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level."[61] We possess the operational capacity and expertise needed to build upon the Department's information systems, perform sophisticated analyses and successfully implement a data-driven approach to delivering and coordinating care and services across the continuum.

Anticipating and responding to the unique needs of each Member is essential to provide the appropriate array of services to improve health outcomes, maintain function and promote whole person wellness. This process starts with a clear strategy to *predict* changes in health and social circumstances, and proactively coordinate the delivery of services to meet anticipated needs. Our population health management strategy incorporates the needs of the Member as a whole person, moving beyond traditional data sources and strategies that contemplate a Member's health simplistically as the sum of diagnoses, prescriptions, costs and utilization. The Partners' approach is grounded in Member goals and preferences, expressed through direct engagement and participation in care planning, as well as the judgment of front line clinicians and skilled human and community services personnel.

ASSESSING, TRACKING AND MANAGING HEALTH NEEDS & OUTCOMES

The combined experience of our integrated partnership has shown that effective population health management entails much more than reactive care coordination. It requires sophistication in data integration, system transformation and management competencies that far exceed the resources found in traditional care management programs. In traditional models, health and behavioral service systems identify the health needs or diseases of individuals who present at the point of care, and then respond with clinical services -- which often vary from site to site without a basis in evidence or efficiency. Likewise, traditional managed and accountable care models focus heavily on the delivery of services and supports *after* problems

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[61] Kindig, D., Stoddart, G. What is population Health? Am J Public Health. 2003 March; 93(3): 380–383.

have been identified through retrospective data analysis. The same is true for many human services and community resource programs, which depend upon Members being referred to appropriate services -- or simply on their own ability to find and qualify for what they need. These traditional modalities are necessary – *but far from sufficient* – for effective population health management, because symptoms, diseases, functional declines, significant social insecurities and/or trauma must materialize before a person receives assistance.

In contrast, the Partners' population health management strategy brings together leaders from across the community to analyze emerging trends and problems, integrate multiple sources of data, and prioritize goals for addressing those needs. Responses follow at both the community and individual level, and include the implementation of health promotion activities, root cause interventions, health maintenance activities and systems that connect members to needed clinical or social service supports. Our population health strategy is a dynamic process that utilizes data to proactively identify Member needs, engage community leaders and continuously evaluate impact as needs, resources and system capacity change over time.

The Three P's: Predict, prioritize and prevent

Today's patient with diabetes may have been pre-diabetic last year. Not only is the patient sicker today, but he or she probably generates higher costs than a year ago. **Risk stratification** is a systemic process for *predicting* which people are likely to develop greater needs—and *prioritizing* defined clinical and programmatic interventions to *prevent* deterioration and destabilization.

Risk stratification is an *intentional, planned* and *proactive* process carried out with the support of the RAE to effectively target program services to patients. It is just one technique—albeit a very important one—in the broader process of population health management. The Partners' population management strategy leverages the collective capacity of the community-based RAE structure to:

- Predict future health, behavioral and human service needs
- Prioritize community responses RAE activities and provider interventions
- Prevent disease, loss of function and overall human potential

Put simply, to risk-stratify Members is to categorize them **in high, moderate** and **lower health risk tiers** for coordinated action. Risk stratification allocates limited resources in a manner that produces the greatest possible impact. The Partners will utilize data resources provided by the Department within BIDM, as well as additional tools at the point of care (described in Offeror's Response 21) that support sophisticated algorithms and robust data registries, to prioritize activities that will create the greatest possible positive impact upon Member health and well-being. Additionally, the Partners and participants in the Provider Network will incorporate Member feedback and clinician judgment, while improving performance in a continuous, feedback driven process.

Risk is Dynamic, Not Static

The Partners recognize that people can't be simplistically categorized, and that needs change over time – sometimes quite rapidly. Members move up and down tiers of risk, or experience

social or other transitions that disrupt complex systems of supports. This is why retrospective, claims-based analyses are useful, but insufficient. A person can have a heart attack one year, but recover, stop smoking, lose weight and start exercising. By the next year, he's at a different risk level, but the historic diagnostic data do not yet reflect the change. Predictive models that integrate recent utilization, pharmacy and lab values, community registries with aggregated clinical data and concrete social and health information exchange use cases can close this gap. Patient reported data is also essential.

Population heath management entails actively monitoring individuals as they move into and out of risk categories – in real time. The Partners have the defined processes and inter-organizational platforms necessary to anticipate Member needs more accurately, and respond faster when transitions occur – or when stable social and caregiver arrangements change.

Accordingly our strategy supports a Population Health Management at both the RAE-level and at points of care. It is consistent with the American Academy of Family Physicians framework, in which care managers and frontline clinicians are empowered to:[62]

- Proactively identify patients who need chronic or preventive care using health data collected and stored in patient registries
- Provide planned care and outreach based on patient diseases or conditions
- Provide patient self-management support
- Monitor patient progress, identify appropriate care plans, and recommend changes to care plans by including prompts in the electronic health record
- Monitor practice performance by tracking patient data and comparing it with national guidelines and/or internal benchmarks

In order to achieve these objectives, the Partners will leverage a powerful care coordination solution, *CommunityCare*, as well as extensive Health Information Exchange services provided by QHN that are already networked widely within the Health Neighborhood to convey real time alerts for both health *and* social transitions of care.

DATA-DRIVEN IDENTIFICATION OF HEALTH CONDITIONS, BEHAVIORS AND SOCIAL DETERMINANTS

The Partners will assess the distinctions and impact of both *chronic* and *episodic* risks and factors. A Member with multiple co-morbidities who requires complex care, but has access to a stable, supportive environment and well-coordinated support services, requires relatively less intense assistance from their care team than a Member without such supports. Major events, such as unemployment or eviction, and chronic unmet needs, such as lack of shelter, describe members with "high" SDoH risk that warrant prioritized responses by human services organizations and related RAE partners. The tables below capture the myriad of drivers, for both adults and children, which can impact a Member's health condition and behaviors.

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[62] AAFP, 2017. "High Impact Changes for Practice Transformation", http://www.aafp.org/practice-management/transformation/pcmh/high-impact.html#rscm

Adults	Physical Health	Behavioral Health	Social Determinants of Health
Chronic	• Total cost • Multiple-system involvement • Disease acuity/diagnosis Medication compliance, prescription fill rate • Duplicate/redundant prescription; multiple prescribers, doctor shopping, multiple pharmacies • Clinical indicators: glucose levels, lipids, BMI • MPP eligibility • Independent functioning measured by ADL or IADL • No PCP or dental involvement	• Total cost • Multiple-system involvement • Disease acuity/diagnosis (incl. SUD) • Assessments: PHQ, Edinburgh, SBRIT, PAM • Medication compliance/prescription fill rate • Duplicate/redundant prescription; multiple prescribers, Doctor shopping, multiple pharmacies • Functioning measured by ADL, IADL, or Locus • Prior suicidal/homicidal attempt • Family history of mental health issues /substance use	• Multi-system involvement • Low economic self-sufficiency, unemployed (or seeking employment • Inadequate transportation, housing, access to healthy food, child care • Domestic violence • Lack of social support
Episodic	• Admission to crisis center, hospital, ER • Appointment no show • Rapid change in BMI • Provider termination • Pregnancy • Increase in system calls • Dental claims for major procedures caused by lack of dental hygiene • Changes in medication dose/type	• Admission to crisis center, hospital, ER • Suicidal/homicidal ideation or attempt • Appointment no show • Increase in system calls • Sexual assault/domestic violence • Provider termination • Abuse behaviors • ACT and HET involvement	• Loss/reduction of transportation, housing, food, childcare • First time mother/unplanned pregnancy • Criminal justice involvement, parole enrollment • 911-calls • Unsafe environments, sexual assault, harassment • Loss of a loved one, divorce, changes in social connectedness

Child	Physical Health	Behavioral Health	Social Determinants of Health
Chronic	• Total cost • Multiple-system involvement • Disease acuity/diagnosis • Medication compliance, prescription fill rate • Clinical indicators: glucose levels, lipids, BMI, etc. • Functioning measured by missed developmental milestones • No PCP involvement or dental claims data	• Total cost • Multiple-system involvement • Disease acuity/diagnosis (incl. SUD) measured by PHQ, SBIRT, etc. • Medication compliance, prescription fill rate • Child abuse, neglect, foster care/DHS involvement • Functioning measured by IEP, 504, missed developmental milestones • Prior suicidal/homicidal attempt • Family history of mental health issues /substance use	• Multi-system involvement • Inadequate transportation, housing, access to healthy food, child care • Runaway or homeless youth • Child abuse, neglect, foster care/DHS involvement • Bullying, harassment, dating violence • Lack of permanent positive adult relationships
Episodic	• Admission to crisis center, hospital, ER • Appointment no show • Rapid change in BMI • Provider termination • Adolescent pregnancy • Increase in system calls • Dental claims for major procedures caused by lack of dental hygiene • Changes in medication dose/type	• Admission to crisis center, hospital, ER • Suicidal/homicidal ideation or attempt • Appointment no show • Increase in system calls • Provider termination • Abuse behaviors • Expelled or suspended	• Loss/reduction of transportation, housing, healthy food, or education • Adolescent pregnancy • Legal issues / criminal justice involvement • 911-call to residence • Unsafe environments, sexual assault, bullying • Loss of a loved one, changes in social connectedness • Expelled or suspended

Health Needs Assessment

The Partners will also incorporate results from the Department's Health Needs Survey as a core part of our stratification and prediction activities, and we will incorporate survey data into the 3D Risk Stratification Model. Survey responses will be used to augment claims data and other data sources. Questions from the survey, such as "Do you need or want help with resources?"

and "What are your top health goals this year" will provide insight into Member-identified health needs and outcomes. The value of the needs survey for stratification is unique; it provides immediate information on the Member that can be used for stratification, and a method for stratification that is not tied to claims data.

ACCOUNTABLE CARE COLLABORATIVE RISK STRATIFICATION FRAMEWORK

The Partners look forward to collaborating with the Department and stakeholders to develop an Accountable Care Collaborative (ACC) stratification framework to be used by all RAEs in order to support the Department's program evaluation and to facilitate transition of Members from one RAE to another RAE. The data-driven stratification concept articulated by the Department in Appendix I of the RFP establishes a clear, actionable framework for the integration of physical, behavioral and social health risks in the population health management plan. We will build upon the basic stratification framework developed for the ACC to ensure it effectively identifies the unique physical and behavioral health needs, and social disparities that impact the health of Members in Region 1.

Distribution of Health Conditions and Behaviors: The Four Quadrant Model

The Partners have considerable experience utilizing the Four Quadrant Clinical Integration Model, developed by Barbara Mauer and the National Council for Community and Behavioral Healthcare, to determine the most appropriate settings for integrated behavioral and physical health services. The Four Quadrant Model stratifies members between "high" vs "low/moderate" categories across the axis of physical health (PH) and behavioral health (BH). Members are divided into four basic categories based on the co-morbid complexity of physical and behavioral health needs.

Below is a stratification based on actual Region 1 physical and behavioral health administrative data. In this analysis, integrated physical, behavioral and pharmacy data for State Fiscal Year 15-16 are grouped according to the *acuity* and *prevalence* of physical and behavioral conditions, based upon the Medicaid *Chronic Disability Payment System* (CDPS) developed by faculty at the University of California, San Diego. Members with behavioral health conditions categorized by CDPS in the "low" or "medium low" groupings are stratified in Quadrants 1 and 2, while those with "medium" or "high" acuity behavioral conditions are stratified in Quadrants 3 and 4. Breakouts by broad eligibility cohorts of **children, adults** and **people with disabilities** are applied to accurately depict variation in total cost, as follows:

DISABLED POPULATION IN LARIMER COUNTY - 4 QUADRANT STRATIFICATION (SFY 2015-16)

The prevalence of the top 22 health and behavioral conditions in Larimer County is shown below for 5,562 unique individuals in Medicaid disability categories of coverage (similar patterns are reflected in the Prime and other RCCO populations). Of note, co-morbid behavioral conditions are highly prevalent in every category.

Disabled Population

Quadrant 1		Quadrant 2		Quadrant 3		Quadrant 4	
Physical	Low	Physical	High	Physical	Low	Physical	High
Behavioral	Low	Behavioral	Low	Behavioral	High	Behavioral	High
Top 22 Conditions by Prevalence		**Top 22 Conditions by Prevalence**		**Top 22 Conditions by Prevalence**		**Top 22 Conditions by Prevalence**	
Psychiatric-medium low	24.3%	Psychiatric-medium low	43.2%	Psychiatric-medium	56.7%	Psychiatric-medium	69.8%
Cardiovascular-extra low	14.3%	CNS-low	34.1%	Psychiatric-high	43.2%	CNS-low	46.5%
CNS-low	14.0%	Pulmonary-very high	28.6%	CNS-low	21.8%	Pulmonary-very high	34.9%
Pulmonary-low	12.3%	Cardiovascular-medium	28.2%	Pulmonary-low	17.7%	Gastro-low	33.3%
Gastro-low	12.0%	Gastro-low	27.6%	Gastro-low	17.2%	Cardiovascular-medium	31.8%
Cardiovascular-low	9.7%	Renal-very high	27.3%	Renal-low	16.6%	Psychiatric-high	30.2%
Renal-low	9.0%	Cardiovascular-low	25.0%	Cardiovascular-extra low	16.1%	Renal-very high	25.6%
Skeletal-low	8.9%	Skeletal-low	21.8%	DD-low	12.0%	Skeletal-low	25.6%
Eye-very low	7.2%	Skeletal-medium	20.4%	Cardiovascular-low	11.4%	Renal-low	24.0%
Skeletal-very low	7.0%	Renal-low	19.8%	Skeletal-low	9.7%	Cardiovascular-extra low	21.7%
Skeletal-medium	6.6%	Eye-very low	19.0%	Skin-very low	9.2%	Metabolic-high	20.9%
Diabetes-type 2 low	6.3%	Metabolic-medium	16.9%	Eye-very low	8.5%	Skeletal-medium	19.4%
Skin-very low	5.4%	Diabetes-type 2 medium	16.6%	Skeletal-very low	7.8%	Cardiovascular-low	18.6%
CNS-medium	5.3%	Cardiovascular-extra low	16.5%	Metabolic-very low	7.5%	Gastro-medium	17.1%
Metabolic-very low	5.1%	Metabolic-very low	16.1%	Diabetes-type 2 low	7.1%	Metabolic-medium	16.3%
Cardiovascular-medium	4.7%	Pulmonary-low	14.6%	Skeletal-medium	6.1%	Pulmonary-low	16.3%
Pulmonary-medium	4.2%	Gastro-high	14.5%	Pulmonary-medium	5.0%	Skin-very low	16.3%
DD-low	4.0%	Diabetes-type 2 low	13.8%	CNS-medium	4.3%	Diabetes-type 2 low	15.5%
Gastro-medium	3.9%	Metabolic-high	13.8%	Gastro-medium	4.3%	Infectious-low	14.7%
Psychiatric-low	3.7%	Pulmonary-medium	13.5%	Genital-extra low	3.6%	Metabolic-very low	14.7%
Genital-extra low	3.6%	Skin-high	13.5%	Metabolic-medium	3.6%	Pulmonary-medium	14.7%
Diabetes-type 2 medium	3.3%	Skin-very low	11.8%	Infectious-low	3.5%	Diabetes-type 2 medium	14.0%

DISABLED POPULATION IN LARIMER COUNTY - VARIATION IN TOTAL COST BY QUADRANT (SFY 2015-16)

As one would expect, total costs per Member, per Month are as much as five times higher for individuals in Quadrants 2 and 4 than for those in Quadrant 1, as are corresponding risk scores. Individuals in Quadrant 3 have intermediate costs and risk scores.
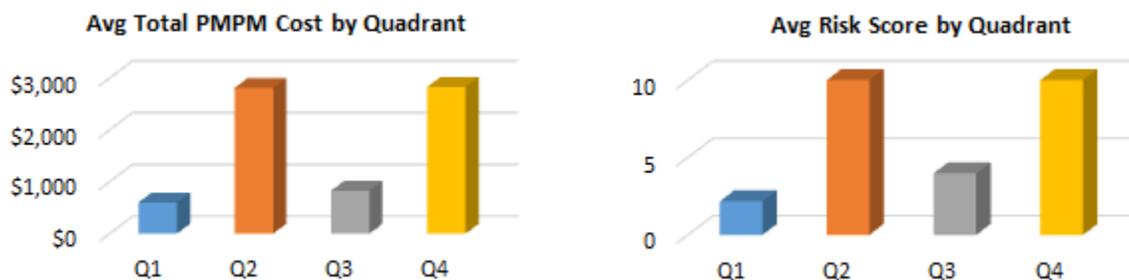
ADULT POPULATION IN LARIMER COUNTY - 4 QUADRANT STRATIFICATION (SFY 2015-16)

The prevalence of the top 22 health and behavioral conditions in Larimer County for this time period is shown below for 35,896 unique individuals in Medicaid adult categories of coverage. Again, co-morbid behavioral conditions are highly prevalent in every category.

Adult Population

Quadrant 1	
Physical	Low
Behavioral	Low

Top 22 Conditions by Prevalence	
Psychiatric-medium low	11.1%
Pulmonary-low	6.1%
Gastro-low	5.6%
Cardiovascular-extra low	5.3%
Skeletal-low	4.3%
Skeletal-very low	3.9%
Genital-extra low	3.4%
Pregnancy-complete	3.2%
Skin-very low	3.0%
CNS-low	2.8%
Cardiovascular-low	2.4%
Diabetes-type 2 low	2.0%
Skeletal-medium	1.8%
Gastro-medium	1.6%
Pregnancy-incomplete	1.6%
Psychiatric-low	1.5%
Metabolic-very low	1.4%
Renal-low	1.3%
Pulmonary-medium	1.2%
Infectious-low	1.1%
Eye-very low	0.9%
Metabolic-medium	0.9%

Quadrant 2	
Physical	High
Behavioral	Low

Top 22 Conditions by Prevalence	
Psychiatric-medium low	29.9%
Metabolic-high	29.1%
Cardiovascular-extra low	20.8%
Gastro-low	20.8%
Renal-very high	19.1%
Pulmonary-high	18.6%
Cardiovascular-low	17.2%
CNS-low	16.8%
Skeletal-low	13.6%
Gastro-high	12.7%
Genital-extra low	12.7%
Pulmonary-low	12.3%
Skeletal-very low	11.2%
Cancer-high	11.0%
Skeletal-medium	10.6%
Diabetes-type 2 low	10.3%
Skin-very low	10.1%
Gastro-medium	10.0%
Cardiovascular-medium	9.4%
Metabolic-medium	9.4%
Pulmonary-medium	8.8%
Renal-low	7.2%

Quadrant 3	
Physical	Low
Behavioral	High

Top 22 Conditions by Prevalence	
Psychiatric-medium	76.6%
Psychiatric-high	23.0%
Pulmonary-low	17.5%
Gastro-low	15.4%
Cardiovascular-extra low	13.4%
CNS-low	10.5%
Skeletal-low	10.5%
Genital-extra low	9.0%
Skin-very low	8.2%
Cardiovascular-low	7.6%
Skeletal-very low	7.3%
Infectious-low	5.8%
Skeletal-medium	5.6%
Pulmonary-medium	5.3%
Gastro-medium	4.7%
Metabolic-very low	4.6%
Renal-low	4.6%
Diabetes-type 2 low	4.3%
Metabolic-medium	3.8%
Pregnancy-complete	3.0%
Pregnancy-incomplete	3.0%
CNS-medium	1.4%

Quadrant 4	
Physical	High
Behavioral	High

Top 22 Conditions by Prevalence	
Psychiatric-medium	87.7%
CNS-low	40.4%
Metabolic-high	29.8%
Gastro-low	28.1%
Renal-very high	24.6%
Pulmonary-high	19.3%
Cardiovascular-low	17.5%
Metabolic-very low	15.8%
Skeletal-low	15.8%
Cardiovascular-extra low	14.0%
Pulmonary-low	14.0%
Skeletal-very low	14.0%
Gastro-high	12.3%
Genital-extra low	12.3%
Psychiatric-high	12.3%
Pulmonary-medium	12.3%
Skeletal-medium	12.3%
Skin-very low	12.3%
Infectious-medium	10.5%
Cardiovascular-medium	8.8%
Eye-very low	8.8%
Gastro-medium	8.8%

ADULT POPULATION IN LARIMER COUNTY - VARIATION IN TOTAL COST BY QUADRANT (SFY 2015-16)

As one would expect, total costs per Member, per Month are about 9 times higher for individuals in Quadrants 2 and 4 than for those in Quadrant 1, as are corresponding risk scores. Individuals in Quadrant 3 have costs and risk scores about 4 times greater than those in Quadrant 1.
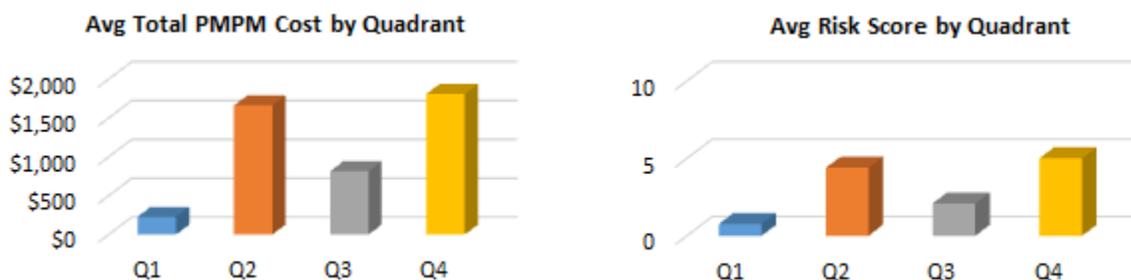
Claims, eligibility and diagnostic data create a baseline stratification for population targeting, but provide an incomplete picture of population health and intervention opportunities. The Partners will address these limitations through adoption of a model that includes additional risk factors and incorporates more comprehensive Member data.

The Next Step: 3 Dimensional Logic Model

Social risk factors must be viewed as a significant driver in any root cause analysis of avoidable disease, disability and diminished quality of life. We will incorporate social risk factors in our stratification and intervention logic model to achieve whole person health for our Members.

Four-Quadrant Model
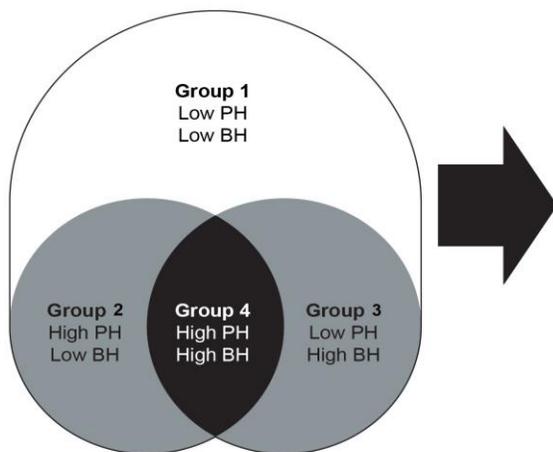
3D Model
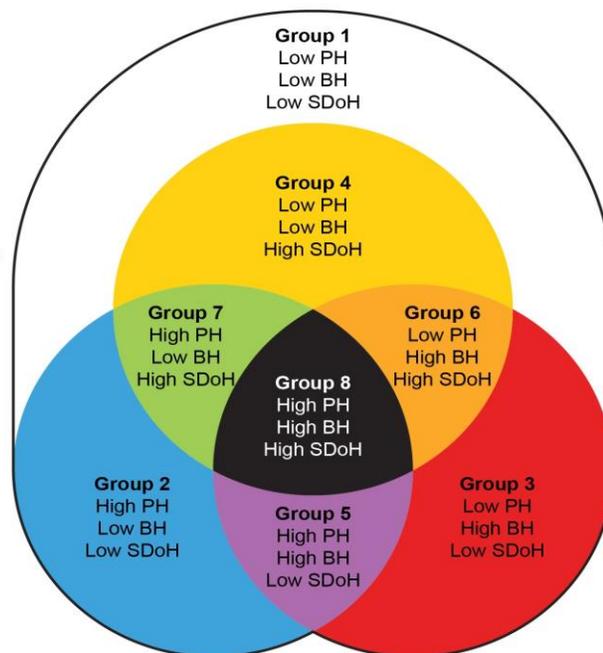
The Venn diagram on the left side of the graphic above provides a visualization of the Four Quadrant Model. Group 1 describes Members with low/moderate needs or risk in both physical and behavioral health. In the left circle are those Members with high physical health needs and in the right circles are those Members with high behavioral health needs. The intersection of the physical and behavioral health domains in the center represents those Members with both high behavioral health needs and high physical health needs – sometimes referred to as the "co-morbid" population.

Our three-dimensional model (3D Model) builds upon the four-quadrant concept by incorporating a third axis, reflecting social determinants of health (SDoH); thus creating eight possible population stratification groupings by which to align and integrate community interventions. The right side of the diagram above depicts the new 3D Model by adding an additional circle for Members with high SDoH. We further calibrate the model by including specific functional needs, incorporating individual and social level risk factors and differentiating between chronic and episodic risks.

The 3D Model encompasses broad segments of Member health needs and provides a framework for aligning programs and community initiatives to support healthy communities. The model is not a static categorization of Members or a prescriptive treatment tool. This model also supports community planning, as leaders in the ACC Health Neighborhood and Community conduct gap analyses and align community strategies within a consistent, comprehensive logic model.

The Partners will build on existing data sharing and management relationships to enable the integration and matching of individual Member data from county human services departments, such as Mesa County. We also have the ability to integrate SDoH Data from health needs assessments, such as the one that the Department will collect for ACC Phase 2 participants, in our stratification plan.

In the model below, SDoH prevalence rates from actual health needs assessment data for people with disabilities, collected by RMHP within its current Region 1 operations for the SFY

2015-16 time period, are integrated with physical and behavioral health claims and eligibility data to produce a more comprehensive stratification analysis.

Disabled Population

Quadrant 1		Quadrant 2		Quadrant 3		Quadrant 4	
Physical	Low	Physical	High	Physical	Low	Physical	High
Behavioral	Low	Behavioral	Low	Behavioral	High	Behavioral	High
Top 12 Conditions by Prevalence		Top 12 Conditions by Prevalence		Top 12 Conditions by Prevalence		Top 12 Conditions by Prevalence	
Psychiatric-medium low	28.3%	Psychiatric-medium low	47.0%	Psychiatric-high	53.1%	CNS-low	66.7%
Cardiovascular-extra low	21.2%	CNS-low	38.7%	Psychiatric-medium	46.0%	Psychiatric-medium	57.6%
CNS-low	19.3%	Cardiovascular-medium	34.3%	CNS-low	25.7%	Gastro-low	45.5%
Cardiovascular-low	16.6%	Renal-very high	33.7%	Gastro-low	24.8%	Psychiatric-high	42.4%
Renal-low	15.9%	Cardiovascular-low	33.1%	Cardiovascular-extra low	23.9%	Pulmonary-very high	36.4%
Gastro-low	15.6%	Gastro-low	32.6%	Pulmonary-low	21.2%	Renal-very high	33.3%
Eye-very low	14.0%	Pulmonary-very high	32.6%	Renal-low	15.9%	Eye-very low	27.3%
Pulmonary-low	13.5%	Eye-very low	24.3%	Cardiovascular-low	13.3%	Cardiovascular-extra low	24.2%
Skeletal-low	13.5%	Skeletal-low	22.7%	Skeletal-low	12.4%	Cardiovascular-low	24.2%
Skeletal-medium	9.3%	Renal-low	21.0%	Skin-very low	12.4%	Cardiovascular-medium	24.2%
CNS-medium	8.4%	Metabolic-medium	20.4%	Diabetes-type 2 low	10.6%	Pulmonary-low	24.2%
Skeletal-very low	8.2%	Skeletal-medium	20.4%	Eye-very low	9.7%	Diabetes-type 2 low	21.2%
Top SDoH by Prevlence		Top SDoH by Prevlence		Top SDoH by Prevlence		Top SDoH by Prevlence	
Rural	60.1%	Rural	76.2%	Rural	61.9%	Rural	69.7%
Transportation needs	12.5%	Need help caring for home	17.7%	Multiple care coordinators	13.3%	Multiple care coordinators	27.3%
Need help caring for home	11.3%	Transportation needs	16.6%	Transportation needs	13.3%	Transportation needs	21.2%
Multiple care coordinators	10.0%	Multiple care coordinators	15.5%	Need help caring for home	11.5%	Need help caring for home	21.2%
Limited access to food	6.4%	Limited access to food	11.6%	Limited access to food	4.4%	Limited access to food	6.1%
Neigh. food access - low	3.5%	Neigh. food access - low	5.0%	Neigh. racial minority -high	2.7%	Neigh. racial minority -high	3.0%
Neigh. Hispanic - high	1.9%	Homeless	2.2%	Neigh. poverty - high	1.8%	Neigh. food access - low	3.0%
Neigh. education - low	1.9%	Neigh. racial minority -high	1.7%	Unsafe at home	0.9%		
Neigh. racial minority -high	1.8%	Unsafe at home	1.1%	Neigh. food access - low	0.9%		
Dental needs	1.4%	Dental needs	1.1%				
7+ drinks per week	1.4%	7+ drinks per week	1.1%				
Neigh. Foreclosure - high	1.1%	Neigh. Hispanic - high	1.1%				

Multiple care coordinators and transportation needs are some of the most prevalent indicators of risk in the SDoH domain, given the eligibility groups represented, and the relatively high prevalence of behavioral conditions in all of the quadrants. Other significant stressors, such as housing insecurity or safety concerns and neighborhood risk factors (such as poverty or low access to food) are prevalent as well. Moving forward, through social information exchange and the Department's Health Needs Survey, we will have much more robust SDoH data. The social risk factors present in this analysis, represented by the patterned bars in the charts below, are correlated with substantially higher total Per Member Per Month (PMPM) costs for Members in Quadrants 2 and 4:
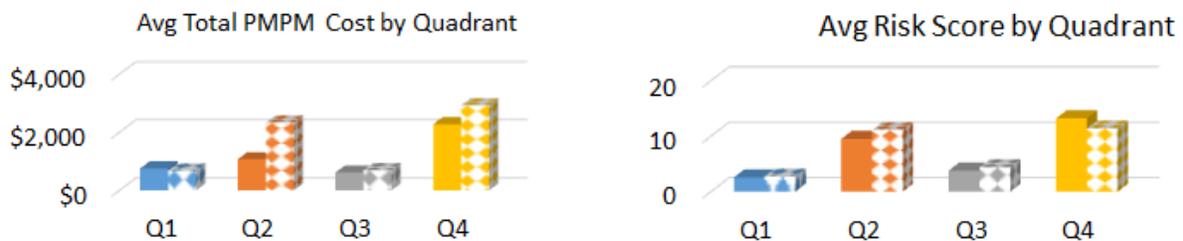
The solid bars denote costs and risk scores for people with disabilities who do not have a major SDoH (see top SDoH by prevalence in table above). The patterned bars represent costs and risk scores for people with disabilities and one major SDoH.

SUPPORT FOR MEMBERS AT ALL LIFE STAGES AND LEVELS OF HEALTH

Given the essential role of predictive modeling, risk stratification and workflow redesign across the community, the Partners' population health interventions will focus on providing supports to improve health outcomes, Member experience and access to providers and services in all parts of the community service delivery system. Our strategy will simultaneously identify appropriate action at Member, provider and community levels.

Member-Centered Interventions Aligned with Level of Health

A Population Health Management and risk stratification framework is effective only to the extent it can be made operational. This will require role definition, staffing, task assignment, reporting and evaluation as well as an actionable management and feedback processes. Based upon criteria above, each Member will be categorized by the Partners in one of the following levels of community-based care coordination and management:

Level	Description
Healthy/Stable	Healthy/Stable Members will receive access to wellness resources, self-management tools and health education through navigation and community initiatives, as well as confirmation of access to a Medical Home.
Episodic Care Needs (e.g. single episode depression, job loss, pregnancy)	Members with a single episodic need for care will receive warm-hand off access to acute services, coordinated navigation and follow-up, education on self-management tools and connection to community initiatives.
Non-Managed Elevated Risk	Members with an elevated risk based upon either a medical, behavioral or social unmanaged need, will receive targeted care coordination to support condition management and connection to the appropriate specialty provider to develop a treatment plan.
Co-Occurring Conditions High Risk/High Cost	Members with high risk co-occurring conditions and adherence problems will receive intervention from Care Management staff to stabilize the Member, provide skills for adherence to medication, diet and activity plans, and support Member health literacy and self-management skills.

Member assignment into risk groupings will be performed by the Partners at a minimum of monthly intervals – or immediately upon an adverse event or Member transition – with capacity to track the migration of the population over time into higher or lower risk categories. Members will also be identified for rising risk through indicators such as hospitalization, multiple pharmacy prescriptions, and major health or life event. The **Stratification Report** will be submitted quarterly to the Department. In order to ensure that these reports are as accurate and actionable as possible, the Partners will continuously update Member status to reflect health or social changes identified through administrative, clinical, social or Member reported data sources.

Member-Centered Interventions Aligned with Life Stages

The Partners will apply a clear **logic model** to align appropriate interventions with the individuals in each of the stratified categories – and move from *analysis to action*. In addition to a three-dimensional stratification process (PH, BH, SDoH), in which both chronic and episodic risk factors are reflected, we will categorize the population across life stages and functional needs. This approach will enable an evolution within RAE operations – from a narrow focus on individual Members, to a broader recognition of the important role that family, friends, peers, caregivers and social support networks play in health outcomes. We have adopted the nine life stages developed by the Colorado Opportunity Project for this purpose. We also adopt the Colorado Opportunity Project's grouping for members living with disabilities. Below is an outline of our population health approach for each life stage.

Family Formation services focus on early intervention and screening, maternal depression, intendedness of pregnancy, breastfeeding supports, healthy birth outcomes, food insecurity, and family stability and resources.

Early and Middle Childhood services focus on social/emotional/behavioral functioning, trauma, school readiness, food insecurity, and family stability and resources.

Adolescent and Transition to Adulthood services focus on prevention activities, oral health, reducing criminal justice involvement and substance use, high school graduation status, and supports for transitions into adulthood.

Adult Services focus on routine screening for health conditions, oral health, chronic disease management, housing, and economic self-sufficiency.

Older Adult services focus on aging in place through employment, housing and financial resources; social connectedness, access to caregiver; fall and hospital prevention; level of functioning; and advanced care planning.

End of life services focus on advancing care planning and services aligned with the individual's end of life goals.

Population-Wide Interventions

As the model indicates, some interventions are specific to stratified populations, while others will impact the entire population. The Partners will utilize our management resources to align population health interventions with health needs in a manner that best utilizes limited resources. We will also adhere to the requirement established by the Department that every Member will receive at least two (2) proactive health contacts or interventions every year.

As an example of how we evaluate our interventions for a particular desired health outcome, below is our set of interventions to address Obesity. The interventions address a full spectrum of obesity risk factors-- from health behaviors to food insecurity-- and include specific interventions like screening for depression, a potential driver of obesity, and referral to the provider most able to assist them. Some interventions, like motivational interviewing, are only used for Members who require behavior change. We also note that certain interventions will be inappropriate for certain strata.

Logic Model Example: Obesity Interventions

BH	PH	SDoH	Family Formation Life Stage	Early Childhood Life Stage	Middle Childhood Life Stage	Adolescence Life Stage
Low	Low	Low	Sweetened Beverage Campaign Lactation Consultation Pregnancy Related Depression Screening	Sweetened Beverage Campaign	Sweetened Beverage Campaign Positive Psychology	Sweetened Beverage Campaign Positive Psychology Depression Screening
High	Low	Low	Sweetened Beverage Campaign Pregnancy Related Depression Screening	Sweetened Beverage Campaign	Sweetened Beverage Campaign Positive Psychology	Sweetened Beverage Campaign Positive Psychology
Low	High	Low	Sweetened Beverage Campaign Subsidized Fitness Pregnancy Related Depression Screening	Sweetened Beverage Campaign	Sweetened Beverage Campaign Positive Psychology Subsidized Fitness School-based Nutrition Assessment	Sweetened Beverage Campaign Positive Psychology Depression Screening Subsidized Fitness Motivational Interviewing School-based Nutrition Assessment
Low	Low	High	Sweetened Beverage Campaign SNAP/WIC Enrollment Pregnancy Related Depression Screening	Sweetened Beverage Campaign SNAP/WIC Enrollment	Sweetened Beverage Campaign Positive Psychology SNAP/WIC Enrollment	Sweetened Beverage Campaign Positive Psychology Depression Screening SNAP/WIC Enrollment
High	High	Low	Sweetened Beverage Campaign Subsidized Fitness	Sweetened Beverage Campaign	Sweetened Beverage Campaign Positive Psychology Subsidized Fitness School-based Nutrition Assessment	Sweetened Beverage Campaign Positive Psychology Motivational Interviewing Subsidized Fitness School-based Nutrition Assessment

BH Risk Factor	PH Risk Factor	SDoH Risk Factor	Transition to Adulthood Life Stage	Early Adulthood Life Stage	Adulthood (independent) Life Stage	Adulthood (with support) Life Stage	End of Life Stage
Low	Low	Low	Sweetened Beverage Campaign Text4Health Depression Screening	Sweetened Beverage Campaign Text4Health Depression Screening	Sweetened Beverage Campaign Text4Health Depression Screening	Sweetened Beverage Campaign Text4Health Depression Screening	NA
High	Low	Low	Sweetened Beverage Campaign Text4Health	Sweetened Beverage Campaign Text4Health	Sweetened Beverage Campaign Text4Health	Sweetened Beverage Campaign Text4Health	NA
Low	High	Low	Sweetened Beverage Campaign Text4Health Depression Screening Subsidized Fitness Motivational Interviewing Bariatric Surgery	Sweetened Beverage Campaign Text4Health Depression Screening Subsidized Fitness Motivational Interviewing Bariatric Surgery	Sweetened Beverage Campaign Text4Health Depression Screening Subsidized Fitness Motivational Interviewing Bariatric Surgery	Sweetened Beverage Campaign Text4Health Depression Screening	NA
Low	Low	High	Sweetened Beverage Campaign Depression Screening SNAP/WIC Enrollment	Sweetened Beverage Campaign Depression Screening SNAP/WIC Enrollment	Sweetened Beverage Campaign Depression Screening SNAP/WIC Enrollment	Sweetened Beverage Campaign Depression Screening	NA
High	High	Low	Sweetened Beverage Campaign Text4Health Subsidized Fitness Bariatric Surgery	Sweetened Beverage Campaign Text4Health Subsidized Fitness Bariatric Surgery	Sweetened Beverage Campaign Text4Health Subsidized Fitness Bariatric Surgery	Sweetened Beverage Campaign	NA

Method of Accountability

Clear organizational accountability for activities related to Population Health Management is essential to maintain adherence to stratification criteria, incorporate emerging evidence, improve operational efficiency and conduct performance evaluation and continuous

improvement. The Partners have created a simple, four-pillar assessment framework for each Population Health Management processes we put into production:

- **Pillar 1 - People:** Who are the individuals a population health intervention will serve? Are they objectively identified and are their needs clearly defined? How specific are the criteria for inclusion or exclusion in an intervention grouping? How do unanticipated episodes, transitions and fluctuations in circumstances and supports impact identification of the people and their needs within the grouping?

- **Pillar 2 - Intervention:** What is the intervention being implemented? Can it be described discretely? Is there a supporting evidence base or logic model? How well does the intervention align with the needs of the people identified in a stratified subgroup?

- **Pillar 3 - Systems:** Is there a specific, demonstrable workflow, set of organizational relationships or processes that actively connect the people identified in pillar one to the interventions defined in pillar two? "Care coordination" programs might serve this purpose, but are much less meaningful to the extent they depend upon passive referral processes, or lack criteria driven functions, clear objectives or boundaries.

- **Pillar 4 - Measurement**: How is the impact of the intervention measured? Can outcomes for the identified population group be tied to intervention and management process? Can a ratio of people who have actually received support be calculated against a population "denominator"? What feedback and performance improvement processes are established to improve the measurement? Is there a routine, widely communicated and understood internal reporting process for management and staff so that the state of system performance can be understood at any given time?
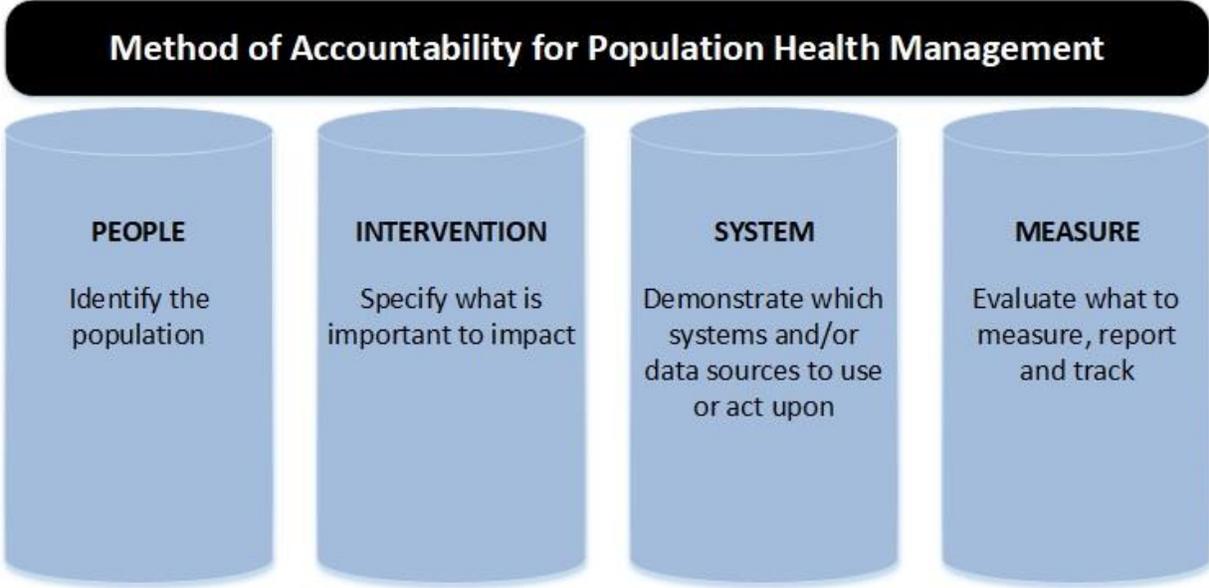
An illustration of how the four pillar framework is applied by the Partners to interventions following a hospital discharge is provided below.

- **Pillar 1**: The "denominator" or universe of people for this intervention is all Members discharged from an inpatient physical or psychiatric hospital facility.

- **Pillar 2**: All discharged Members receive follow-up contact and needs assessment from a care coordination team member within seven days of discharge. The follow-up contact and needs assessment is the "numerator" for this intervention. This process is documented in all organizational policies and procedures, and incorporated in routine staff training and oversight processes.

- **Pillar 3:** The Partners will utilize real time HL-7 alerts from the Health Information Exchange(s) (HIE) for knowledge of discharge, and will document completed, time-stamped Member or caregiver contact in CommunityCare, the care coordination tool.

- **Pillar 4:** The Partners will report the ratio of contacts completed within seven days to the total number of inpatient discharge alerts, to the Quality Improvement Committee on a quarterly basis. Corrective action and process improvement activities will be implemented whenever the ratio of timely follow-up to discharges drops below 97 percent.

This method of accountability should be part of every population health and care management strategy, but contemporary accountable care and managed care programs often lack this basic discipline, operating without clearly defined population targets, documented procedures, functional workflows or measurement based accountability and improvement processes. Without this discipline, opportunities for meaningful impact can be missed, resources can be misallocated, and unproductive processes and concepts "live on" for years in organizational business and program models. The Partners will continuously evaluate whether we are *actually making an impact* in every facet of our operations.

COMMUNITY-LEVEL STRATEGY

Population health data also reveals the potential for proactively improving the health of every individual in the RAE Community. Annual reviews of population health data (and overall RAE performance) by the Executive and Directors Committees will build momentum for continuing cultural shifts in the healthcare community.

Winning the battles and breaking the cycle

Our population health agenda at the community leadership level, within our committees and management structure is in alignment with the public health objectives established in the Colorado's Ten Winnable Battles campaign. The Partners will also focus on multi-generational strategies, which provides an opportunity to break the cycle of poverty and improve health. These include:

- Reduce obesity

- Reduce impact of chronic disease

- Increase functional independence for individuals with disabilities

- Improve oral health

- Reduce prevalence of substance abuse

- Improve access to safe and affordable housing
- Focus on family formation and early childhood – reduce unintended pregnancies and promote maternal and child health

As demonstrated in our population health **logic model**, as well as in the detailed description of our major population health initiatives within the template provided in Exhibit I, the Partners' strategy is well-aligned with these statewide policy objectives.

A participatory process

Promoting a collaborative understanding of Member needs will enable community organizations and providers to empower Members, their families and caregivers through data-driven insight, better knowledge, knowledge of their rights and resources and personalized, goal-oriented self-care techniques. The Partners' strategy in developing the Population Health Management Plan entails engagement and collaboration with the full spectrum of Health Neighborhood and community partners.

The Partners have organized our Governance Structure to meet this objective. We will have a Directors Committee which includes representatives from each of the Advisory Councils (PCMP Council, Behavioral Health Independent Provider Council, Hospital and Specialty Care Transformation Council, Program Improvement Advisory Committee, Member and Family Advisory Council, Community Leadership Council). The Directors Committee will be informed by representation and feedback from six Advisory Councils to provide a clear method for participation by community stakeholders, Members and families, behavioral health providers, primary care providers and hospitals in the development of population health strategies and delivery of interventions.

The Advisory Councils will provide direct input to our Population Health Management Plan, and will guide ongoing improvements to our risk stratification model and spectrum of population health interventions. The Population Health Management Plan will be available to all Network Providers, Members and community partners. Network Providers will receive ongoing support to improve the health literacy of their Members, operational assistance to deliver evidence-informed interventions, and practice transformation support to enhance internal capacity to address population health needs.

Additionally, the Partners' inclusive, community-based governance model and practice transformation resources are explicitly designed to align with major model tests and transformation initiatives underway within Colorado. These include the State Innovation Model's **Regional Health Connector** initiative, as well as the **Accountable Health Communities Model** test, which is currently receiving substantial support from RMHP and partner organizations in Region 1.

Our Directors Committee and Advisory Council swill integrate leadership from community health alliances and local public health agencies into the planning, execution and evaluation of our population health management plan. The Population Health Management Plan will be submitted to the Department 60 days after the Contract's Effective Date, and will be updated annually and with any changes to our population health strategy.

Below are the major social, behavioral and physical health interventions we are developing for ACC Phase 2, in the presentation and detailed documentation format set forth in Exhibit I.

Pediatric Population Health Initiatives

Stratification Level	Low PH Risk / Complexity Low BH Risk / Complexity	High PH Risk / Complexity Low BH Risk / Complexity	Low PH Risk / Complexity High BH Risk / Complexity	High PH Risk / Complexity High BH Risk / Complexity
Sugar/Sweetened Beverage Campaign	X	X	X	X
Subsidize Fitness for Overweight Members		X		X
Increase SNAP/WIC referrals	X	X	X	X
School-based Health Clinic Nutrition Assessment		X		X
Promote Dentaquest Preventistry Program	X	X	X	X
School-based Sealants Program	X	X	X	X
Dental Annual Wellness Mailings	X	X	X	X
Disease-Specific Annual Wellness Mailings		X		X
Communities that Care	X	X	X	X
Adolescent Substance Abuse Screening			X	X
MyStrength			X	X
Medication-Assisted Therapy			X	X
School-based Models for Substance Abuse Prevention			X	X
Mental Health First Aid	X	X	X	X
Zero Suicide			X	X
Positive Psychology	X	X	X	X
Primary Care Depression Screenings (PHQ-9)	X	X	X	X
Adverse Childhood Experience (ACES) Screening	X	X	X	X
Crisis Services – Behavioral Health			X	X
Assertive Community Treatment (ACT)			X	X
LARC Availability	X	X	X	X

Stratification Level	Low PH Risk / Complexity Low BH Risk / Complexity	High PH Risk / Complexity Low BH Risk / Complexity	Low PH Risk / Complexity High BH Risk / Complexity	High PH Risk / Complexity High BH Risk / Complexity
Promote Over-the-Counter Oral Contraception	X	X	X	X
Combine Education Family Planning and Contraception Access	X	X	X	X
In Case You're Curious Text Line	X	X	X	X
Nurse Family Partnerships	X	X	X	X
B-4 Baby	X	X	X	X
Ages and Stages	X	X	X	X
Baby and Me Tobacco Free	X	X	X	X
Housing Screening and Referral Based on Housing Risk	X	X	X	X

POPULATION HEALTH MANAGEMENT PLAN

Name of Intervention: Sugar and Sweetened Beverage Campaign

Description: RMHP will conduct a campaign to reduce consumption of sugar and sweetened beverages in Medicaid members. The target of this program is all Medicaid Members. The intervention will be a multi-pronged informational campaign including direct to member information and will include engaging with schools, hospitals and other willing partners to reduce access to sugar and sweetened beverages. Several LPHAs in this Region are working in this area already, and we will offer our assistance. The desired outcomes of our obesity and healthy eating initiatives can be measured by the percent of overweight and obese patients as well as the proportion of diabetic and prediabetic patients.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: We will collaborate with LPHAs and partner organizations in nutrition, assessing readiness to change for facilities and schools.

Potential Outcomes: The rise of sweetened beverages has plateaued over the last decade. However, they still contribute roughly 9% to Americans' caloric intake, far more than nutritional guidelines recommend.[63] Many institutions that have implemented healthy food and beverage rules have seen the intake of these beverages drop dramatically.[64] Reducing sweetened

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[63] Nielsen SJ, Popkin BM. Changes in beverage intake between 1977 and 2001. Am J Prev Med. 2004;27:205-10.
[64] Niebylski ML, Lu T, Campbell NRC, et al. Healthy Food Procurement Policies and Their Impact. International Journal of Environmental Research and Public Health. 2014;11(3):2608-2627. doi:10.3390/ijerph110302608.

beverage intake in children and adults has the potential to reduce rates of obesity, diabetes, and other weight-related conditions.

Name of Intervention: Subsidize Fitness for Overweight Members

Description: With a doctor's prescription (as part of a weight loss plan), Members can qualify for discounted rec center memberships. The RAE partners will work with local recreation and exercise providers to subsidize low-cost classes or memberships for obese, overweight, and at-risk Members. Members eligible for this program—those with a weight loss plan for overweight or obesity—will be identified based on diagnoses of those conditions and by "prescription" from a provider. The desired outcomes of our obesity and healthy eating initiatives can be measured by the percent of overweight and obese patients as well as the proportion of diabetic and prediabetic patients.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: Prescriptions will be provided by a PCMP or a CMHC as part of a patient's weight loss plan.

Potential Outcomes: Low-income individuals are 50% less likely to utilize exercise as a weight-loss method.[65] Many cannot afford gym memberships, and some live in neighborhoods unsafe for outdoor exercise. This practice has been shown to increase activity by up to 10% for at least a year.[66] Often, exercise is a family affair.

Name of Intervention: Referrals to SNAP and WIC

Description: All clinical sites will screen for food insecurity. Members identified as food insecure will receive support from care coordinators in applying for SNAP or WIC benefits. The target population is low-income and food insecure members. The desired outcome is an increased number and proportion of eligible Medicaid clients who participate in SNAP/WIC.

Type: Promising Practices

How the frequency of intervention will be determined: Assessment for food insecurity will be conducted in primary care, behavioral health and hospital encounters.

How the method of delivering the intervention will be determined: All Members will be screened for food insecurity and referred if they are identified as food insecure. Members engaged in care coordination can receive 1:1 support in applying for SNAP or WIC.

Potential Outcomes: Increased utilization of WIC benefits. Only about 66% of eligible individuals participate in SNAP or WIC. Most SNAP and WIC dollars go to families, and 67% of

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[65] Kakinami, L., Gauvin, L., Barnett, T. A., & Paradis, G. (2014). Trying to lose weight: the association of income and age to weight-loss strategies in the US. American journal of preventive medicine, 46(6), 585-592.

[66] Landro, L. "Doctors Dole Out Prescriptions for Exercise." Wall Street Journal, December 8th, 2014. https://www.wsj.com/articles/doctors-dole-out-prescriptions-for-exercise-1418080961

SNAP dollars go to families with children.[67] Having options for healthy food can help increase nutrition.

Name of Intervention: School-Based Health Clinic Nutrition Assessment

Description: Pediatric Members at risk of weight problems are eligible to receive school-based nutrition assessments as well as basic education on the importance of activity and diet to their health. The target population for this intervention is school-age Members identified as overweight or obese. They will be identified through school-based or clinic-based weight screenings, which children receive during EPSDT screenings. The effectiveness of this program is measured by reduction in BMI after the nutrition assessment.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing during the school year

How the method of delivering the intervention will be determined: The RAE will verify that school health clinics across the region have the tools and resources to do nutrition and weight assessments. HIE data will allow tracking of children who are overweight or obese and the RAE will work with school clinics to confirm they are receiving care.

Potential Outcomes: Pediatric obesity is associated with a number of chronic health conditions, including Type II Diabetes, hypertension, joint problems, asthma, sleep apnea, heart disease, and gout.[68] Early assessment and treatment of this problem is essential. We know that obesity is not only a physical disease but a condition with socioeconomic determinants. Utilizing both health care and social service supports to establish a healthy lifestyle early in life can avoid major health problems later in life.

Name of Intervention: Promote Dentaquest Preventistry Program

Description: DentaQuest, the dental benefits provider for Colorado Medicaid, works with primary dentists to help them identify and treat eligible Members, focusing on preventative care such as sealants. Dentaquest gives dentists a list of Medicaid clients seen in their office in the last year and notifies them when the Member is due for preventative care. DentaQuest follows up with evaluations of the provider's performance in relation to peers.

All dentists who accept Medicaid clients are eligible for this program. The intervention involves working with Dentaquest to improve uptake of this program among dental providers. The RAE will work with Dentaquest to identify opportunities for collaboration. The success of this program will be measured by the number of dentists participating in Preventistry.

Type: Evidence-Based

How the frequency of intervention will be determined: The timeline for this intervention will be determined in conjunction with Dentaquest.

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[67]USDA Food and Nutrition Service, "A report finds that SNAP Benefits are Crucial for Families but Sometimes Inadequate." https://www.fns.usda.gov/pressrelease/2015/wh-120815
[68] CDC, 'Childhood Obesity Facts." https://www.cdc.gov/healthyschools/obesity/facts.htm

How the method of delivering the intervention will be determined: RMHP will partner with DentaQuest to promote this service among dental providers, many of whom work in conjunction with our partner providers and schools.

Potential Outcomes: Sealants can reduce cavities by up to 80% when delivered early. However, only 50% of pediatric Medicaid clients saw a dentist last year.[69] Having systematic follow-up could increase the rates of clients who get simple interventions, many of which can be provided by a hygienist.

Name of Intervention: School-Based Sealants Program

Description: Many schools are eligible for school-based dental clinics, but do not take advantage of them. It is recommended that low-income schools be home to a primary care and dental clinic, but less than 50% of eligible Colorado school partake in this program. These dental clinics focus on preventative care such as fluoride, sealants, and early treatment of cavities.

We will identify schools that are eligible for this program, discussing their participation with school administrators familiar with the schools. The success of this program will be measured by the proportion of students who get sealant treatment.

Type: Evidence-Based

How the frequency of intervention will be determined: Yearly

How the method of delivering the intervention will be determined: RMHP and providers will work with schools identified as eligible for this program, which many of the schools in this region are.

Potential Outcomes: Sealants can reduce cavities by up to 60% when delivered early. However, only 50% of pediatric Medicaid clients saw a dentist last year. Having systematic follow-up could increase the rates of clients who get simple interventions, many of which can be provided by a hygienist.

Name of Intervention: Annual Dental Wellness Mailings

Description: In order to improve uptake of dental services, we will include an annual reminder to use their dental benefits in our Member communications.

Type: Promising Practices

How the frequency of intervention will be determined: Annual

How the method of delivering the intervention will be determined: Information will be mailed or emailed.

Potential Outcomes: Less than 50% of children on Medicaid see a dentist each year. While the Preventistry program targets children who have seen a dentist recently, this program could

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[69]Fox, M. "Dental Sealants Prevent Cavities and More Kids Need Them, CDC Says." NBC News Oct. 18th, 2016. http://www.nbcnews.com/health/kids-health/dental-sealants-prevent-cavities-more-kids-need-them-cdc-says-n668266

help remind parents to make appointments for both their children and themselves. Early prevention of dental issues helps improve a host of physical health issues.

Name of Intervention: Disease-specific Wellness Mailings

Description: We will use claims data and disease registries to identify clients with conditions amenable to systematic improvement, such as hypertension and diabetes. Appropriate health-related information will be mailed to patients and their parents We can measure improvement in a range of conditions through regular labs and vital signs, such as blood pressure for hypertension or A1c for diabetes. We can also monitor prescription drug utilization for these conditions to optimize therapy.

Type: Promising Practices

How the frequency of intervention will be determined: Quarterly, annually

How the method of delivering the intervention will be determined: Information will be mailed or emailed.

Potential Outcomes: Patients will have appropriate health-related information and will be informed consumers of their health care.

Name of Intervention: Communities that Care

Description: A CDC-supported public health, community-based approach to prevent negative behaviors by youth. Communities that Care (CTC) provides a structure for engaging community stakeholders, a process for establishing a shared community vision, tools for assessing levels of risk and protection in communities, and processes for prioritizing risk and protective factors and setting specific, measurable, community goals. CTC guides the creation of a strategic community prevention plan designed to address the community's profile of risk. The success of CTC is based on reductions in violence, truancy, and substance use, which can be measured with school absenteeism statistics and risk surveys such as BRFSS.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: RMHP and Partners will work with willing anchor institutions across the region to implement Communities that Care.

Potential Outcomes: Substance abuse, tobacco use, and violence have been shown to be reduced in communities that implement CTC.[70] Given the pervasive effects of juvenile delinquency, this investment in the youth of our communities provides for a bright future.

Name of Intervention: Adolescent Substance Abuse Screenings

Description: Several validated screening tools are in broad use for adults and pediatric primary care populations, including AUDIT-C, CAGE, and SBIRT. We will ensure that screenings are carried out for all patients, preferably during EPSDT screenings

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[70] Communities that Care Plus, "Research and Results." http://www.communitiesthatcare.net/research-results/

The target population for this intervention is adolescents ages 12 to 18. The intervention is a yearly screening exam. Training physicians on these screening exams and their response in the case of a positive screen can improve uptake of these tools. We can measure screening exams through the utilization of EPSDT and look at rates of youth substance abuse and suicide as indirect measures of this program's success.

Type: Promising Practices

How the frequency of intervention will be determined: Annual

How the method of delivering the intervention will be determined: In person but screenings can be carried out online or via telephone. These screenings will be done during yearly wellness visits.

Potential Outcomes: Less than half of pediatricians screen adolescents for use of tobacco, alcohol, and other drugs, and even fewer report confidence in treating these issues. With estimates of substance use disorders in adolescents of 5-6%, and with substance use during adolescence correlating with later substance use disorders, these are important public health issues.[71]

Name of Intervention: Mystrength.com

Description: This website, and associated mobile app, is self-billed as the "health club for your mind". It provides adolescents with personalized information to enhance the therapeutic process and/or as a way to learn about topics including, but not limited to symptom reduction, stress management, coping skills, trigger avoidance, distraction, parenting, feelings identification, and spirituality. Activities and information are based in Cognitive Behavioral Therapy ideals.

Type: Promising Practice

How the frequency of intervention will be determined: As per patient-centered theory, individuals have the choice to participate in this type of intervention outside of the therapeutic setting. Individuals are able to utilize this service as often as deemed necessary.

How the method of delivering the intervention will be determined: Mystrength.com is promoted at all locations of Mind Springs Health and West Springs Hospital. Information is available on Mind Springs Health website and is distributed to agency partners. Anyone, regardless of their status as a patient of Mind Springs Health, is welcome to this service.

Potential Outcomes: This therapy extender may assist patients with behavioral health diagnoses to complete therapeutic activities in between sessions. This may reinforce skills learned in therapy and enhance the recovery process. Decreased symptomology related depression, anxiety, chronic pain, and substance use may be observed.

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[71] Winters KC, Kaminer Y. Screening and Assessing Adolescent Substance Use Disorders in Clinical Populations. Journal of the American Academy of Child and Adolescent Psychiatry. 2008;47(7):740-744. doi:10.1097/CHI.0b013e31817395cf.

Name of Intervention: Medication-Assisted Therapy Hub-and-Spoke Model

Description: Medication-Assisted Therapy (MAT) for substance dependence, most often opioid dependence, utilizes one of three medications, methadone, buprenorphine, and naltrexone, all of which are covered by Medicaid, to help Members maintain long-term recovery. However, there are too few providers to keep up with demand.

The target population for this intervention is primary care providers and some specialists who are interested in caring for their clients' opioid use disorders. The intervention is helping providers get trained in MAT and coordinated with the hub-and-spoke model. We will identify the target population through established peer networks, existing MAT trainings, and outreach to midlevel providers. We will measure the success of this program by the number of providers who take trainings, the number of providers within the hub-and-spoke model, and the number of buprenorphine prescriptions.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: The intervention will be delivered to providers in person, by telephone, and via email. Depending on their readiness to engage, the intervention could consist of them attending a training or simply consulting with the hub-and-spoke team to discuss clients.

Potential Outcomes: Buprenorphine-- the preferred MAT drug-- can only be prescribed by providers who take a special education course. Of those who take the course, less than 50% ever prescribe the medication.[72] Many who do prescribe it do not accept Medicaid.

We propose establishing a Hub-and-Spoke model, developed in Vermont that allows for coordination of providers within the Region.[73] This would allow more experienced addiction specialists to take more difficult cases in the "hub" and then refer them to trusted "spokes" in local areas.

Name of Intervention: School-Based Models for Substance Abuse Prevention

Description: While DARE has given school-based substance abuse programs a reputation for ineffectiveness, there are school programs that have been shown effective. These include PATHS, Second Step, Across Ages, and Positive Action. The curriculums are designed to be used by educators and counselors in a multi-year, universal prevention model. To encourage parent involvement and support, parent letters, home activity assignments, and additional information are also provided. The success of these programs is based on reductions in violence, truancy, and substance use, which can be measured with school absenteeism statistics and risk surveys such as BRFSS.

Type: Evidence-Based

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[72] Stein BD, Gordon AJ, Dick AW, et al. Supply of Buprenorphine Waivered Physicians: The Influence of State Policies. Journal of substance abuse treatment. 2015;48(1):104-111. doi:10.1016/j.jsat.2014.07.010.
[73] Care Alliance for Opioid Addiction: "The Hub and Spoke Model." March 2017.
http://docs.wixstatic.com/ugd/bfe1ed_fe1ef90362ad45e0bd8da6111244b59f.pdf

How the frequency of intervention will be determined: Yearly

How the method of delivering the intervention will be determined: In conjunction with school and community leaders. All schools will be offered tools resources and support to execute the program of their choice.

Potential Outcomes: Model programs for substance abuse have been shown to diminish substance abuse in adolescents as well as decrease a number of negative behaviors, including aggression. They work for a males and females and a range of ethnic and cultural groups.[74]

Name of Intervention: Mental Health First Aid (MHFA) Training – Youth

Description: MHFA is a course designed to provide youth with the skills to help other youth who may be experiencing mental health crises or problems. Goals of training include decreasing stigma associated with mental illness, helping the public respond appropriately, and building mental health literacy. These endpoints can be measured through rates of suicide and bullying.

Type: Evidence-Based

How the frequency of intervention will be determined: Courses are offered by a variety of trainers throughout the year.

How the method of delivering the intervention will be determined: The course is offered in a classroom setting. It may be presented in one day or over multiple sessions.

Potential Outcomes: Outcomes include hundreds of educated and informed community members. Youth who are trained in mental health first aid may be less likely to engage in or fall victim to bullying.[75]

Name of Intervention: Zero Suicide

Description: The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems. It is a practice- and systems-based intervention that makes suicide prevention and mental health screenings viable in primary practices, giving technical advice and assessment tools to providers. We will identify providers through professional networks as well as referrals. We will measure the success of this program by looking at rates of depression and suicide in the target areas.

Type: Evidence-Based

How the frequency of intervention will be determined: Zero Suicide works with providers to improve their practices on an ongoing basis.

How the method of delivering the intervention will be determined: In person

Potential Outcomes: Zero Suicide is a key strategy of the 2012 National Strategy for Suicide Prevention and a SAMSHA-endorsed intervention to improve systems wide mental health.

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[74] CDC, "ACE Prevention Strategies." https://www.cdc.gov/violenceprevention/ace/prevention_strategies.html
[75] Mental Health First Aid, "Research and Evidence Base."
https://www.mentalhealthfirstaid.org/cs/about/research/

Suicide is a leading cause of death among 10-to 34-year-olds in rural areas,[76] so reducing the stigma and improving treatment for this age group is very important.

Name of Intervention: Positive Psychology

Description: Positive Psychology is the scientific study of the strengths that enable individuals and communities to thrive. The field is founded on the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play. Positive psychology emphasizes strengths and experiences that promote optimism and progress in Members.

Positive psychology is delivered to adolescents in a classroom-based setting. We can measure the success of this program through rates of suicide and utilization of mental health services.

Type: Evidence-Based

How the frequency of intervention will be determined: The frequency will be determined in conjunction with participating schools.

How the method of delivering the intervention will be determined: In person

Potential Outcomes: Positive psychology has been shown to improve affect and behavioral health. Implementing this broadly for both young and adult clients can improve overall community functioning.

Name of Intervention: Primary Care Depression Screenings

Description: Screening for depression in youth, using a validated assessment tool such as PHQ-9, can help identify and treat this condition before it progresses. The USPTF recommends screening for depression in youth ages 12 to 18. The target of this intervention is all adolescents and it will be delivered during office visits, preferably during EPSDT screenings. We can measure the success of this programming through EPSDT rates as well as the number of adolescents undergoing counseling or pharmacotherapy for depression.

Type: Evidence-Based

How the frequency of intervention will be determined: Annual screening is recommended

How the method of delivering the intervention will be determined: In person or on paper during EPSDT screening.

Potential Outcomes: Suicide is one of the leading causes of death in youth. Screening for and treating depression can reduce suicide as well as a range of negative behaviors.[77] Furthermore, studies have shown that the simple act of screening can help open a dialogue between provider and client that leads to productive exchanges and education.

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[76] Kegler SR, Stone DM, Holland KM. "Trends in Suicide by Level of Urbanization — United States, 1999–2015." MMWR 66(10): 270–273. Published: 17-March-2017. DOI: 10.15585/mmwr.mm6610a2.

[77] USPSTF, "Final Recommendation Statement: Depression in Children and Adolescents: Screening." https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1

Name of Intervention: Adverse Childhood Experience (ACES) Screening

Description: Adverse childhood experiences, such as physical or sexual abuse, loss of a loved one, or divorce, have pervasive effects on youth. Screening for these experiences and referring pediatric clients with positive screens can lead to closure and more effective outcomes.

The target for this intervention is adolescents. We will train providers on this intervention and try to include it in yearly screens for substance abuse and depression. The measurement is the proportion of positive screens who receive counseling.

Type: Promising Practices

How the frequency of intervention will be determined: Screening is recommended annually

How the method of delivering the intervention will be determined: In person or on paper during regular visits.

Potential Outcomes: Medicaid clients may have a higher rate of ACES than non-Medicaid clients, so it is particularly important to ensure that young Members are screened for ACES. Since this condition is potentially treatable with therapy and screenings for this are easy, it is worthwhile to screen. Furthermore, studies have shown that the simple act of screening can help open a dialogue between provider and client that leads to productive exchanges and education.

Name of Intervention: Crisis Services-Behavioral Health

Description: Crisis services operate 24 hours a day, seven days a week. Anyone-- including youth-- in a crisis can call or walk-in to the crisis center and speak with a trained professional who provides confidential and immediate help and support. We also provide information for referrals and connection for on-going services and supports.

The target for this intervention is youth undergoing stressful situations, substance use disorders, or mental health crises. We will connect the target population through publicizing the Crisis Services phone number in our materials for both clients and providers. We will measure the success of this program based on the utilization of crisis services.

Type: Evidence-Based

How the frequency of intervention will be determined: Services are offered 24 hours a day, seven days a week.

How the method of delivering the intervention will be determined: In a moment of crisis, any young person can speak face-to-face, or via telephone, with a trained professional and participate in a comprehensive assessment. Crisis staff members are able to provide mobile services to anywhere in the community, if conditions are safe.

Potential Outcomes: Individuals receive the care needed when they are in a crisis situation. This allows them to remain safely in the community or to receive the appropriate level-of-care needed to remain safe.

Name of Intervention: Assertive Community Treatment (ACT)

Description: Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for people with severe mental illness who are most at risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system. We already utilize this model through several partner organizations and will implement it further.

The target audience for this intervention is Members with severe, persistent mental illness (SPMI). We can connect them with this service through a variety of diagnostic codes indicating SPMI, combinations of medication claims, and referrals by service providers. We can measure the effectiveness of this program through the SIE by determining Members' utilization of emergency services as well as other life events like incarceration.

Type: Evidence-Based

How the frequency of intervention will be determined: As needed. The need for ACT services is determined on an individual basis, but often take place outside of normal business hours.

How the method of delivering the intervention will be determined: In person or by telephone

Potential Outcomes: ACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness. Studies have shown that ACT reduces psychiatric hospitalizations, shortens hospital stays, and helps clients stay in the community.[78]

Name of Intervention: Long-Acting Reversible Contraception (LARC)

Description: Long-acting reversible contraception (LARC) allows women reliable contraception without taking a medication daily. Since 2009, Colorado has offered LARC to females of all ages at no cost. We will help Members access this highly effective form of contraception.

The target audience for this intervention is women of child-bearing age who do not wish to be pregnant. They are identified through conversations with health care providers or other service providers and referred to a health care provider who can place a LARC device. The measurement of the success of this program is through rates of teen and unplanned pregnancies.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: In person during provider visits and discussions with service providers. RMHP will work with all providers serving child-bearing age women to ensure they have the information and resources to provide interested women with LARCs.

Potential Outcomes: Colorado has experienced a 50% drop in both teen pregnancy and teen abortion since it funded long-acting reversible contraception. This has saved nearly $70 million

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[78] Ziguras, S., & Stuart, G. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatric Services, 51, 1410–1421.

in public assistance, not to mention the negative outcomes associated with unplanned pregnancies.[79]

Name of Intervention: Promote Over-the-Counter Oral Contraception

Description: Oral contraception, a widely-used for of birth control previously only available by prescription, was recently made available from a pharmacy without a prescription. Women need only meet the requirements and fill out a form to receive oral contraceptives. We plan to promote this idea, since the doctor visit is cited frequently as a barrier to using oral contraceptives, especially for adolescents. Oral contraceptives are covered by Medicaid.

The target audience for this intervention is women of child-bearing age who do not wish to be pregnant. The measurement of the success of this program is through rates of teen and unplanned pregnancies.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: In person and by phone. Anyone can inform Members about the availability of OTC contraception.

Potential Outcomes: Colorado has experienced a 50% drop in both teen pregnancy and teen abortion since it funded long-acting reversible contraception. Having over-the-counter birth control easily available for all could help to improve these rates even further.

Name of Intervention: Combined Family Planning Counseling and Contraception Access

Description: Studies have shown that abstinence-based education does not reduce sexual activity in teens. However, combined education and access to contraception can lower rates of pregnancy, and some studies have even shown this combination to reduce early sexual activity.

The target audience for this intervention is women of child-bearing age who do not wish to be pregnant. They can be identified through provider visits either in the office or at school-based health centers. The measurement of the success of this program is through rates of teen and unplanned pregnancies.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing in providers' offices

How the method of delivering the intervention will be determined: In person by providers, either in offices or school-based health centers.

Potential Outcomes: Reducing teenage pregnancy is a prime goal of several public health initiatives including the Colorado Opportunities Project and 10 Winnable Battles. While there has been great success with LARC, many teens do not utilize LARC. Furthermore, many are misinformed about contraception and sexual education. Improving education and access to

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[79] Colorado Department of Public Health and Environment, "Colorado's success with long-acting reversible contraception." January 2017 https://www.colorado.gov/pacific/cdphe/cfpi-report

contraception can reduce public assistance costs as well as provide for more sound futures for teens.

Name of Intervention: In Case You're Curious Text Line

Description: Text message line for questions about reproductive health. All texts are anonymous and confidential and answered with medically accurate information by an expert.

The target audience for this intervention is adolescents who are sexually active or considering becoming sexually active. They will be identified by texting the hotline; the number for the hotline is promoted in schools, at providers' offices, and on the World Wide Web. The success of this program can be measured by number of texts as well as STD and pregnancy rates.

Type: Promising Practices

How the frequency of intervention will be determined: Texts are answered within 24 hours.

How the method of delivering the intervention will be determined: SMS or text message.

Potential Outcomes: The program, aimed at teens, could result in more accurate information about reproductive health. Furthermore, it can open a dialogue between health educators and teens.

Name of Intervention: Nurse-Family Partnerships (NFP)

Description: NFP involves ongoing home visits from registered nurses to low-income, first-time moms who receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. From pregnancy until the child turns two years old, NFP Nurse Home Visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

The success of this program can be measured by a range of indicators of infant health, such as miscarriage rates, low-birth-weight babies, SIDS, maternal smoking, number of successive pregnancies, and breastfeeding rates.

Type: Evidence-Based

How the frequency of intervention will be determined: Monthly visits from pregnancy until the child is two years old.

How the method of delivering the intervention will be determined: Eligible moms can be referred by health care providers and social service professionals. They meet in the home.

Potential Outcomes: Many studies have shown the benefit of nurse family partnerships, including decrease injuries to children, improved prenatal health, fewer subsequent pregnancies, increased maternal employment, and improved school readiness.[80]

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[80] Evidence-Based Programs, "Social Programs that Work," http://evidencebasedprograms.org/1366-2/nurse-family-partnership

Name of Intervention: B-4 Baby

Description: Helps low-income pregnant women connect with and attend prenatal visits, improving the health of mothers and their children. This program also connects Members with social service resources and involves fathers in pregnancies. Translation and transportation services are provided for expecting mothers. This program is currently operating in Region 1 through RMHP and several partner organizations.

Eligible Members are identified based on referrals from providers and care coordinators and could be identified through SIE data in the future. The success of this program can be measured by a range of indicators of infant health, such as miscarriage rates, low-birth-weight babies, SIDS, maternal smoking, number of successive pregnancies, and breastfeeding rates.

Type: Evidence-Based

How the frequency of intervention will be determined: Services are offered throughout the course of pregnancy and early childhood.

How the method of delivering the intervention will be determined: Mostly in person but also by telephone

Potential Outcomes: Our state has very high rates of low birth weight babies. Good prenatal care has been shown to improve rates of low birth weight, which has pervasive effects on children. This model has been shown to work by the US Department of Health and Human Services.[81]

Name of Intervention: Ages and Stages

Description: Children or a guardian (depending on age) are given an assessment to fill out that measures developmental milestones. The assessment provides an immediate risk level. Based on the resulting scores, the provider may make a referral to a specific intervention or specialist, such as speech therapy, PT, ophthalmology, or an integrated behavioral health clinic.

The target audience for this intervention is all children. The assessment would ideally be given at EPSDT screenings. The measurement of success is the number of preventable complications averted. For example, certain types of hip problems can be prevented through proper early screening for hip dysplasia.

Type: Evidence-Based

How the frequency of intervention will be determined: At regular well-child visits

How the method of delivering the intervention will be determined: In person

Potential Outcomes: Ensure that children meet developmental milestones. Meeting developmental milestones is associated with a host of improved outcomes in adolescence and

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[81] Lofholm, N. "Mesa County's B4 Babies is model for prenatal care." Denver Post October 4th, 2009. http://www.denverpost.com/2009/10/04/mesa-countys-b4-babies-is-model-for-prenatal-care/

adulthood.[82] Furthermore, some developmental delays, such as orthopedic problems, can be easily treated when detected early.

Name of Intervention: Baby and Me Tobacco Free

Description: An evidence-based smoking cessation program for expecting mothers and people who live with them. Women attend counseling programs and earn diaper vouchers by staying abstinent from tobacco. Our partner organizations and providers refer women to the program.

The target audience for this intervention is newly pregnant women who use tobacco. They can be identified through referrals from health care and social service providers as well as through the SIE in the future. The measure or the success of this program is based on rates of smoking throughout pregnancy and indirectly on the rate of low-birth weight babies.

Type: Evidence Based

How the frequency of intervention will be determined: Women have four prenatal counseling sessions and can also earn diaper vouchers for a year after birth.

How the method of delivering the intervention will be determined: In person

Potential Outcomes: Smoking during pregnancy is associated with a range of adverse birth outcomes, including preterm birth, low birth weight, and fetal and infant mortality. Quitting smoking before or even during pregnancy can significantly lower these risks.[83]

Name of Intervention: Housing Screening and Referral

Description: There are several free, standardized tools to screen for the need for housing assistance. These allow our social service partners to assess housing needs and resources in a standardized fashion and determine whether Members qualify for housing assistance.

The target audience for this intervention is Members who are marginally housed or insecure in their housing. They can be identified through referrals from health care and social service providers as well as through the SIE in the future. The measure or the success of this program is based on the rate of Members who are identified as housing-insecure or homeless through the SIE.

Type: Promising Practices

How the frequency of intervention will be determined: Upon contact with new clients and during life changes thereafter

How the method of delivering the intervention will be determined: In person or by phone

Potential Outcomes: Ensure that Members have adequate and safe housing. When people are adequately housed, they have less exposure to environmental toxins, less stress, and better

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[82] Murray GK, Jones PB, Kuh D, Richards M. Infant Developmental Milestones and Subsequent Cognitive Function. Annals of Neurology. 2007;62(2):128-136. doi:10.1002/ana.21120.

[83] National Vital Statistic Reports, "Smoking Prevalence and Cessation Before and During Pregnancy: Data from the Birth Certificate, 2014." February 10, 2016. https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_01.pdf

nutrition. People who are housed have fewer mental health crises and often reduce their use of substances.[84]

ADULT POPULATION HEALTH INITIATIVES

Many of the pediatric population interventions described above are also applicable to adults. All interventions applicable to the adult population are listed in the chart below; summaries provided above are not duplicated.

Stratification Level	Low PH Risk / Complexity Low BH Risk / Complexity	High PH Risk / Complexity Low BH Risk / Complexity	Low PH Risk / Complexity High BH Risk / Complexity	High PH Risk / Complexity High BH Risk / Complexity
Lactation Consultant	X	X	X	X
Sugar/Sweetened Beverage Campaign	X	X	X	X
Subsidize Fitness for Overweight Members		X		X
Increase SNAP/WIC	X	X	X	X
Text4 Health		X		X
Bariatric Surgery	X	X	X	X
Annual Dental Wellness Mailing	X	X	X	X
Disease-Specific Wellness Mailings		X		X
Care4Life Diabetes Text Line	X	X	X	X
Text2 Quit		X		X
Medication Therapy Management	X	X	X	X
Comprehensive Home-Based Telehealth		X		X
Care Management for Super Utilizers		X		X
Intensive Care Transitions—RED		X		X
Screening for Substance Abuse in Primary Care	X	X	X	X
Motivational Interviewing		X	X	X
MyStrength			X	X
Medication-Assisted Therapy			X	X

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[84] Maqbool N, Viveiros J, Ault M. "The Impacts of Affordable Housing on Health: A Research Summary." Center for Housing Policy April 2015. http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf

Stratification Level	Low PH Risk / Complexity Low BH Risk / Complexity	High PH Risk / Complexity Low BH Risk / Complexity	Low PH Risk / Complexity High BH Risk / Complexity	High PH Risk / Complexity High BH Risk / Complexity
Mental Health First Aid	X	X	X	X
Zero Suicide			X	X
Primary Care Depression Screenings (PHQ-9)	X	X	X	X
Crisis Services-Behavioral Health			X	X
Assertive Community Treatment (ACT)			X	X
LARC Availability	X	X	X	X
Promote Over-the-Counter Contraception	X	X	X	X
Nurse Family Partnerships	X	X	X	X
B-4 Baby	X	X	X	X
Baby and Me Tobacco Free	X	X	X	X
Text 4 Baby	X	X	X	X
Screen and Refer Based on Housing Risk	X	X	X	X
Supportive Housing			X	X
Energy Outreach and Assistance	X	X	X	X

[Note: Interventions applicable to both pediatric members and adult members are only described under pediatric]

Name of Intervention: Lactation Consultant

Description: Lactation consultants help new mothers learn how to breastfeed their babies. They also help them gain access to lactation equipment, such as breast pumps, to sustain breastfeeding. Often, lactation consultants visit new mothers in the hospital, but a lack of access can result in new mothers not breastfeeding for the recommended 6 months. We currently have a project in progress to ensure that mothers meet with a lactation consultants both pre- and post-natal.

The target audience for this intervention is pregnant women. They can be identified through referrals from health care and social service providers as well as through the SIE in the future. The measure or the success of this program is based on the rate of breastfeeding.

Type: Evidence-Based

How the frequency of intervention will be determined: At least two outpatient visits, prenatal and postnatal

How the method of delivering the intervention will be determined: In-person

Potential Outcomes: Breastfeeding has any number of positive outcomes that last for many years beyond birth and into adulthood. These include improved birth weights, immunity, and bonding.[85] While Colorado has breastfeeding rates slightly above the national average, it trails some other states significantly. Furthermore, WIC participants in Colorado have lower breastfeeding rates than non-WIC participants, so improving breastfeeding in a Medicaid population is particularly important.[86]

Name of Intervention: Text 4 Health

Description: Text4Health is a mobile health program with the goal of improving immunization rates for underserved, low-income populations using text messaging. The program offers reminders for early childhood vaccinations as well as flu vaccines and allows participants to report adverse effects from vaccinations.

The target audience for this intervention is low-income mothers and fathers who use text messaging. They can be identified through referrals from health care and social service providers as well as through the SIE in the future. Furthermore, the app is promoted on the World Wide Web. The measure or the success of this program is based on the rate of completed immunizations series.

Type: Promising Practices

How the frequency of intervention will be determined: Per accepted vaccination schedules

How the method of delivering the intervention will be determined: SMS or text message

Potential Outcomes: In Colorado, rural counties have far lower vaccination rates than their urban counterparts, with some clusters of counties in regions 1 and 4 below 50% of recommended vaccination rates.[87] This program can help improve uptake of vaccinations through texts, as research has shown text message to be an effective method for delivering reminders.[88] Other text-based programs help people remember medical appointments and oral contraceptives.

Name of Intervention: Bariatric Surgery

Description: Bariatric surgery is a procedure of last result for obese adults who are facing life-threatening consequences of morbid obesity in the near future. We offer bariatric surgery at several of our partner hospitals and surgery centers.

The target audience for this intervention is morbidly obese people and obese people with complications of obesity. They are identified primarily through health care referrals. The

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[85] Lawrence, R. A. (2000). Breastfeeding: benefits, risks and alternatives. Current Opinion in Obstetrics and Gynecology, 12(6), 519-524.

[86] Colorado.gov "Colorado Breastfeeding Rates."
https://www.colorado.gov/pacific/sites/default/files/PF_BF_Colorado-Breastfeeding-Rates.pdf

[87] Colorado Children's Immunization Coalition "Vaccine-Preventable Disease Report."
https://www.childrensimmunization.org/uploads/Vaccine-preventable-disease-report-2016-FINAL-rev-5-19jkt.pdf

[88] Kannisto KA, Koivunen MH, Välimäki MA. Use of Mobile Phone Text Message Reminders in Health Care Services: A Narrative Literature Review. Eysenbach G, ed. Journal of Medical Internet Research. 2014;16(10):e222. doi:10.2196/jmir.3442.

measure of the success of this program is based on weight loss after surgery as well as the rates of morbid obesity in the population.

Type: Evidence-Based

How the frequency of intervention will be determined: Bariatric surgery is most often a once-in-a-lifetime intervention.

How the method of delivering the intervention will be determined: In-person

Potential Outcomes: Weight loss after bariatric surgery is significant and rapid. Clients of bariatric surgery lose, on average, between 71 and 117 pounds. Weight loss from bariatric surgeries is associated with reductions in some comorbidities of obesity, such as diabetes, metabolic syndrome and sleep apnea.

Name of Intervention: Care4 Life Diabetes Text Line

Description: Care4Life helps people living with diabetes improve their outcomes through healthy eating, weight management and blood glucose control through text reminders.

The target audience for this intervention is Members with diabetes. They are identified primarily through health care referrals. The measure or the success of this program is based on weight management, exercise, and blood glucose control.

Type: Promising Practices

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: SMS or text message

Potential Outcomes: Diabetes is associated with a range of chronic illnesses, including metabolic syndrome, hypertension, and kidney failure. Diabetes is also very common, with diabetes prevalence in Colorado increasing from 4.7% to 7.4% between 2002 and 2012.[89] Progression of diabetes can be prevented through exercise, weight management, and medication.

Name of Intervention: Text 2 Quit

Description: Text 2 Quit is a text-message based, free service that assists members in quitting smoking. It consists of an opt-in platform with personalized tips, motivation and support, and interactive tracking. It helps smokers create a personal quit plan.

The target audience for this intervention is Members who smoke. They are identified primarily through health care referrals and social service providers. The measure or the success of this program is based on smoking cessation rates.

Type: Evidence-Based

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[89]CDPHE, "Diabetes' Impact in Colorado." https://www.colorado.gov/pacific/sites/default/files/DC_fact-sheet_Diabetes_Nov-2013_without-Appendix.pdf

How the frequency of intervention will be determined: The intervention can last as long as the client desires.

How the method of delivering the intervention will be determined: SMS or text message

Potential Outcomes: While smoking rates have declined precipitously, there remain many people in the US who smoke, particularly in rural areas. The health consequences of smoking are well-documented. Research has shown text message to be an effective method for delivering reminders. Other text-based programs help people remember medical appointments and oral contraceptives.

Name of Intervention: Medication Therapy Management (MTM)

Description: MTM is provided by pharmacists whose aim is to optimize drug therapy and improve therapeutic outcomes for patients. MTM includes five core components: a medication therapy review (MTR), personal medication record (PMR), medication-related action plan (MAP), intervention and/or referral, and documentation and follow-up.

The target audience for this intervention is Members with multiple medications for chronic disease. They are identified primarily through health care referrals but could be identified through pharmacy claims as well. The measure or the success of this program is based on the number of medication interactions, pharmacy expenditures, and functionality.

Type: Promising Practices

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: In person, by telephone, or telepharmacy

Potential Outcomes: MTM has been shown to increase adherence to drug regimens in chronic conditions such as COPD, diabetes, and congestive heart failure, reducing hospitalizations and overall costs.[90]

Name of Intervention: Comprehensive Home-Based Telehealth

Description: For adults with multiple chronic conditions, doctor visits are frequent and difficult. Many adults with disabilities have trouble entering and exiting their homes and using automobiles or public transportation, contributing to no-shows, trouble getting medications, and non-adherence to medication regimens. Comprehensive home-based telehealth allows providers to not only talk with patients in their homes but also check vital signs, symptoms, and medication adherence.

The target audience for this intervention is primarily homebound or mobility-limited Members with multiple chronic conditions. They are identified primarily through health care referrals. The measure or the success of this program is based on the no-show rate for appointments, utilization of EMS, medication utilization, and patient activation.

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[90] Perlroth D, Marrufo G, Montesinos A, et al. Medication Therapy Management in Chronically Ill Populations: Final Report. Prepared for CMS by Acumen, LLC and Westat; 2013

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: Telehealth

Potential Outcomes: Patients with home-based telehealth have lower no-show rates. Nurses who utilized home-based telehealth saved many hours by not having to drive to patients' homes. Furthermore, concerning symptoms can be addressed immediately, sometimes without the use of NEMT, EMS, or ED.[91]

Name of Intervention: Care Management for Super Utilizers

Description: Intensive care management for super utilizers, defined as four or more unnecessary ED visits in a year, can help to reduce ED visits as well as overall costs. Pioneered in Camden, New Jersey, these programs pay close attention to social determinants of health as well as ensuring excellent outpatient care to help people stay healthy in the community. We utilize care management for super utilizers through Community Care and hope to improve this with the SIE. The success of this program is measured by ED utilization, medication utilization, and inpatient hospitalizations.

Type: Evidence-Based

How the frequency of intervention will be determined: As needed by the client.

How the method of delivering the intervention will be determined: In person and telephone, at regular primary care visits as well as social service provider and care coordinator interactions.

Potential Outcomes: Super-utilizers account for an outsize proportion of costs in health care. In New Jersey, where the pioneering work on intensive case management was done, 20% of clients accounted for 90% of the costs. Avoiding even one ED visit can save well over $500 and make Members feel more independent.[92]

Name of Intervention: Intensive Care Transitions, Project Re-Engineered Discharge (RED)

Description: Project RED is a systematic intervention to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce re-hospitalizations and yields high rates of patient satisfaction. We plan to implement Project RED or a similar standardized discharge plan.

The target audience for this intervention is Members being discharged from an inpatient hospitalization. They are identified primarily through ADT records and inpatient censuses. The measure or the success of this program is based on re-hospitalization and ED utilization post-discharge.

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[91] DelliFraine, J. L., & Dansky, K. H. (2008). Home-based telehealth: a review and meta-analysis. Journal of telemedicine and telecare, 14(2), 62-66.

[92] Johnson, T. L., Rinehart, D. J., Durfee, J., Brewer, D., Batal, H., Blum, J., ... & Gabow, P. (2015). For many patients who use large amounts of health care services, the need is intense yet temporary. Health Affairs, 34(8), 1312-1319.

Type: Evidence-Based

How the frequency of intervention will be determined: Every patient discharge utilizes project RED.

How the method of delivering the intervention will be determined: In person and by telephone

Potential Outcomes: Project RED, supported by the AHRQ, NIH, and several other major health care organizations, has the potential to reduce expensive and preventable readmissions. AHRQ stated that, in one study, Project RED avoided one ED visit per 7.3 discharges.[93]

Name of Intervention: Motivational Interviewing

Description: Motivational interviewing is a psychotherapeutic approach that attempts to move an individual away from a state of indecision or uncertainty and towards finding motivation to making positive decisions and accomplishing established goals. Motivational interviewing, once used primarily with substance use disorders, is now gaining favor to assist in other behavior changes, such as weight loss and smoking cessation. We provide information and trainings to our providers about motivational interviewing.

The target audience for this intervention is people with conditions that can be ameliorated, at least partly, through behavior changes, such as substance use disorder, diabetes, and depression. Individuals are identified primarily through health care providers, who usually also provide the intervention. The measure or the success of this program is based on goal behavior change specific to the condition; for instance, exercise for diabetes or abstinence for substance use disorders.

Type: Evidence-Based

How the frequency of intervention will be determined: At health care visits

How the method of delivering the intervention will be determined: In person or via telehealth

Potential Outcomes: Motivational interviewing, in a population study, significantly improved cholesterol levels, alcohol intake, blood pressure, and weight.[94] It is effective on both physical and behavioral health conditions and can be utilized in any setting. Furthermore, this modality improves patients' self-sufficiency.

Name of Intervention: Supportive Housing

Description: Supportive housing is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities. We partner with supportive housing organizations to ensure that Members in need of this service can access it.

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[93] Jack BW, et al. The Re-Engineered Discharge: A RCT of a Comprehensive Hospital Discharge Program. Annals of Internal Medicine 2009;150: In Press - Feb 2009.

[94] Rubak, S., Sandbæk, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: a systematic review and meta-analysis. Br J Gen Pract, 55(513), 305-312.

The target audience for this intervention is Members who are marginally housed or insecure in their housing. They can be identified through referrals from health care and social service providers as well as through the SIE. The measure or the success of this program is based on the rate of Members who are identified as housing-insecure or homeless through the SIE.

Type: Evidence-Based

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: In person

Potential Outcomes: Research has proven that supportive housing is a cost-effective solution to homelessness, particularly for people experiencing chronic homelessness. Many studies have shown that supportive housing not only resolves homelessness and increases housing stability, but also improves health and lowers public costs by reducing the use of publicly-funded crisis services, including shelters, hospitals, psychiatric centers, jails, and prisons.[95]

Name of Intervention: Energy Assistance

Description: Two programs, Energy Outreach Colorado, and the Low-Income Energy Assistance Program, help low-income residents of Colorado pay their energy bills. Our partner social service programs assess Members for eligibility and help them get connected with these programs.

The target audience for this intervention is Members who are low-income or marginally housed who have trouble paying for their energy bills. They can be identified through referrals from social service providers as well as through the SIE in the future. The measure or the success of this program is based on the percent of eligible members who received services.

Type: Promising Practices

How the frequency of intervention will be determined: Ongoing

How the method of delivering the intervention will be determined: In person and via telephone

Potential Outcomes: Many low-income residents, particularly those in rural areas, spend a significant portion of their income on energy. Improved home environment can lead to better control of chronic diseases like asthma.

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[95] Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent supportive housing: assessing the evidence. Psychiatric Services, 65(3), 287-294.

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, Delivery and Tracking of Care Coordination

The Partners' strategy for care coordination is based on a comprehensive approach to community integration. We are experienced in developing successful care coordination models for Rural and Frontier areas that are efficient, effective and that focus on the building of capacity in communities with limited resources. Our approach focuses on the basic building blocks of effective care coordination: collection of data related to physical health, behavioral health, and social determinants of health, assessment of needs and potential barriers to getting these needs met and development of a plan of action, and connecting the member with the needed resources. Traditional, centralized and "third party" approaches to these functions are insufficient to reduce the fragmentation that exists across the health care, public health, and human services systems that comprise the Health Neighborhood. *Community integration* describes our whole person framework for care coordination, in which all resources and services within a community are brought together in an inclusive, person-centered structure.

We prioritize the development of care coordination processes in primary care, behavioral health and community based settings among multiple providers and at different levels of care, through defined, inter-organizational workflows that facilitate efficient teamwork in a distributed network model. The Regional Accountable Entity (RAE) program structure, with its flexibility and focus on community system development, is well aligned with our values and vision. The Partners are uniquely positioned to succeed within this program structure by virtue of several key differentiators:

- Strong local relationships and established, inter-organizational business processes

- An interdisciplinary model for care coordination, which is staffed by medical and behavioral health clinicians, as well as social workers, and other specialty providers, all of whom are trained to and experienced in connecting Members to community resources

- Superior technology, data sharing and data management resources

- A well-defined, transparent and inclusive governance model that makes best use of all of the available community resources closely connected to our communities

- The leadership, intellectual and financial capital necessary to achieve the Department's vision for Phase 2 of the ACC

We do not conceive of care coordination and management functions merely as a set of services the RAE will provide to Members, providers or the Department. Rather, these functions are designed and delivered in a manner that serves a transformative purpose within the community and in the lives of our Members. This fundamentally different and innovative approach, which goes well beyond the traditional third-party care management concepts, is necessary to evolve from a fragmentation and coordination paradigm toward community integration and a whole person approach to health.

Our strategy is predicated upon the following basic principles, reflecting our commitment to a transformative care coordination and program management strategy:

- **Account for every person** – through our partnerships, network strategy, technology and resources

- **Continually review and align interventions** to address emerging trends in the community, new evidence, feedback from Members, and lessons learned from a rigorous, continuous performance improvement process

- Shift care coordination and management functions **to the point of care** to the greatest extent possible, by investing in practice transformation support services and the advancement of Primary Care Medical Provider (PCMP)-based care coordination

- Extend comprehensive primary care services **beyond the walls of traditional clinical settings** to deliver care where the Member is, at a time that is convenient to the Member

- **Prioritize** care coordination activities and related resources to **prevent the progression of disease, disabilities or health inequities**, to maximize the potential of every individual through whole person care that addresses medical, behavioral health and social determinants of health

- **Integrate** all sources of **data** in an **efficient, non-duplicative and person-centered** manner, for use by the distributed network of care coordinators in PCMP offices, Community Mental Health Centers (CMHC), and communities

- Continually review and **align care coordination** interventions with each **Member's need**

- **Promote cross-disciplinary, Community-based Care Teams** (CCT) that are anchored in the neighborhood, are part of practice care teams, and bring diverse expertise and resources to meet Members unique needs

- Identify and complete a **comprehensive assessment** for clients with complex medical, behavioral and/or social needs to **close gaps** and disparities

These principles are present in every facet of the Partners' care coordination model and operational strategy. Moreover, our inclusive, community-based oversight framework will support adherence and accountability to these principles in every aspect of our care coordination activities.

Care Coordination Program
Our transformative care coordination program will build on our current Region 1 model and include multiple modes of intervention to support varying levels of Member and provider

needs. All care coordination processes entail a broad range of tactics to streamline services for each Member, as well as deliberate, provider-based interventions to produce the best possible outcomes. Our spectrum of care coordination support is predicated on a clear delineation of roles and services among providers and community-based organizations. Supported by our sophisticated CommunityCare technology platform, which is shared by PCMPs, CMHCs and the RAE itself, our care coordination services will ensure timely, efficient and complete communication about each Member's care, as well as 'loop closure' information when services are received. All care coordination information will be readily accessible to Members and providers, in an aligned process. All services will be tailored to meet Member needs, with emphasis upon Member goals and preferences in the design of the plan of care.

The Care Coordination Team

The Care Coordination Team, which includes Care Coordination Specialists, Care Managers and Community Health Workers (CHWs), also includes the Care Coordinators and Care Managers working within PCMP practices and CMHCs. The Partners want to shift care coordination and management functions to the point of care to the greatest extent possible. For PCMP practices and CMHCs that employ their own care coordinators, the Partners' will provide access to our shared care coordination platform, CommunityCare. PCMP and CMHCs, as well as other key community providers, such as Single Entry Points (SEPs), Community Centered Boards (CCBs), human services and local public health agencies will have access to the platform, which can be linked to most PCMP and CMHC records systems, or can be used as a stand-alone tool. While Health Neighborhood partners are not required to use CommunityCare, a single shared platform will facilitate efficient communication and reduce duplication services across systems.

The Partners' Care Coordination Team members will perform the following activities based upon their individual expertise:

Care Coordination Team

All care coordinators will conduct the following universal activities in addition to the activities associated with their specialty:

- Comprehensive assessments
- Basic care coordination tasks, such as supporting members to schedule appointments, navigate the system and facilitating communication across systems
- Accompaniment to appointments
- Support Health Literacy
- Outreach and coordination with care providers
- Documentation of activities in CommunityCare
- Participation in Interdisciplinary care team meetings

Care Coordination Team Member	Specialty Care Coordination Activities
Medical Specialist: Registered Nurse	• Assigned to Members with multiple complexities, with a primary medical condition • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • Medical condition education and self-management skill-building, health coaching on recommended prevention activities and routine screenings • Follow up on treatment plans, referrals and resources • Referral and coordination to specialty care, network providers, home health, hospitals and other care team members • Review treatment plan recommendations, coordinate with PCMP and specialists to coordinate care • Send appointment reminders, follow up letters, and other materials • Engage with Member and family as appropriate to coordinate care and assess progress toward meeting goals
Behavioral Specialist: Behavioral Health Professional, Bachelor's Degree required	• Assigned to Members with multiple complexities, with a primary behavioral health condition • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • Behavioral health condition education and self-management skill-building, health coaching on wellness activities, recovery • Frequent follow up on treatment plans, referrals and resources • Re-screening and tracking progress toward achieving goals • Referral and coordination to primary care, home health, hospitals and other care team members • Review treatment plan recommendations, engage with PCMP and specialists to coordinate care • Send appointment reminders, follow up letters, and other materials • Engage with Member and family as appropriate to coordinate care

Care Coordination Team Member	Specialty Care Coordination Activities
Substance Use Specialist: a Behavioral Health Clinician or other credentialed clinician with an additional CAC or equivalent certification	• Assigned to Members with multiple complexities, with a primary SUD condition • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • Substance use condition education and self-management skill-building • Follow up on treatment plans, referrals and resources • Health coaching on relapse prevention skills • Referral and coordination to MSO services (e.g., residential treatment, medication assisted treatment) • Review treatment plan recommendations • Send appointment reminders, follow up letters, and other materials
Social Determinants Specialist: Bachelor's level Social Worker	• Assigned to Members with multiple complexities, with primary needs related to social determinants • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • Public benefits application and access (e.g., SNAP, TANF, WIC) • Home visits • Education on community resources • Follow up on basic needs referrals and resources • Send appointment reminders; follow up letters, and other materials. • Coordination with County Department of Human Services (DHS), Public Health, and social services organizations for resources and to align across care coordinator supports

Care Coordination Team Member	Specialty Care Coordination Activities
Care Manager: RN or credentialed Behavioral Health Specialist, Bachelor's degree required	• Assigned to Members with multiple complexities who need intensive and sometimes longer term care coordination • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • Caseloads are smaller to accommodate more intensive work with the Member • Connects Member with a primary care medical home • Works with the Member to establish measureable goals and tracks progress towards goals • Supports attainment of basic social resources: safe housing, transportation, food, clothing and other needs • Coordinates across multiple systems, including criminal justice, SUD services, long term care supports and services specialty medical care and others
Care Transitions Specialist: Bachelor's Degree in a human services field *preferred but not required*	• Assigned to Members who need support transitioning from a facility setting to community based living, typically a hospital transition or ER follow up • Serve as hospital and facility liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members • In-person meeting in the inpatient, or other setting prior to discharge or release • In-person and/or phone-based outreach to Members within 48 hours of discharge to home and again within 30 days • Review of discharge summary with Member • Collaborative transition of care planning with Member • Coordination with care transition staff from Health Neighborhood organizations, criminal justice services, and local hospitals to align supports • Support for Member reengagement with ongoing care at their medical home • Referral and coordination to intensive support

Care Coordination Team Member	Specialty Care Coordination Activities
Community Health Worker: Bachelor's Degree in a human services field *preferred but not required*	• Assigned to lower complexity Members with 1 or 2 concerns in any domain • Serve as community liaison and advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for Members • Educate and assist identified Members about behaviors that can enhance their health successfully navigating the health system. • Facilitate access to medical, behavioral health and community services. • Develop a plan of care with measureable goals in collaboration with the Member, which is Member-centered and culturally appropriate • Serves as a consultant to care coordination teams

Our Care Coordinators work in numerous settings across the community, as part of Community Care Teams (CCTs), described later in this response, and as part of care coordination programs, like the Health Engagement Team (HET). The Partners' Care Coordination Program is inclusive of Care Coordinators and Care Managers working within PCMP practices and CMHCs.

The Care Coordination Program organizational structure is depicted below. This is a detailed portion of the full RAE organizational chart. Positions and services named in the gray circles are employed by either RMHP or by an anchor organization; the blue circles indicate positions hosted by Reunion Health, including PCMP offices, CMHCs and anchor organizations in the Health Neighborhood. RMHP provides direct oversight and support for all positions in the gray "Care Coordination and Care Management Staff" circle.
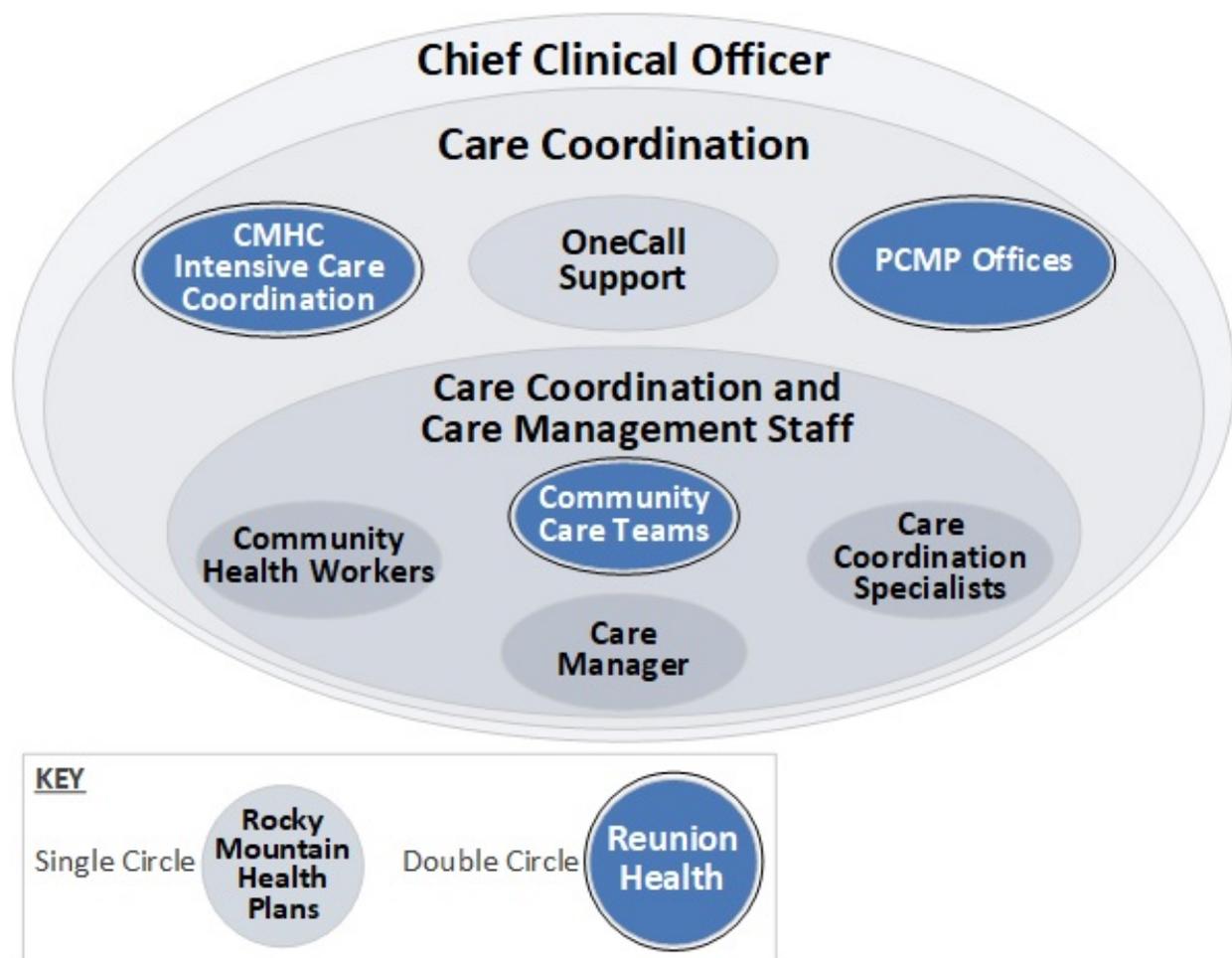
Care Coordination Oversight Framework

The Care Coordination Manager will supervise all aspects of the Care Coordination Team, including **Care Coordinators, Care Managers, Community Health Workers (CHWs) and Community Care Teams (CCTs)**, with leadership-level oversight from the Chief Clinical Officer. The organizational structure depicted above shows that care coordination is includes all the places where a Member may receive care coordination or care management services. The Partners' care coordination network will be comprised of care coordination specialists, care managers, CHWs and CCTs.

As part of the care coordination framework, the RAE will develop a Care Coordination Manual, which will be a living document containing all policies and procedures. The CCT will continually review and update the Care Coordination Manual in collaboration with all care coordination professionals to reflect the most current research into care coordination and care management, management of chronic conditions, tailoring of interventions for special Member populations, and incorporating regional resources, solutions and best practices.

A Shared Workspace: CommunityCare

The Partners have adopted CommunityCare, a rights- and roles-based care coordination platform that supports identification and documentation of Member needs, task assignment

and workflow management among care coordination staff. CommunityCare is HIPAA-compliant and integrates evidence-based guidelines, gaps in care reporting and hospital *admission, discharge and transfer* (ADT) messaging. CommunityCare includes a record of a Member's acute care, preventive care, chronic disease management, medical, behavioral health, social and long-term care services. This dynamic, person-centered electronic record also houses the Member's individualized care plan and provides our interdisciplinary team of care coordinators with real-time online access to view, update and communicate 24 hours a day, seven days a week.

CommunityCare is a community-level care coordination tool, with the capacity to connect to other information systems, including medical records systems such as Epic, and other community based technology, including the local 2-1-1-information line resource directory.

The platform prioritizes end-user ease of navigation and usability, with access to the most relevant and timely data about each Member. A robust permissions framework allows each member of the care team access to the appropriate level of information, allows for direct communication among care coordinators across health, behavioral health and social sectors.

The tool also provides a framework to develop a multidisciplinary, Member-centric care plan, as well as the ability to create goals based on measurable outcomes and Member-driven wellness goals. CommunityCare allows for the customization of forms and assessments to support practice-specific processes while at the same time supporting the Partners' goal to create a standardized set of core social determinants. Finally, CommunityCare supports a closed loop referral process, and will generate real-time alerts to identified intervention staff through the individual practice's care coordination tool.

Practice Access to CommunityCare

PCMP practices and behavioral health providers, in the broader Region 1 Provider Network beyond the Reunion Health Partners, will have access to CommunityCare at their option for use with their entire patient populations, regardless of payer or RAE enrollment status. We will support existing provider workflows while offering providers the opportunity to receive new information about their patients. CommunityCare will accommodate practices that need the support of a full care coordination platform, as well as those who already have a tool they are using successfully.

CommunityCare incorporates real time ADT alerts from HIE that providers and care coordination staff use to identify and implement needed interventions, such as care transition support or follow-up after an unexpected emergency room visit. Practices will be able to view specific panels of patients, and can set up email notifications from CommunityCare when there is a significant update or action needed for an attributed Member.

To achieve high levels of practice transformation incentives through the alternative payment methodology (APM), practices will need to develop and implement their own care coordination tool and process to receive structured stratification data and intervention alerts in a manner that is clinically pertinent. Our Practice Transformation team works with providers to analyze current workflows for efficiency, and build new workflows to accommodate new technology and services. The Partners will provide practice transformation support to assist practices in

setting up workflows, work with their current technological infrastructure, and with CommunityCare, adhere to interventions identified in the Population Health Management Plan.

The Partners' Care Coordination infrastructure will support the use of CommunityCare by the CCTs, and provide oversight to make sure assessments, planning, interventions and coordination across systems are aligned with the Partners' criteria and the defined role of the CCT.

Community-based Care Teams - An Effective Strategy for Rural & Frontier Regions

Region 1 is comprised of Urban, Rural and Frontier areas and covers a large geographic footprint. The Partners *live and breathe* Rural and Frontier strategies in all aspects of service and care delivery. An important component of our care coordination strategy is the Community Care Team (CCT). The CCT model builds capacity and infrastructure in communities with limited resources. In our 40-year experience in Rural and Frontier communities, we have learned that solutions aimed at improving the overall health of the population must capitalize on existing organizational leadership and infrastructure. Relationships matter in these communities, and the Partners are committed to building trust-based partnerships to create a system of care that is tailored to each community's needs and resources.

A first step to building an effective CCT is to identify an **anchor organization** in a given community, by looking at established patterns of care, as well as the leadership and convening capability of the anchor organization. We know that in Rural and Frontier areas, local, credible leadership is key to developing a care coordination infrastructure that best serves the unique needs of the community. A wide array of entity types are supported by RMHP in anchor organization roles, including community Health Alliances, Local Public Health Agencies (LPHAs), hospital systems and Federally Qualified Health Centers (FQHC).

The Partners will enter into a contractual agreement with each anchor organization that describes the Partners' approach to care coordination and population health management, identifies community partners, and describes the CCT's role, as well as documentation and reporting requirements. The anchor organization will employ care coordination team members with resources provided by the RAE. Local oversight committees with stakeholder membership, including local Network Providers, community service providers, advocates, and Member and Partner representation, will contribute to developing workflows and discuss long-term strategies and systemic approaches to improve health in the community.

We want to emphasize that the anchor organization is not a delegated relationship, but is part of an **integrated network model** with multiple, sophisticated touch points, shared information systems, and comprehensive training and oversight. RMHP serves as the single point of accountability, and possesses the systems and insights necessary to account for every facet of RAE operations.

Community Care Team Structure

CCTs are multi-disciplinary and will be comprised of the care coordination positions described earlier in this response. RMHP's CCT structure is flexible and can be adapted to the needs of the community being served. For example, in a geographic area experiencing a high level of opioid use, the anchor organization may choose to employ more than one care coordinator specialist

trained in substance use disorder (SUD). This flexibility makes the CCT model adaptable to the Rural, Frontier and Urban areas found in Region 1.

Anchor organizations, in collaboration with PCMPs, may have CCT members integrated into a PCMP practice's care team. This aids smaller practices that do not have in-house care coordination resources to build capacity to serve more complex Members.

The map below depicts the current distribution of CCTs in Region 1.

Community Care Team (July 2017)
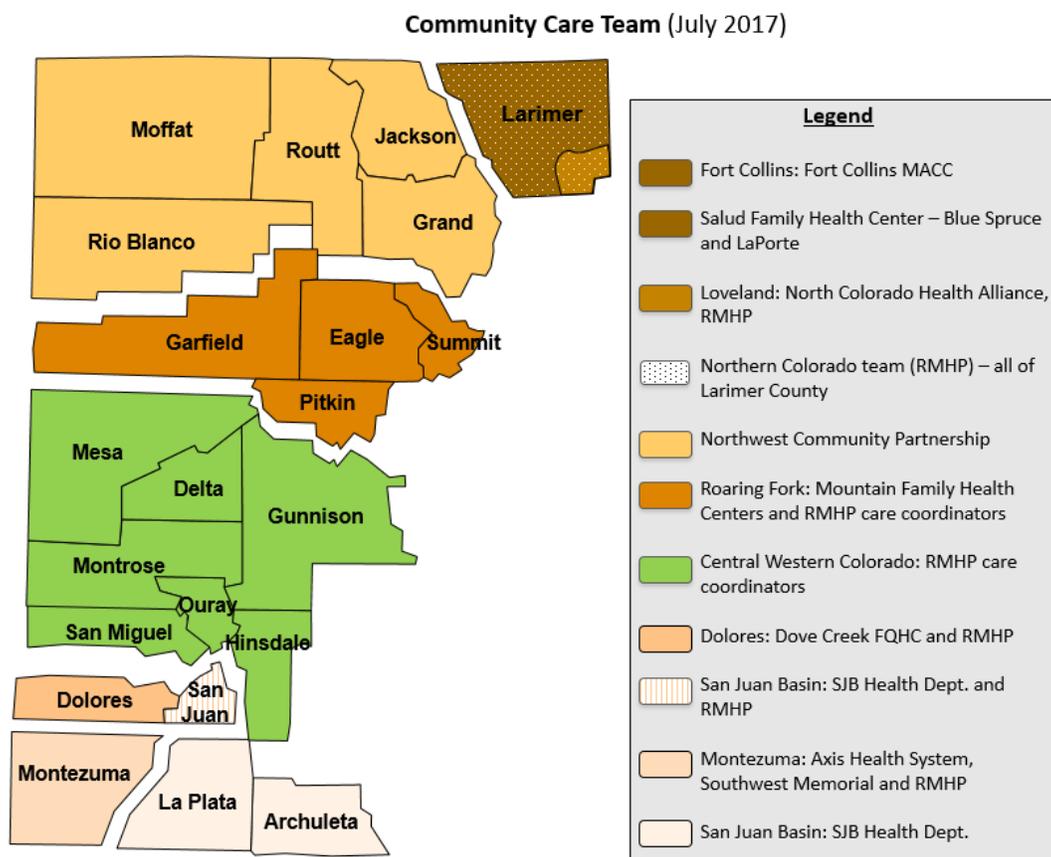
The table below shows the current anchor organizations hosting Community Care Teams and geographic areas covered. This structure will continue to evolve as Region 1 transitions from RCCO to RAE infrastructure.

Geographic Area	Current Organization Hosting Community Care Teams in Region 1
Fort Collins[96]	Poudre Valley Hospital Foundation/ Health District of Northern Larimer County, Salud Family Health Center and RMHP Northern Colorado Team
Loveland	North Colorado Health Alliance

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[96] The Fort Collins and surrounding area contains approximately a third of the entire RCCO population in Region 1, therefore it is heavily resourced with 3 CCTs.

Geographic Area	Current Organization Hosting Community Care Teams in Region 1
Routt and Moffat Counties	Northwest Colorado Community Health Partnership and RMHP Care Team
Roaring Fork - Pitkin, Garfield and Eagle Counties	West Mountain Regional Health Alliance/ Mountain Family Community Health Clinic and RMHP Care Team
Central Western Colorado	RMHP Care Team
Southwest Counties – La Plata, Archuleta, San Juan, Dolores, San Miguel, Ouray	San Juan Basin Public Health and RMHP 4 Corners Team
Montezuma County	Axis Health Systems and RMHP 4 Corners Team
Dolores County	Dove Creek and RMHP 4 Corners Team

The Whole Person in Community Integrated Care

The Partners recognize that robust, person-centered care coordination is one of the many important interventions under the Population Health Management umbrella. In our effort to achieve population health at all levels of wellness – and at every life stage – the Care Coordination Team will implement a range of deliberate activities to organize and facilitate the appropriate delivery of health and human services that support Member health and well-being. We will accomplish this by providing resources to maintain wellness, prevent avoidable health conditions, coordinate acute care needs, support recovery from adverse episodes and manage chronic health conditions. Services and supports are available to Members along a continuum, from self-management and health education to intensive care management.

How Risk Stratification Ties to Care Coordination

Our risk stratification model, as described in Offeror's Response 15, uses data from multiple sources to risk adjust each Member related to the *three dimensions* of physical, behavioral and social determinants of health. The risk adjustment model informs our care coordination work by allowing us to proactively identify and outreach to Members with potentially high needs in one or more of the dimensions. Sometimes a brief connection with a Member who appears to be high risk reveals that needs are met, while another Member might welcome the support of their PCMP's office or a care coordinator. We understand that risk is dynamic, not static, and is often best assessed from actual interaction with Members.

In addition to risk stratification through the process outlined above, we will assess the whole-health of each Member based upon their life stage, and intersecting social, physical, and behavioral health risks. The Life Stages Risk Assessment and Stratification model below outlines our approach, which is to conduct life stage-appropriate assessments throughout the continuum of care. Age-appropriate assessments are completed for Members proactively identified or referred for care coordination, care management or care transitions services.

Our model is designed to bring together all entities within the Health Neighborhood that are providing care for the Member, and to leverage existing community-based systems for tracking and managing complex services. Through coordination of services, we will reduce redundancies, promote Member health literacy along with active engagement in their care, and deliver the appropriate level of care coordination interventions.

This approach is consistent with the framework set forth in the Health Literate Care Model,[97] in which health care delivery system design and coordination functions are expanded to include **child welfare, the criminal justice system, Long-Term Services and Supports (LTSS) service providers, schools,** as well as **providers of community based services,** like **housing** and **food** support, **transportation** and **personal safety** support.

Life Stages Risk Assessment and Stratification

Family Formation and Early Childhood
Assess: Early screening and intervention; maternal depression; intendedness of pregnancy; birth weight; family income; developmental milestones

Middle Childhood and Adolescence
Assess: Math and reading skills; concentration; social/emotional/behavioral functioning; trauma; family hx behavioral health conditions/SUD; foster care

Adolescence and Transition to Adulthood
Assess: HS graduation status; criminal justice involvement; MH screen; SUD screen; PH status; employment; income

Early Adulthood and Adulthood
Assess: Employment status; housing; income; social connectedness; PCP engagement; criminal justice; PH/BH functioning; Suicide RIsk; SUD

Adulthood with Suport and Decline/End of Life
Assess: Employment; housing; social connectedness; financial resources; access to caregiver; falls; hospitalizations; PCP engagement; advance care plan; PH/BH functioning; SUD

Low Risk / Moderate Risk / High Risk / Physical Health / Behavioral Health / Social Determinants

Our Model: Collect, Assess and Connect

The Care Coordination Team will use a data-driven process and logic model for risk stratification, as described in Offeror's Response 15, to proactively identify and categorize Members for stratified outreach. Once stratification is complete, a clearly defined operational process must ensue to meet Member needs and take advantage of opportunities for meaningful impact. The Care Coordination Team will accomplish this objective through a comprehensive system to **collect** information, **assess** Member risk, and **connect** the Member to appropriate services, as illustrated below:

[97] Koh, H.K., et al. A proposed 'health literate care model' would constitute a systems approach to improving patients' engagement in care. Health Aff. 2013 Fed; 32(2): 357-67

Step 1. Collect: Identifying Member Needs

The Partners will collect and integrate data from all available sources to identify needs and gaps in a timely and efficient manner. Sources of data include:

- **Administrative data** – The Team looks for inappropriate utilization, diagnosis of a major chronic condition or severe and persistent behavioral illness, potential gaps in care, social determinants of health screening, and county DHS service utilization.

- **Clinical Data:** - We connect with the PCMP and behavioral health provider as the best sources for this information, when possible. We look for gaps and opportunities in clinical treatment(s) and outcomes, which inform care planning and prioritization.

- **Social Data:** The Partners identify changes in housing, program eligibility, family status, living and caregiver arrangements, criminal justice system involvement and other social transitions that indicate long term or episodic needs.

- **Patient Reported Data:** We examine results from the Department's Health Needs Assessment, results from evidence-informed and life-stage appropriate assessment tools, evidence-informed screening tools for depression and other compounding factors and individual client outcomes, as reported by the Member.

As part of the *Collect* process, the Partners will leverage the extensive experience within our organizations, and across the community, in screening Members for physical health, behavioral health and social determinants of health needs using evidence-informed and Member-centric tools, including the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.

PRAPARE is a validated, national tool with a set of core measures to identify social determinants of health, which aligns with national initiatives such as Healthy People 2020, Meaningful Use, ICD-10 and UDS coding. Due to widespread adoption of PRAPARE by FQHCs and other primary care providers, templates for this tool have already been developed for several major EHR vendors, including NextGen and eClinicalWorks. The tool, which is meant to augment the risk stratification process with Member-reported information, will identify Members who need coordination of services for housing, food and other basic needs, employment and financial stability support, transportation, criminal justice and veterans' services that are available for Health Neighborhood members.

Additionally, our Care Coordination Program is open and responsive to Member and provider requests for assistance as follows:

- **Direct Request**: Members, Providers, community organizations, and other service organizations are encouraged to request care coordination support directly through our OneCall Support (described in further detail below). A OneCall Representative will respond to calls, review requests and referrals for care coordination, and provide warm-transfers to the appropriate level of coordination support.

- **Provider Request:** Providers may inform the Care Coordination Team through OneCall Support, via the CommunityCare care coordination platform, or directly with a Care Coordination Team member that they have identified issues indicating a need for

support navigating the system, such as lack of Member engagement or treatment progress, unsuccessful referrals, complex social needs, or other Member behaviors.

Member preferences will be our primary focus in assessing needs, planning care and following-up. The appropriate level of care coordination will be further determined by the Member's functional needs, level of engagement and motivation, and ability to follow through with recommendations and referrals. We will use the Patient Activation Measure (PAM) to guide our activities and engage Members in shared decision-making. If a Member is identified as not needing a warm hand-off or targeted outreach to follow through on their health plan, the provider or Care Coordination Team will still track if a referral was used, and will conduct outreach if the Member was not successful in coordinating the resource on his/her own.

Care coordination staff will outreach to the Member's current PCMP as well as County DHS, CMHCs, and other organizations involved in the Member's current care to determine what care coordination resources the Member is already receiving from their care network. The Care Coordination Team will only step in to work with the Member if additional resources beyond those provided by the care network are needed and the Member chooses to accept additional care coordination. The Member will choose the care coordinator with whom they feel most comfortable to serve as the lead on their care team as the single point of contact for the Member. Care coordination will be Member-centered, collaborative with the Member's chosen providers, and driven by Member engagement in their care plan.

The Care Coordination Team may offer collaborative support to the care network to enhance communication and integration of activities among care coordination staff already working with the Member. The Partners' data analytics team will provide additional utilization information and data analysis to the care network to increase knowledge of Member behaviors, share Member-facing education and engagement materials, and facilitate connection with county and other public services.

Step 2. Assess: Member Goals & Planning
All care coordination activities will be designed and delivered using a person- and family-centered approach, which considers the individual health goals and choices of Members and their families.

Our goal is to:

- Activate Members in their own care
- Enable self-management by providing education and support for health and well-being literacy
- Encourage adherence to self-established goals by providing support for building habits of needed health behaviors
- Connect Members to timely resources

Member preferences concerning where care coordination takes place (provider's office, member's home, etc.), who does the care coordination, and cultural needs and community context will drive much of the planning. Assessments are comprehensive, and will take into

account medical and behavioral health history, substance use, social structure, functional status, cognitive status, social determinants, the person's understanding of their condition and the person's stage of change. Assessments also incorporate information from key sources, including the Department's Health Needs Assessment (HNA), PCMP and CMHC information, and PRAPARE as well as other community assessment tools. All available assessment data is recorded in CommunityCare.

Care coordination services will be accessible to Members in a culturally responsive manner that respects Member preferences and protects Member privacy. Services will be provided at or as close to the point of care as possible. Regular communication between participants will be supported by CommunityCare, which will reduce duplication of services and create a continuous Member experience within the Health Neighborhood. Care coordination support will be available for both short and long-term health needs, and will address physical health, behavioral health- and the Member's interrelated social determinants of health so that Members can achieve their health goals in a whole person setting.

Step 3. Connect: Open doors and possibilities for every Member

The Partners will use a targeted, tailored care coordination and management process so that all Members receive the coordination support they need while eliminating unnecessary steps and redundancies. A structured approach, with clearly defined functions and team member roles, is necessary to optimize available resources and improve experience and outcomes for Members, providers and community partners. The Partners' Care Coordination Program structure reflects the stratification and Member empanelment process described above, and operates at four distinct levels: **OneCall Support, Care Coordination, Care Transitions** and **Care Management**, as described below.

OneCall Support

High level navigation is supported by an easy-to-access call center. OneCall Representatives receive training in trauma-informed care, telephone skills, evaluating caller needs, and available RAE, Department and community resources. The OneCall Center will be available 24 hours a day, seven days a week, offer language interpretation and Relay services, and will fulfill the following inbound and outreach functions:

Inbound

- Respond to, and if needed, transfer incoming calls
- Answer questions and requests for information from Members, providers and community members
- Provide connection to the Member's PCMP and other providers in the Network
- Review current services and care team with the Member
- Provide information about community resources or specialty care referrals from the Network Directory
- Educate the Member about additional sources of such as websites, the RMHP Member portal, or other regional sources
- De-escalation and connection to crisis support

Outbound

- Welcome calls to new Members

- Outreach calls to identified Member populations based on rising risk, such as women with a new positive pregnancy result, Members with high emergency department utilization, or Members with polypharmacy claims

- Needs Assessment: a basic phone-based assessment to determine Member-specific needs and ask about potential barriers to accessing services

- Review current services and care team with the Member

- Provide information about community resources or specialty care referrals from the Network Directory

- Offer prevention and wellness resources to support health literacy

- Provide connection to the Member's PCMP and other providers in the Network

- Educate the Member about additional information available on the website, through Member portals or other regionally-specific sources

We recognize that Members may enter the healthcare system from multiple points, as not all Members will routinely visit their PCMP or contact OneCall Support. If the Member presents to a community partner organization, anchor organization, PCMP, CMHC or other resource, they can access in-person navigation with a CCT resource, like a community health worker (CHW) or health navigator. Our **Open Door** process and community based approach provides for alignment across all possible entry points, from medical home to care coordination to local social services provider, with the goal of achieving the same consistent and comprehensive identification of needs, tracking, and follow-up for every Member. If a Member who has contact with OneCall Support expresses a need for additional help, or if a OneCall representative suspects more support is needed, the Member will be transferred to the care coordination staff for further assistance.

Care Coordination

Care Coordination Specialists and CHWs will assess and provide care coordination for Members with low to medium complexity and at least one of the following needs: episodic care support, one or more chronic physical or behavioral health conditions, substance use disorder, or a social determinant of health need. Care Coordination Specialists will provide phone and in-person navigation to help Members connect with care providers across systems to address their complex needs in a coordinated manner. Care Coordination Specialists will work together to coordinate supports for Members, work across systems, such as primary care, LTSS providers and providers of community based services, like housing, food and transportation. They prioritize needs, and provide a seamless experience to meet the whole health needs of the Member. The expected timeframe for these basic care coordination activities is 60 days or less.

Care Transitions

Our Care Coordination Team will include dedicated Care Transition Specialists to focus on care transitions, to include the medical, behavioral and social service needs a Member may have post-hospitalization. Care Transition Specialists will have expertise in working with hospital and

other care systems, understand discharge planning, and have detailed knowledge of available community resources. These specialists will engage the Member in determining what kind of support is needed during the transition, such as help understanding medications, making a follow up appointment, connecting to post-partum or respite care, and/or social supports such as meals or transportation to appointments. This transition assistance promotes continuity of care and prevents avoidable readmissions. We expect that in the first 30 days after discharge, Care Transitions Specialists will be most engaged with the Member. After 30 days, as long as the Member is doing well active engagement will lessen and maintenance, including periodic phone calls and monitoring of hospital ADT data, will continue through 90 days post discharge.

Care Transition Specialists perform a critical role at a time when Members are most vulnerable, or prone to "fall through cracks" due to the fragmentation of services. Their activities include:

- In-person meeting in the inpatient, institutional, or criminal justice setting prior to discharge or release
- In-person and/or phone-based outreach to Members within 48 hours of discharge to home and again within 30 days of release
- Review of discharge summary with Member
- Collaborative transition of care planning with Member
- Coordination with care transition staff from Health Neighborhood organizations, criminal justice services, and local hospitals to align supports
- Support for Member reengagement with ongoing care at their medical home
- Referral and coordination to intensive support

Client Vignette – Value of Hospital Transition Support

Without Support:

A Member in Steamboat Springs presents at primary care provider for a follow-up visit after discharge from Yampa Valley Medical Center. The Member was discharged after knee replacement surgery and taken in an ambulance from the hospital to the homeless shelter in Steamboat Springs the night before. The Member did not have follow-up physical therapy arranged by the hospital, and had no place to stay other than the shelter, which was not an appropriate recovery location. The primary care provider is part of an Integrated Health Home and is able to outreach to multiple community organizations to seek respite care for the Member. No respite care is available for at least two weeks, and the earliest physical therapy appointment at the local hospital is in two weeks.

With Support:

The Community Care Team is notified via ADT alert in CommunityCare that the Member has been admitted for surgery. The Care Coordinator reaches out to the Member while in the hospital to confirm a follow up plan of care. The Care Coordinator involves the Member's case manager from his outpatient treatment team, and reaches out to a community foundation to obtain short-term financial support for a 3-week hotel stay in Steamboat Springs. The Care Coordinator arranges non-emergency medical transportation for the Member through Routt

County Council on Aging, which provides the service. The Member is picked up at the hospital upon discharge and transported directly to the hotel. The Member successfully completes intensive physical therapy at the hotel, and receives continued transportation support to attend outpatient physical therapy at the hospital.

During this time, the Complex Social Determinants Specialist also works with the Community Care Team and the Member to obtain temporary housing and applications for available housing vouchers.

Care Management

Care Management is an intensive intervention for the highest risk clients who often generate a disproportionate share of cost and utilization. The Care Coordination Team will use Care Managers for care planning and coordination for Members with high-risk chronic physical health and behavioral health conditions, Members who demonstrate health behavior patterns indicative of a lack of self-management or health literacy, and members who have high complexity in two or more domains of the three-dimensional risk strategy model, which includes physical health, behavioral health and social determinants of health. Patients with conditions that significant non-elderly healthcare costs (e.g., addiction disorders, anxiety or phobia disorders, congestive heart failure or hypertension, congestive obstructive pulmonary disorder or asthma, depressive disorders, type II diabetes, and psychotic disorders) often need the more intensive level of coordination that Care Managers are trained to provide.

To help identify these high-risk individuals, the Partners' coordinated data management system includes analytics that identify high outcomes representative of poor health behaviors, such as poor medication adherence, increased weight gain and blood pressure, and infrequent or irregular visits to address a chronic condition. Additionally, Care Managers will work with those Members exhibiting overutilization of services.

We expect that Care Managers will engage with their Members for at least 90 days and maybe longer, depending on the Member's resources for self-management. Care Managers' caseloads may be smaller to accommodate a higher frequency of contact with their assigned Members and other parts of the Members' care team. Care Managers work across systems; including child welfare, the criminal justice system, LTSS providers and schools, as well as providers of community based services, like housing and food support, transportation and personal safety support. Care Managers coordinate closely with Members' primary sources for medical and/or behavioral health care to promote support for the Member as close to their primary point of care as possible.

Community Health Workers

CHWs may work as part of a Community Care Team (CCT), as part of a specific care coordination program like the Health Engagement Team (HET), or in another capacity. These individuals serve as consultants to the other members of the care team and they also work with Members who have lower levels of complexity or episodic needs. CHWs work with Members to connect and engage them with a PCMP, and support members to access other needed providers and services in the community. They work across systems and may sometimes support a care manager to access services for more complex members

The Health Engagement Team – a Resource for Members in Rural Areas

The Health Engagement Team was established as a partnership between RMHP and Whole Health, LLC, a subsidiary of Mind Springs Health. It was conceived out of a need for a solution to a common rural concern – individuals with chronic physical or behavioral health conditions and unreliable transportation might call for emergency transport for concerns that would be better addressed in a primary care or behavioral health setting. CHWs embedded in high volume PCMP practices on the Western Slope engage with Members identified as having high utilization during routine appointments. CHWs support the Member in accessing the right care at the right time and place by helping to coordinate services as well as provide transportation to medical and behavioral health appointments and other appointments to support the Members' goals, such as court dates, classes and community services. CHWs, who are trained to support behavior change with Motivational Interviewing techniques, indicate that some of the most productive, Member-empowering interactions they have is in the car, where conversations are relaxed and Members can explore their goals and what it will require to achieve their goals.

Levels of Care Coordination

The Care Coordination Team will provide four levels of Care Coordination: OneCall Support, Care Coordination, Care Transitions and Care Management, which correspond to the levels of acuity and expected length of engagement with the Member. These levels are fluid, are based on the Member's level of acuity and need, and will change based on the changing needs of the Member. The Care Coordination Team will define processes and a targeted length of time for care coordination engagement. For example:

- **OneCall Support** - Members who are generally healthy but need help finding a PCMP or specialist will generally receive one-time help through OneCall Support or via a Community Health Worker, with an explanation that additional help is available from the Member's PCMP office or from the RAE Care Coordination Team.

- **Care Coordination** Members who are coping with one complex issue, like managing diabetes or finding housing, will be supported by a Care Coordination Specialist, who has credentials or training specific to the Member's need, or, for lower acuity members, a CHW may provide assistance. We expect engagement of 60 days or less to support coordination of services and self-management for individuals with one complex issue.

- **Care Transitions** - Members who are transitioning care from hospital to home or facility to community will be supported by a Care Transitions Specialist, who will help the Member and his/her support system coordinate needed services to support a smooth transition. Expected length of engagement is 30 days, with periodic follow-up through 90 days post discharge.

- **Care Management** - Members who have highly complex needs and those with one of the seven identified most costly conditions will be supported by a Care Manager, who will work closely with the Member on activation, self-management and adherence to support sustained behavior change, in addition to coordinating services across systems. The expected length of engagement for these very complex Members is 3-6 months, with a structured plan for follow-up to maintain behavior change.

Care Coordination Approach

The Partners will use elements of the Care Management model developed by Mental Health Corporation of America as the framework for our approach and interventions. This model includes the four key components to a comprehensive care management framework identified by the Center for Healthcare Strategies:[98] Identification/Stratification/Prioritization, Intervention, Evaluation and Financing.

- **Identification/Stratification/Prioritization** - Identify consumers at the highest risk who offer the greatest potential for improvements in health outcomes

- **Intervention** - Should be tailored to meet individual Member need and choice, and should be multi-faceted, improve quality and cost effectiveness, and support coordination of care

- **Evaluation** - Analyze to determine if interventions improve quality, efficiency, and effectiveness

- **Financing** – As in the RAE model, payment is aligned to support improvements in care management by rewarding providers for taking accountability for quality and cost

The Care Coordination Team will use the following behavior-focused techniques to support Members in care management and in care coordination: ***activation, self-management, and adherence***. Activation will target the Member's attitude toward and ability to pursue health goals within the limitation of their illnesses; self-management will foster increased Member knowledge of illness and health literacy; and adherence will build habits for improved health behaviors.

Our detailed Care Management Manual provides standardized protocols for care coordinator and care manager training, appropriate interventions, communications, follow-up processes, and evaluation methods. As a result of these protocols, Members will experience continuous and clear support individually tailored to their conditions, behavior patterns, and stage of change. While the complexity of Members in care management will be higher than the complexity of Members in care coordination or care transitions, all coordination specialists will be aligned with our approach as described below.

Adherence support is especially critical in strengthening Member self-management of high-risk chronic health conditions that are typically treated with prescription medication in addition to lifestyle and behavior changes. Non-adherence can lead to significant escalation of the condition, often resulting in avoidable hospital admissions. The American College of Preventive Medicine indicates that factors which impact non-adherence often fall within one of five dimensions: social and economic (e.g., low health literacy, cost of medication); health care system (e.g., provider-patient relationship and communication); condition-related (e.g., symptom interference); therapy-related (e.g., complexity of regimen such as number of doses,

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[98] Center for Healthcare Strategies' Care Management Framework is adapted from: Adapted from: R. Mechanic. Will Care Management Improve the Value of U.S. Health Care? Background Paper for the 11th Annual Princeton Conference. For more information: https://www.chcs.org/media/Care_Management_Framework.pdf

need for injections); and patient-related (understanding need and benefit of medication, physical or cognitive impairments caused by illness). Care coordination approaches can address all five of these dimensions through a set of core competency skills: patient engagement, stages of change, motivational interviewing, care coordination, behavior change, adherence support, and group self-management.

Member engagement and the Trans-Theoretical Models of Stages of Change[99] will serve as the models we use to actively involve Members in their own health. Care Managers will assess Member stage of change, and provide education about their illnesses and the impact their personal actions can have to achieve and maintain health -- tailored to the Member's awareness of unhealthy behaviors and readiness to act. To support their ability to educate Members, care coordination staff will be trained in the basics of the seven-targeted chronic disorders, as well as the key modifiable health behaviors that have greatest impact on those conditions. The Partners will provide training on additional conditions that have a significant impact on Region 1 costs and Member outcomes as trends arise.

Care managers will use **Motivational Interviewing** and active listening techniques to guide individual interactions with Members. Motivational Interviewing is a psychotherapeutic approach that uses the principles of empathy, developing discrepancy, rolling with resistance and supporting self-efficacy to motivate individuals to make a behavioral change. Through Motivational Interviewing, members of the Care Coordination Team will develop a supportive environment for contemplation and preparation for change, and assist Members in developing their personalized action plan for healthy behaviors. Care Managers will also have access to CommunityCare and other supports described above.

A Member's social determinants can impact health behaviors and further compound cognitive and physical limitations caused by their conditions The Partners' Care Coordination Team will leverage the Partners' process for streamlined referral and coordination among entities in the Health Neighborhood to mitigate barriers to behavior change, e.g., limited English proficiency, lack of transportation, or insecure housing. Care coordination staff will also address condition-specific barriers to care. They may, for example, coordinate with a behavioral health specialist to provide onsite support if a Member with an anxiety disorder needs a procedure they find overwhelming, such as a blood draw or mammogram. Care coordination staff will utilize CommunityCare to track all referrals and make sure resources are appropriately used.

The Partners will designate Care Coordination Team resources to provide a spectrum of interventions informed by the methods of behavior change, adherence support, and group self-management. Interventions will be designed to meet Members at their current stage of change and elicit Member-driven advancement toward action and self-maintenance. The Care Coordination Team will also support Members in overcoming triggers for negative health behaviors and provide self-management tools for relapse prevention. Care coordination staff will utilize five key steps for each intervention, first presenting the behavioral challenge as common and relevant to the Members' health, secondly discussing how the behavioral challenge is currently handled by the Member, thirdly presenting the intervention; next

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[99] https://www.ncbi.nlm.nih.gov/pubmed/10170434

personalizing the intervention to the Members' stage of change and social determinants of health; and lastly problem-solving any barriers to implementing the change. The Care Management Manual will provide specific guidance on how to apply the stages of change processes.

The Care Coordination Team will develop local Member learning community groups staffed by Care Managers, Care Coordination Specialists and CHWs. Group settings can stimulate readiness to change by reducing isolation and creating supportive relationships between participants. It can be a relief for individuals to know they are not alone in their struggle, and to benefit from the perspectives and experiences of their peers in implementing healthy behaviors. The sense of community that can develop between participants offers opportunity to develop prosocial skills, as well as generate an inclusive, public commitment for change. Groups are also an ideal format to combat key modifiable behaviors such as poor nutrition and lack of exercise that impact preventable health conditions by completing physical activities or sharing a healthy meal together.

Care Coordination Team Trainings Provide High Quality, Member-Centered Care

The Partners' internal Care Coordination Team (including the CCTs) will receive mandatory interdisciplinary training and professional development opportunities from RMHP and the Partners. Care coordinators and care managers affiliated with PCMP practices, CMHCs and other Health Neighborhood partners will have access to the same training and development opportunities. This will increase care coordination competency and fidelity across the network. All trainings will have a focus on providing Members with integrated support that addresses medical, behavioral health and social care coordination needs. While we will have care coordinators who have specific credentials or experience in the domains of medical, mental health, substance use disorder (SUD) and social services support, all care coordinators will be cross-trained so they can support Members with issues that cross these domains.

The Partners' care coordination program will include multiple models of intervention to support varying levels of Member and practice needs. To support adherence to our standards, we will train care coordination team members in essential care coordination skills, and we will leverage the expertise of our CMHC, FQHC and PCMP providers, Colorado Cross-Disabilities Coalition, CCBs, SEPs, hospitals, and local leadership to develop and facilitate trainings.

The table below lists required care coordinator trainings and core competency trainings.

Care Coordination Team Basic Training – *For all OneCall Support and Care Coordination Staff*

Training Type	Training Provider
Cultural Competency	Provided by SummitStone Health Partners – structured 4-module training
Disability Competency	Provided by Colorado Cross Disabilities Coalition and CCB partners
Culture of Poverty	Bridges Out of Poverty – Provided by RMHP staff

Training Type	Training Provider
Trauma-Informed Care	Provided by Partner CMHCs
Person-centered approach	Provided by Partner CMHCs and FQHCs
Knowledge of local resources & services	Provided by Care Coordination Team and local partners
Ethics	Provided by Care Coordination Team
Healthy Eating and Active Living	Provided by Care Coordination Team
Stress management & self-care	Provided by Partner CMHCs
Zero Suicide	Provided by Partner CMHCs
Knowledge of Medicaid benefits, SNAP, WIC, and other state services	Provided by Care Coordination Team and local county agencies
Training for the 7 core competency skills: patient engagement, stages of change, motivational interviewing, care coordination, behavior change, adherence support, and group self-management.	Provided by Care Coordination Team and Partner CMHCs and FQHCs
How to use documentation and communication systems	Provided by Care Coordination Team

Care Coordination Team Advanced Training - for Care Coordinators, Care Transitions Specialists, Care Managers and CHWs

The Partners' Care Coordination Team training will include the *all* of the trainings listed above, plus the following:

Training Type	Training Provider
Trans-Theoretical Models of Stages of Change	Provided by Partner CMHCs
Mental Health First Aid	Provided by Partner CMHCs
Motivational interviewing	Provided by Partner CMHCs
Chronic Pain	Provided by Care Coordination Team and subject matter experts among the Partners
Family Planning & Pregnancy and Child Development	Provided by Care Coordination Team and subject matter experts among the Partners
Basic understanding of common disease processes, such as addiction disorders, diabetes, anxiety, depression, cardiovascular diseases, pulmonary diseases, etc.	Provided by Care Coordination Team and subject matter experts among the Partners
Knowledge of principals and protocols for Care Coordination and Population Health	Provided by Care Coordination Team and subject matter experts among the Partners

Tracking and Reporting Care Coordination Activities

The Partners will track all Care Coordination Team and Network Provider care coordination activities through CommunityCare, and related data interfaces with network providers. CommunityCare is a comprehensive care coordination platform that features customized analytics to track all care coordination activities and to facilitating reporting.

At the *Member level*, Care Coordination Team users will have their own dashboard that will show their panel of Members, where they are in the care coordination process and next steps i.e., Is the assessment complete? Have requested records been sent? Was a referral sent, accepted by the provider, and closed? Are there notes from other coordinators? Are there ADT messages indicating that the Member has had a recent ER visit?

At the *community level*, CommunityCare can support management of targeted populations, such as Criminal Justice-Involved (CJI) Members or children involved in wrap-around services, Foster or Kinship Care; or population management tracking of targeted conditions, such as diabetes or depression, to make sure Members are receiving timely, evidence-based care according to clinical guidelines.

At the *Provider level*, CommunityCare can group Members by their attributed PCMP or CMHC, supporting the ability for Care Coordination Team staff to communicate with providers on their specific panel of patients.

Finally, at the *systems level*, CommunityCare will support all required reporting as defined in Section 5.9.4 of the RFP – Care Coordination Activity Report, including:

- Care coordination performed by Network Providers and the Care Coordination Team
- Statistics related to:
  - Number of unique Members that received any care coordination service provided by the Care Coordination Team
  - Types and number of deliberate interventions provided to Members
- Examples of deliberate interventions and activities performed to support Members
- Examples of specific types of care transitions, including RAE to RAE transitions, CJI involved Members transitioning out of the criminal system and Members transitioning from facility to community settings

We will develop and submit to the Department a comprehensive report of all care coordination activities every six months. The report will inform quality improvement activities, Care Coordination Team staffing levels and responsibilities, and development of provider practice transformation goals.

B. ALIGNMENT AND COLLABORATION OF CARE COORDINATORS ACROSS SYSTEMS

Care Coordination Program Collaboration

The Partners' Care Coordination Program is fully integrated, meaning social services, behavioral health, substance use and medical care coordination specialists work on the same team, and all

are working in the community as close to the point of care as possible. This community-based model is ideal for collaboration across systems, as the Care Coordination Team will be well known in the community as a resource for supporting Members with complex needs. For example, when the MACC Team in Fort Collins was first established, they reached out to PCMP offices, CMHCs and providers of long term care supports and services to introduce the team and its purpose. As they became better known in the community, they became a resource for individuals needing comprehensive support. As they coordinated services with Members, they connected to additional systems and resources, including SUD providers, the Larimer County Department of Human Services and SummitStone's Crisis Center and are now an integral part of the comprehensive system of care coordination in the Fort Collins and surrounding community.

In addition, the Partners' robust, HIPAA-secure, roles-based CommunityCare solution connects all of the entities involved in a Member's care, including the PCMP, CMHC, care coordinators and others in the Health Neighborhood. We understand that not every system will use CommunityCare as their document of record; however, its ability to support view-only access and secure messaging will help to support communication across systems. Depending on their role, community-wide care coordinators will see critical screening results, care plans, and referrals, as well as send brief messages to one or all members of an individual's care team**.** We will provide technology adoption and workflow support for Network Providers and other Health Neighborhood partners to support use of CommunityCare as an information resource for shared Members.

The Partners' Care Coordination Team, at all levels, will also receive training in how to work with their counterparts in the Health Neighborhood, including hospitals, specialists, behavioral health and substance use disorder (SUD) providers; and criminal justice, human services and community agencies. Many Region 1 practices, community organizations and county services have internal care coordination or navigation staff that support the needs of their patient/client population. The Partners Care Coordination Team will designate a single contact person as each entity's primary contact to exchange information regarding shared Members. Once a Member is assigned to a lead care coordinator, this person will outreach to all involved providers to determine gaps or duplication of activities and opportunities to provide additional resources, facilitate communication among providers, and outreach to the Member. For example, Care Transition Specialists will work with Network Providers, hospital discharge planners and care transition staff embedded in or collaborating with, local hospitals to maximize the number of Members receiving transition support. If services are needed beyond the care transitions services, these Care Transition Specialists will communicate with the assigned outpatient care coordination specialist to make sure updates in the care plan are understood by the whole team.

In addition to collaboration to meet individual Member needs, the Partners will host and facilitate rotating quarterly regional meetings among all Care Coordination Team, PCMP, CMHC and community organization care coordination staff. These meetings will provide an opportunity for staff to discuss and develop solutions to care coordination barriers and improve communication and referral processes. We will bring findings from regional Learning collaboratives to the Region 1-wide level to determine the need for additional training,

technology or other solutions to further support collaboration among care coordinators and spread best practices.

Referral Loop Closure

The Partners will build on protocols and data-sharing practices created for care coordination to support practice-level and community-wide tracking of referrals. We will implement a two-pronged approach to tracking referrals: 1) building Network Providers' capacity to develop internal closed-loop processes; and 2) use of the Partners' custom data interface to centrally track referrals. This interface will allow sensitive health information to remain protected, while providing visibility to social determinants service Providers. Each system will also allow for follow-up with Members who choose to make the referral on their own and therefore do not have a care coordinator documenting outcomes in the system.

We will provide training and practice transformation opportunities for all PCMP and CMHC providers to develop or strengthen closed-loop referral tracking processes. The Partners' CommunityCare tool will be made available to all practices, along with support for onboarding, training, and workflow development to facilitate adoption. Providers are not required to adopt the tool, and would also receive support to connect their EMR and individual care coordination processes to the Partners' health information exchange access if they want to receive additional data pertaining to their patients.

The Partners' customized data interface and warehouse will provide linkage to referrals made to any Health Neighborhood entity. We will work with the health information exchange organizations, QHN and CORHIO, to connect to and further the infrastructure of CommunityCare.

Specialty Referrals

Access to specialty care services, particularly in rural and frontier areas can be fragmented and problematic. Aside from reimbursement issues, we know that the primary barriers to specialists' seeing Medicaid patients are the prevalence of no-shows, tardiness, and the high social complexity of patients. An important function of the Partners' Care Coordination Program, with its CHWs is to assess for and address the Member's social needs. Addressing social needs, such as transportation, will help reduce some of the current barriers to receiving specialty care.

System Alignment and Strategies for Special Populations

We will foster collaboration between the RAE and LTSS, hospitals, Colorado Crisis Services, and MSO systems, among others, to promote effective coordination and communication across systems. The Partners will convene and actively participate in quarterly care coordination meetings with representatives from the systems listed above to identify challenges associated with care coordination. Common barriers and solutions will also be shared with Network Providers and community organizations through the Performance Improvement Advisory Committee (PIAC). Leadership, and care coordination/case management staff from each system will also be invited to a large annual care coordination systems learning collaborative to address alignment of systems.

Members who use Long Term Care Supports and Services

On the three-dimensional risk stratification model, individuals may use LTSS due to an intellectual/developmental disability and/or a physical disability. Individuals with high complexity in more than one domain will have an assigned Care Manager that serves as the Member's single point of contact with the system. The Care Manager will assess the Member's needs related to the three domains, as well as their social and familial supports, cognitive status, and ability to perform activities of daily living (ADLs). If the member is receiving waiver services, the Care Manager will work with the SEP or CCB to assess whether the Member's current community based services are aligned with the Member's needs.

With good communication across LTSS and other sources for care and services, such as the PCMP, specialists, human services agencies and community based services, the Care Manager can reduce duplication of services and support the Member achieve his or her health and wellness goals. SEP and CCB agencies will have a single point of contact on the Partners' Care Coordination Team to refer Members that need services above and beyond what the SEP or CCB can provide.

Criminal Justice-involved (CJI) Members

CJI Members often have high complexity in each risk domain: medical, behavioral health and social. Many CJI Members have a behavioral health, mental health or co-occurring condition that precipitates their criminality. CJI Members who have been incarcerated for several years may also have chronic physical health conditions. Additionally, these Members may be released in a community that is far away from their home and family support, often do not have transportation and have only temporary housing. A Care Manager assigned to a CJI Member will perform the comprehensive assessment with special focus on social determinants needs and behavioral health needs. The Care Manager will make sure the Member establishes a contact with a PCMP and CMHC to prescribe and manage needed medications, since CJI Members are often released with a limited amount of medication.

If indicated, the Care Manager will work with the Member's parole officer and other involved corrections and court officials and keep them informed of the Member's health and social needs status as they navigate the legal system. Many of our Care Managers and Care Coordination Specialists have worked with court programs, like Drug Court and Family Court, and can support the Member to successfully meet established goals. Parole Offices and other Department of Corrections officials will be given a single point of contact for the Partners' Care Coordination Team, so that they can reach out when they believe Care Management services would be helpful for a recently released CJI Member. Finally, Reunion Health CMHCs provide jail-based services, so they can continue care during Member transitions to the community.

Children involved with Child Welfare

Children involved with Child Welfare have often experienced deep trauma and may have an emotional disorder as a result of their experiences. They may also have unstable housing or food resources and may also have medical conditions requiring attention. For these children, the assigned Care Manager will conduct an age-appropriate comprehensive care coordination assessment in partnership with the child's support system and/or caseworker. Once the Care Manager understands the immediate medical, behavioral health and social determinants needs

of the child, the Care Manager will help establish care with a PCMP and CMHC to prescribe and manage needed medications, as well as identify any medical concerns and needed behavioral health therapies. The Care Manager will work closely with the child's support system, caseworker and school to connect the child with needed services. Child welfare agencies will be given a Partners' Care Coordination Team point of contact so they can refer the child for Care Management services when the child comes into their care.

Members transitioning out of Institutional Settings

Members transitioning out of institutional settings, particularly if they have resided in the institution for a significant period of time, will need help with the basics – housing, food, transportation. The assigned Care Manager will assess the Member's needs related to medical and behavioral health conditions and then coordinate services across systems. These individuals may also need help with socialization – many of Reunion Health CMHCs host Clubhouses, which can serve as a critical social outlet for individuals who would otherwise be isolated. Once basic needs are met and the Member has established care with a PCMP and CMHC, the Care Manager will work with the Member on ways to sustain behavior change and self-management support, as well as adapt to a new environment. The Partners will have a specifically assigned team member to interact with institutional settings, so that representatives from the institution can connect with the Partners' Care Coordination Team to proactively establish care coordination for any transitions.

Members needing Substance Use Disorder Management - Opioids

The Colorado Department of Public Health and Environment estimated that 4.9 percent of adults in Colorado misused prescription painkillers in 2013-2014, slightly above the national average of 4.1 percent. Counties with lower median incomes were more likely to have high rates of opioid misuse.[100] On the three-dimensional risk stratification model, these individuals may have high complexity in each domain: medical, due to a precipitating injury or surgery that was treated with opioids; behavioral health due to SUD; and social determinants, if the SUD has persisted long enough for a person to lose employment, family support or housing. The assigned Care Manager will connect the Member to needed services based on a comprehensive assessment. The Care Manager, backed by the Care Coordination Team, will also work to connect the member with an MSO provider to treat the SUD.

RMHP is developing interventions at the Member, Provider and Systems levels to address the opioid crisis. The Partners' Care Coordination Team will work at the Member level to focus on behavior change tactics, including motivational interviewing and group therapy. Community Care Teams will focus on guiding Members to the most effective treatment for opioid misuse, Medication Assisted Therapy (MAT), and partner with the CMHCs and at the systems level to maximize access to these therapies.

At the Provider level, we will support the Department's opioid prescribing policies, and disseminate information to all prescribing Network Providers using all available channels. We

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[100] Rosenthal, A., Bol, K., Gabella, B. "Examining Opioid and Heroin-Related Drug Overdose in Colorado." CDPHE Health Watch November 2016. http://www.chd.dphe.state.co.us/Resources/pubs/Colorado-Opioid-and-Heroin-Overdose.pdf

will use claims data to analyze physician's prescribing patterns, recognizing that the client composition of physicians' practices varies greatly. However, there are certain prescribing patterns--medications, doses, and durations--that put patients at higher risks for dependence problems. We will support Providers by offering resources like patient agreements, informed consents, and adherence monitoring tools like urine drug screens. RMHP's experience in this field can help providers recognize the distinction between opioid dependence and opioid use disorder and to assess function rather than pain as a measure for opioid dosing.

At the community and systems level, we will partner with existing school- and community-based resources for substance abuse education and prevention. We will use multiple data sources to identify adolescents and young adults at high risk for substance abuse and provide extra social supports. For instance, our data analysis strategy, using the two-generation model, will allow us to identify teens with a parent who has recently divorced, lost a job, or been diagnosed with a chronic disease. Identifying and supporting these individuals during vulnerable life events could supplement existing community efforts and assist them in avoiding opioid misuse.

The Partners' Care Coordination Team will have an assigned contact person that MSOs will use to refer Members to Care Coordination Team services, in order to support the Member's needs and give them a better chance of sustained recovery.

Community Collaboration

We will convene a PIAC for Region 1 that will meet quarterly. Members, individuals from the local oversight committees, and additional regional leadership will comprise the PIAC. An annual learning collaborative will bring together the local oversight committee leadership and PIAC members to allow for exchange of best practices, identification of region-wide concerns or barriers and evaluate how we, as a collective, are doing to make the health system less fragmented and more aligned with the needs of our Members.

C. OUTREACH, INTERVENTION AND MONITORING OVERUTILIZATION

The Partners will implement a system for proactively monitoring utilization of services, and will respond quickly to address over treatment and excess resource use as well as gaps in care.

The Partners will leverage data analytics and existing relationships with Members to identify patterns of overutilization and unmet Member needs. Our care coordination process is established to recognize threshold conditions that indicate potential overutilization, which will then trigger review and follow up by the Care Coordination Team. Monitoring involves proactive data analysis, longitudinal health and care planning records (available to all partners through CommunityCare), PCMP electronic medical record data and the Department's Needs Assessment data to identify individuals who meet the threshold criteria that indicates potentially avoidable overutilization. All assessment and intervention processes emphasize Member safety and patient-centered care planning to maximize outcomes.

The following grid depicts the threshold condition(s), data sources, timeframes for addressing overutilization, and parties responsible for implementing an intervention.

Criteria	Administrative Data Definition (depending on available data)	Workflow	Data Source / Definition	Timeline for Needs Screening
COUP	Criteria defined by HCPF • Use of 16 or more prescriptions; • Use of 3 or more pharmacies; • Use of 3 or more drugs in the same therapeutic category • Excessive ER and physician visits; OR • A referral or analysis indicates possible overutilization	Department provides report to RMHP with Members who meet one or more criteria. RMHP reviews report against members currently receiving care coordination services, and against other data sources. RMHP notifies Department of members on the report who are inappropriately using services RMHP adds members who qualify for COUP to CC caseload to intervene and monitor.	Department, ADT data transmitted to CommunityCare	Once list is received from Department, 30 days to review and respond, if utilization is considered inappropriate, the Care Coordination Team will reach out to Member to start the care coordination process.
ER Utilization	4 or more ER visits in 15 month.	Member is flagged in CommunityCare, and assigned to a Care Transitions Specialist who will reach out to the Member and start the care coordination and transitions of care process. In some cases, such as high risk pregnancy, high ER utilization is appropriate. The Care Transitions Specialist will work with the Member and his/her PCMP to make that determination.	ADT data transmitted to CommunityCare	Outreach by care Coordination Team member within 48 hours of visit for high utilizers.
Total Cost	$100k in 15 months	Care Coordination Team member will review data and prioritize Members for outreach to assess current conditions, unmet needs to address urgent and chronic needs, promote self-management and independent living. If warranted, referral is made to Care Coordination	Data related to cost of care is in our data management systems and a flag will appear in CommunityCare when a Member reaches this threshold.	30 days after hitting threshold

Criteria	Administrative Data Definition (depending on available data)	Workflow	Data Source / Definition	Timeline for Needs Screening
		or Care Management for routine follow-up.		
Drug Safety program	More than 8 drugs prescribed concurrently for 90 days or more than $10k in drug costs or more than 90 days on Opioid List	Care Coordination Team member outreaches to the Member to assess needs and appropriateness of drug regimen and documents findings in CommunityCare. If need for coordination is identified, referral to Care Coordination Team for follow-up.	Data related to prescription numbers and cost is in our data management systems and a flag will appear in CommunityCare when a Member reaches this threshold.	30 days after identification

Outreach and Intervention when Overutilization is Detected

The Care Coordination Team will receive automated alerts if a Member's claims or utilization indicates an emerging risk, and will assign a Care Coordination Team member to conduct outreach to the attributed practice for Members whose complex care requires leadership or direction. All providers will have direct access to support through the OneCall Support system, as well as their local CCT, and can request support to coordinate care for individual Members if they observe a pattern of overutilization. The Team will determine the appropriate level of intervention and will leverage other practice and Health Neighborhood partner expertise and resources to make sure the Member's needs are met. Members with high ED and inpatient visits will receive outreach from the Care Transition Coordinators to facilitate reengagement in services at their medical home. The care coordination staff will elevate Members to a higher level of coordination if they identify a behavior or need that warrants additional support.

Members who overutilize services, and have additional physical, behavioral health or social needs complexities will be a priority focus for Care Management intervention. We know that Members who have a serious and persistent mental illness or SUD can generate a significant proportion of emergency room overutilization. The Care Coordination Program model focuses on behavioral health techniques to promote adherence and self-management of chronic health conditions to develop the Member's ability to self-manage their care. Members with overutilization of services will receive outreach from Care Managers, who will collaborate with Members to determine the best interventions and self-management techniques to address Member-specific overutilization challenges. Care Management interventions are specific to the Member's needs, so if the underlying cause for overutilization of services is SUD, the Care Manager will assess the Member's willingness to recognize the issue and engage in recovery support. Interventions are designed to increase Member engagement in their care plan and reduce avoidable escalation of their condition.

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.

INTRODUCTION

As a high performing Colorado health plan delivering every form of coverage, Rocky Mountain Health Plans (RMHP) has deep experience supporting providers in their efforts to deliver the best possible care to their patients. We have substantial expertise regarding Colorado Medicaid operations, and consistently strive to find better ways to improve performance, capacity and outcomes within the Provider Network. We actively collect feedback regarding provider needs and gaps to guide our work. One of the most common, recurring requests for assistance we receive pertains to resources for the support and coordination of services for people with complex behavioral and social needs. RMHP is well-positioned to meet these needs, by building upon existing payment models we have implemented throughout Region 1 for integrated behavioral health services, as well as learning curricula and in-person coaching programs to promote the development of coordinated, team-based and whole person models of care.

Our Practice Transformation programs are designed to meet provider and community needs at every level of development, while maintaining close alignment with state and federal initiatives, such as the Comprehensive Primary Care Plus (CPC+) and State Innovation Model (SIM) programs. We work in a step-wise process to promote the competencies described as the Ten Building Blocks of High Performing Primary Care by Thomas Bodenheimer, et al., which have been adopted by the Department and the Colorado Multi-Payer Collaborative to align the efforts of all major public and private payers, reduce administrative burdens for providers and accelerate the development of a high performing Network.
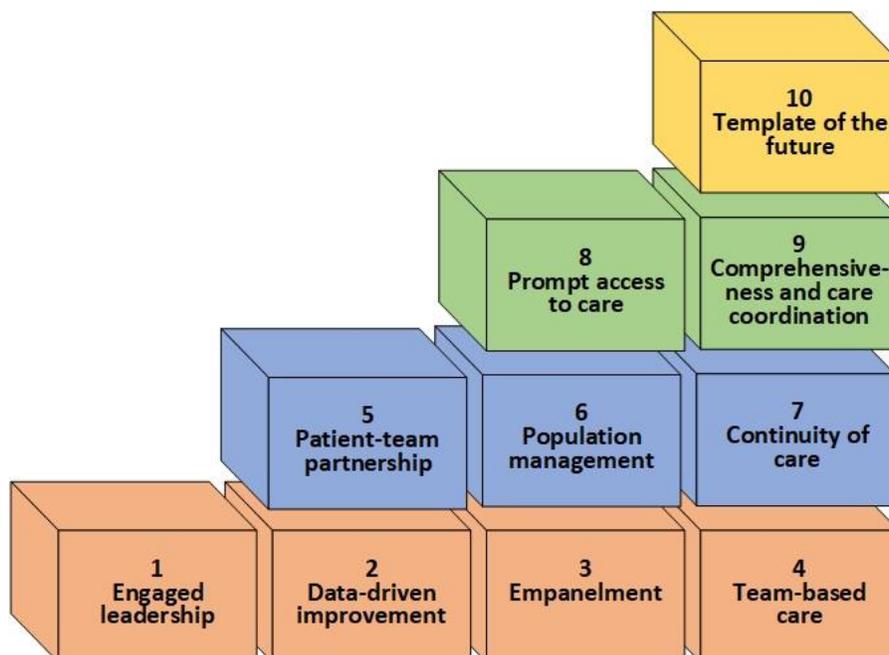
"The 10 Building Blocks of High Performing Primary Care" Annals of Family Medicine March/
April 2014."

RMHP will actively support PCMPs and other participants in the Network as they work to achieve these competencies by developing strong, trusting relationships and engaging in direct, ongoing collaboration. Our comprehensive services include:

- General Information and Administrative Support
- Provider Training
- Data Systems & Technical Support
- Practice Transformation
- Financial Support

GENERAL INFORMATION AND ADMINISTRATIVE SUPPORT

Effective communication with providers is a critical component to building and maintaining a robust Provider Network. RMHP has a proven track record developing and disseminating a wide range of relevant information to providers, and making basic and detailed information about the Medicaid program, relevant policies and procedures, and important contact information available to them.

Information is shared with the network providers in a number of ways, including a comprehensive website, through provision of various manuals, newsletters, bulletins and other informational tools, and by providing knowledgeable and dedicated staff who work both telephonically and in-person to help PMCPs navigate complex Medicaid policies and procedures. The Partners have a proven track record on which to build that gives Medicaid providers access to the tools and resources needed for success.

Provider Relations Representatives and Provider Network Management Staff

One factor contributing to RMHP's success in developing and maintaining its current Prime and Accountable Care Collaborative (ACC) provider network is the support provided by Provider Network Management (PNM) staff. RMHP has a dedicated representative for each participating provider, including all PCMPs and behavioral health providers, in the ACC provider network. These resources work closely with providers and their teams and serve as an essential link between the provider and RMHP.

These "on-the-ground" representatives are available by phone, email, or through face-to-face meetings as necessary. RMHP is a licensed, statewide health maintenance organization, so PNM staff are located throughout Region 1, as well as along the Front Range and in Southern Colorado. Provider representatives are well positioned to perform recruitment, retention, training and administrative support duties throughout Colorado. Staff are trained to support providers with questions about Medicaid and its operational systems, processes, regulations and procedures. They are well prepared to address a multitude of topics, including questions about forms, claims, and reports, attribution and payment issues.

Providers look to RMHP PNM staff for answers or for assistance in problem resolution. This was especially evident during the recent interChange launch and Medicaid revalidation process.

RMHP worked with the Department to develop easy to use instructions and materials to help providers understand the changes and what steps are necessary to resolve payment problems. Representatives spent many hours on the phone, and in-person at the provider's office when necessary, to help providers understand these changes.

RMHP understands that Medicaid providers do not want to contend with unnecessary administrative hassles. Our representatives work to address questions regarding Medicaid enrollment and authorization procedures, so that frustrations do not materialize and compromise access to care. Additionally, personal connections are maintained through semi-annual field visits with participating providers. These visits are educational and relationship building opportunities and, through direct interaction, allow staff to demonstrate and emphasize RMHP's readiness and availability to troubleshoot and resolve issues.

RMHP provider representatives serve all participating providers in a geographic area – often times representing the community in which they themselves live. This allows the representative to understand the dynamics of the community and they will often hear informally from others within the community if providers are coming to the area or leaving. This "human intelligence" is invaluable and helps us anticipate changes in the provider network.

Partner Network Management staff also work to proactively identify systemic issues and problems. When RMHP identifies a recurring question or issue, we develop and disseminate "talking points" or "Frequently Asked Questions" documents to help providers understand the issue and procedures to be followed to achieve resolution. RMHP works closely with the Department's Contract Manager to identify and address root cause problems and communication gaps. RMHP team members also participate in the ACC Program Improvement Advisory Committee (PIAC) and the Department Operations meetings to receive direction on how to advise providers when new questions arise. RMHP consistently receives positive feedback from our provider partners about the ease of working with us, and our shared passion for serving enrolled Members.

General and Medicaid Specific Communications, and Clinical Resources

RMHP currently supports individual Primary Care Medical Provider (PCMP) practices by providing a wide variety of data, tools and concepts to build their capabilities to achieve the ultimate goal of better care at a lower total cost. The Partners will continue to support PCMPs and regional community care teams (CCTs) with data reports, including a monthly attribution report, Care Management Analysis Tool (CMAT) report, Population Report, and an annual Gaps in Preventive Care report. These reports are uploaded to a secure, HIPAA-compliant, web-based portal where providers can download them at their convenience. RMHP and Reunion Health will continue this successful approach as the RAE, with comprehensive support that includes participants in the Medicaid behavioral health network. The Partners will also integrate substantial new resources available through the Department's Business Intelligence and Data Management System (BIDM), including support in setting up user access accounts and sharing information on available BIDM trainings.

Additionally, the Partners will provide a wide range of more general information, as described below.

- **Quarterly Provider Newsletters:** Rocky Mountain Health Provider Edition is a quarterly newsletter posted on the RMHP website. This easy to access, easy to read publication contains a wide range of information important to our provider community. The most recent edition, Summer 2017, contains information on the following topics:

  - New Member ID cards

  - Update on RMHP's Clinical Practice Guidelines

  - Patient Rights and Responsibilities

  - RMHP's Advance Directives Policy and Provider Responsibilities on Advance Directives

  - Wait Time Standards for Access to Care

- **Monthly Prudent Prescriber Newsletter:** Written by a primary care physician in the Network, this monthly publication is posted on the RMHP website. The most recent edition, June 2017, focuses on dosing for a new generic asthma inhaler.

- **Monthly "PharmaSuitables" Publication:** Written by RMHP pharmacists and other medical staff, this monthly publication is posted on the RMHP website. The April issue addresses a new "abuse deterrent" opioid, a new insulin glargine injection with a review of relevant clinical studies, and a new over-the-counter antihistamine.

Medicaid Specific Information

The Medicaid Provider Manual is an essential source of information and serves as a comprehensive provider guide to the program. Below is some of the information currently contained in the manual developed by RMHP, which will be updated to reflect changes associated with implementation of the RAE:

- **The Basics –** What is the ACC and who can participate (Members and Providers)

- **Program Specifics** – Definition of PCMP, introduction to the Department's BIDM, goals of the ACC, performance measurement, contracting with HCPF

- **Member Enrollment** – Selection of a PCMP and attribution, links to the Department PCMP Choice Form for fax enrollment

- **Provider Payments –** Prior authorization requests with a link to the Department's UM vendor portal, and information about incentive payments

- **Data and Reports –** Information on how to access data and reports from the Department's portal, and information about the metrics, reports, and tools available

- **Care Management Information –** Risk/Acuity-Based Levels of Care coordination, Community Care teams, State eligibility portal and how to access the portal

- **Contact information –** For the Partners, State administrations, Nurse Advice Line, Ombudsman for Medicaid Managed Care, Crisis, Behavioral and Mental Health Services, Single Entry Point Agencies, Community Centered Boards, as well as other needed Medicaid contacts

Provider Bulletins and Distribution Lists

Another tool for sharing important Medicaid-specific program information with providers is the **RMHP Region 1 Bulletin,** designed to supply providers with important information on a wide range of issues, including changes and new opportunities within the ACC program. As an example, the Fall 2016 Bulletin contained information on the following topics:

- Health First Colorado branding of the State Medicaid program
- The new State enrollment and claims management system (Colorado interchange)
- The new State pharmacy benefits management system (Magellan Rx)
- New Provider Fee Schedule
- Update on the Client Overutilization Program (COUP)
- Recoupment of Key Performance Indicator Overpayments
- Enhanced Primary Care Program Payments and Recognition Certificates
- New and Free Online Cognitive Behavioral Therapy Service for Western Slope Health First Colorado Members
- New website to support providers who want to improve pain care expertise
- Grant and other funding opportunities
- Contact information for the RMHP ACC team

RMHP will also maintain an ACC provider email distribution database, which includes PCMPs and behavioral health providers participating in the RAE, to send important communications on an ad hoc basis when necessary.

Online Clinical Resources

The RMHP Community website contains a Transformation Resources section for Providers that offers information, including tools for motivational interviewing and patient self-management, patient activation measures and patient resources for specific conditions such as diabetes and high blood pressure. It also includes clinical guidelines and other provider resources on the following topics:

- Asthma
- Cardiovascular
- Communication
- Depression
- Diabetes
- Disabilities
- Medical Home Resources for Providers
- Pregnancy
- Prevention and Safety

RMHP's communication process for network providers is always being developed and refined. RMHP and Reunion Health are committed to building and maintaining the most complete and

comprehensive provider network possible, and recognize that providing tools for physical and behavioral health providers that help them stay informed is an important part of that effort.

PROVIDER TRAINING

The Partners have demonstrated a long-standing commitment to providing useful and timely training to providers. We have a comprehensive library of resources related to practice transformation, the Medicaid population, behavioral health integration, and many other topics that we will be able to quickly deploy for network providers.

The Partners have and will continue to provide training in a variety of modalities, including face-to-face or in person and webinar/virtual learning sessions, and consider the format that will be most helpful for providers when determining which approach to offer. Training may be provided annually, semi-annually, or on an as-needed basis. In order to assist with network provider employee orientations, some trainings may be recorded for future and repeat use.

Below is a description of the Partners' approach to the development and provision of both the standard and customized training we will make available to our Provider Network.

Annual Trainings

Annual trainings offered to Network Providers will include:

- Medicaid Eligibility and the Application Process
- Medicaid Benefits
- Access-to-Care
- EPSDT
- Population Health Management Plan
- Colorado Client Assessment Record Training
- Cultural Responsiveness
- Member Rights, Grievances, and Appeals
- Continuous Quality Improvement
- Recovery and Psychiatric Rehabilitation
- Trauma-informed care

We will work with the Department to identify other training topics that will be useful to providers. Once we develop the curriculum, we will provide the training in the most appropriate modality.

Behavioral Health Integration Trainings

In addition, with the support of CMHC partners within Reunion Health, RMHP will develop and provide training that may be especially important for network providers who are working within integrated behavioral health settings, or who may need additional support in understanding how to work with Members using short-term therapeutic models. This training will include the following:

- Levels of Integration (framework)

- Core Competencies in Integrated Care

- Motivational Interviewing

- Solution-focused Therapy

- Triage and Appropriate Referral to Network Providers Providing Long-term Therapeutic Support (e.g. CMHCs)

- Crisis Intervention

- Ethics and Ethical Decision Making in Integrated Care, including documentation and communication and coordination

- Lifestyle and Medical Knowledge, including pharmacology

- Goal Setting in Primary Care

- Behavior Change in Primary Care (e.g. sleep, medication management, exercise, etc.)

- Working with Family Members

- Self-care and Stress Management

- Culture of Primary Care, including topics such as conducting a huddle, communication within a treatment team, working with a Primary Care Treatment Team and working with a Behavioral Health Consultation

- Appropriate Groups for Primary Care

Disability Competent Care Trainings

Disability Competent Care training will present case studies to walk clinical professionals through the following concepts:

- Basic Requirements of the Americans with Disabilities Act (ADA)

- Effective Communication Requirements of the ADA and Best Practices -- including how to communicate with people with cognitive and psychiatric disabilities

- Psychosocial Issues and Disability Cultural Competency

- Functional Treatment including Pain Management, Durable Medical Equipment and Community-based Treatment

- Other Available Resources

RMHP is able to offer physicians one hour of American Medical Association (AMA) Continuing Medical Education (CME) credit for participation in this training.

Bridges Out of Poverty Training

Bridges Out of Poverty training is presented by trained RMHP Care Management staff members to case managers and staff who work with Prime and ACC members. The RMHP Bridges Out of Poverty presentation includes:

- Creating a true mental model of poverty

- Understanding the barriers and struggles of poverty

- Understanding the hidden rules of poverty
- Understanding the language register and discourse patterns of poverty
- Resource tools
- Video documentaries of life in poverty
- Video examples of the language of poverty

The Program goals include:

- Encourage communication and relationship between member and provider
- Increase awareness and understanding of poverty
- Promote self-management skills for members
- Provide interactive resources to assist in case management

Zero Suicide

Zero Suicide is a commitment made by all clinicians and administrators in physical and behavioral health settings to relentlessly pursue a reduction in suicide deaths to zero. To implement this initiative, The Partners will promote adoption of Zero Suicide principles and assist participating providers by offering training in using and responding to screening tools. The intention of all Zero Suicide activities is to have early identification of those at risk of suicide, to support those in suicide crisis, to apply effective suicide intervention strategies with those in suicide care, and ultimately to reduce the number of member suicide deaths to zero.

Other Provider Training Activities

Additionally, Provider Network Management staff will work closely with provider groups to present information about the Prime and ACC programs, answer questions and assess on-going learning needs, and develop orientation and other programs that support providers' understanding of the features and details of Health First Colorado.

RMHP facilitates quarterly Cross-Community Care Team meetings to provide an opportunity to learn from each other regarding each team's approach to engaging and supporting Members. Each meeting features at least one presentation from a community partner who serves as a resource for Members. Recent presentations have included criminal justice and healthcare reform, the B4Babies program, introduction to the Medicare-Medicaid Advocate, and the Health First Colorado pediatric personal care and adult dental benefits. RMHP and Department updates are also provided.

Additionally, RMHP takes the opportunity to share operational and administrative information about the ACC whenever possible during provider meetings, training sessions, provider learning collaboratives and email communications. Information includes: the benefits package and services available to members, preauthorization and utilization management practices, claims procedures, enrollment issues and other operational matters.

As information needs evolve, and as the modes of dissemination change, the Partners will work to ensure that they equip network providers with the most current information, in the most efficient way possible, to support the shared goal of providing high quality medical care.

DATA SYSTEMS AND TECHNOLOGY SUPPORT

RMHP has invested substantially in technology and related resources to support data-based decision making and facilitate practice transformation. We recognize that to make the best use of data, challenging development projects and activities related to data sharing and data consolidation are required. In this section, we discuss some of our initiatives and activities around the acquisition and sharing of data, and the other exciting and innovative uses of technology being made available to the Network, Health Neighborhood and broader ACC Community.

Predict, Prioritize and Prevent

In order to deliver appropriate care to the patients who need it most, providers must first identify those individuals and understand their needs. Risk stratification is important for identifying and predicting which patients are at high risk (or are likely to be at high risk) and prioritizing the management of their care in order to optimize outcomes. Risk stratification and advanced panel management allow practices to move toward value-based reimbursement, where providers assume increasing responsibility for managing quality and costs for their entire population of patients.

As described in RMHP's 2013 *Issue Brief* "Predict, Prioritize and Prevent: Nine things practices should know about risk stratification and panel management", written by RMHP with Asaf Bitton, MD, MPH, FACP, a practicing primary care physician and researcher at the Center for Primary Care at Harvard Medical School, there are **nine key things** practices need to consider:

1. Better data means better process
2. The patient's voice and the clinician's judgment are both essential
3. Start where you are
4. Know your patient (empanelment)
5. Know why you stratify
6. Risk is dynamic, not static
7. Risk stratification and panel management demand *and* foster workflow design
8. Data alone is a start, not an endpoint; transformation requires action
9. Risk stratification is the way of the future

In support of the goals related to *predict, prioritize and prevent*, RMHP, in close partnership with Quality Health Network (QHN), has facilitated the deployment of tools that are creating immediate impact – at the individual patient, physician and population levels. Some of these efforts are described below.

Individualized Guidelines and Outcomes (IndiGO)

IndiGO utilizes clinical data, extracted from EHRs and enhanced by HIE, that providers can use to collaborate with patients to set personalized goals and understand the positive and negative impact of behavior change and medications on their health. IndiGO algorithms analyze data on human physiology, diseases, behavior, and interventions to generate predictions of the

likelihood of cardiovascular and stroke events based on criteria such as blood pressure, lab results, medication history, body mass index (BMI), and lifestyle factors.[101]

Using IndiGO, practices can take an individually-focused approach, identify high risk patients, and recommend treatment that could avert a serious health event.

This works by clinicians entering a possible change, e.g., begin taking a statin, quit smoking, lose 10 pounds – and showing the patient the impact this change has on his/her overall risk. For example, a physician working with a patient with diabetes could plug in five possible interventions and get a score for each, demonstrating how effective each intervention would be for that patient. This information is presented in an easy-to understand graphic that engages the patient and helps the patient make decisions about his or her own health.

The data and processes to produce IndiGO scores demonstrate RMHP's ability to work with its community partners to gather and use data from different sources:

- Clinical data from PCMP electronic health records is sent nightly to QHN, which is the Western Slope health information exchange entity.

- Lab results and hospital data from numerous facilities on the Western Slope and front range are routed through QHN.

- Administrative/claims data, primarily prescriptions and diagnoses, is provided by RMHP.

All of this data is aggregated by QHN and sent to IndiGO on a nightly basis, and updated risk stratification and recommended interventions are made available to the practices using the tool.

Meaningful Population Targeting Reports
Each month RMHP produces various population-targeted reports for participating providers, care teams, and RMHP management and partners.

- *Care Management Assessment Tool Report*: RMHP uses the Department's fee-for-service raw claims data to create a care management assessment tool (CMAT). The CMAT report contains high-level population management data as well as individual Member level claims data. Reviewers can sort this data by utilization pattern, risk score and disease process, including behavioral health conditions. RMHP providers and care coordinators find this tool to be a useful starting point for identifying patients with complex needs and appropriately organizing resources to serve them best.

- *Attribution Reports*: Each month participating providers receive a report showing their population of attributed patients. Similar to the CMAT report, this report contains high-level population management data for the practice as well as individual Member level claims data available by utilization pattern, risk score and disease process, including behavioral health conditions.

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[101] IndiGO predictive risk scores reduce heart attacks, strokes. September 13, 2013.
http://healthitanalytics.com/news/indigo-predictive-risk-scores-reduce-heart-attacks-strokes

- *Practice Feedback Report*: This report contains a charting tool summarizing longitudinal clinical quality measures provided by participating practices. The report is updated and reviewed by RMHP management and allows them to quickly identify data issues, performance trends, and improvement on targeted measures. It presents data for each practice and for the practices combined, showing the underlying results both numerically and graphically.

Multi-Payer and Multi-Provider Claims and Clinical Data Tool for Practices (Stratus)

RMHP was instrumental development of a multi-payer data aggregation effort by Colorado payers for SIM and Comprehensive Primary Care Plus (CPC+) participating payers and practices. The analytic tool selected for this aggregation, Stratus, serves as a single source for patient-level and practice-level information, allowing providers to access their patients' claims data, across multiple payers, from a single place.

Care providers commonly receive multiple reports from each health plan, making it cumbersome and inefficient to coordinate a patient's care. Aggregated multi-payer data, including RMHP and Colorado Medicaid data, allows clinicians to get an overall snapshot of their patient population to identify care gaps and target areas for population health improvement.

In order to build on the basic functionality of Stratus, RMHP convened a subgroup of CPC practices, payers (including State agencies), and Colorado's Health Information Exchanges (both QHN and Colorado Regional Health Information Organization [CORHIO]) to pilot a process to combine the multi-payer claims data with practice clinical data for a tool that better identifies true gaps in care. Under RMHP leadership and guidance, the subgroup identified three areas of focus for the clinical data integration pilot:

- A1c control
- Depression screening, follow-up and remission
- Breast cancer screenings/ mammograms

The selection of these specific measures was based on a number of factors: 1) clinical relevance; 2) inclusion in the CPC suite of measures; 3) State Innovation Model Office interest; and 4) variety in the actual sources of data, i.e., EHRs, HIEs and payers. For example, much of the data relevant to the A1c measure is available through claims data, so data from EHRs will supplement data already in the aggregation tool. Depression screening, follow-up and remission data will come primarily from practice EHRs, (with the exception of prescription data, some of which may be available through claims) and data that will supplement mammogram claims data will come primarily from the HIE.

To illustrate the importance of this work when measuring depression screening follow-up, the *claims-based* data only identifies if medication was provided after depression diagnosis. By including *clinical* data, measurement can indicate if non-medication follow-up, such as a referral, was provided.

Three practices are participating in the pilot – two on the Western Slope of Colorado, and one with 30+ locations on the Front Range. The long-term goal is to understand benefits and challenges associated with the integration of claims and clinical data, and a look towards expanding data integration to additional practices and additional clinical areas of focus.

Capacity Building through Telehealth Solutions

Telehealth can be a very effective tool to create access to care where it is insufficient or nonexistent. In 2014, RMHP adopted telehealth tools, developed by technology partner CirrusMD, which allow Members to instant message or video chat with a licensed Colorado emergency medicine physician, free of charge. A Member can ask questions, show symptoms, get a diagnosis and receive treatment – including many prescriptions – from any computer or mobile device, which can help reduce unnecessary emergency room or urgent care visits.

RMHP has integrated CirrusMD's solution within QHN, which enables patient interactions to be documented as brief encounter notes, tagged with general categorizations (e.g., prescription, refer to PCP, refer to ED, refer to care manager) and routed to clinical end users in other organizations that serve the Member.

In 2016, RMHP expanded the use of CirrusMD's technology platform by offering *EasyCare Colorado* to several of network providers, including FQHCs, private practices and Community Mental Health Centers, to support a wide variety of virtual clinic and asynchronous practice models. The use cases being explored by the practices include use of EasyCare to facilitate care coordination activities, patient education, and behavioral health interventions and counseling. The goal is to make use of pilot learning and expand the use of EasyCare to additional practices and additional use cases.

Additional RMHP Technology & Data Breakthroughs

- **Real Time Admission, Discharge and Transfer Data** -- RMHP's provider networks and care coordination networks have access to real time hospital admissions, discharge and transfer (ADT) data, including emergency room visits. This access has been accomplished through a collaborative effort between RMHP, QHN, and CORHIO, which feeds data from over 60 hospital systems from across the State into RMHP's care management platform. RMHP primary care and behavioral health providers receive access to this platform at no cost, and use this data daily in the performance of real-time transitions of care activities.

- **Automation of Patient Choice** – Demonstrating its commitment to quality improvement, RMHP is working with practices and QHN to automate the patient choice process, through which Prime and ACC Members select PCMPs. The Member's PCMP selections are documented on a paper form, but demographic, eligibility and PCMP selection information is structured and sent securely from the practice's electronic health record to QHN. This information is then sent via web service to RMHP to support the Member's attribution. This automated, electronic transfer of information replaces a fax process.

- **Social Information Exchange** -- RMHP, in partnership with QHN, is procuring a solution to facilitate three important tasks: 1) facilitate high-level communication across the

Community Resource Network (CRN) to support care coordination; 2) push ADT information to physical health, behavioral health and social services care team members; and 3) track and close the loop on referrals to community services that address Social Determinants of Health such as housing, food insecurity and domestic violence. This initiative acts as a health information exchange for social and community services and the organizations that refer to these services.

- **Impact Pro** – The Partners use Impact Pro, a predictive modeling and care management analytics tool, to view member-centric individual profiles and forecast costs and medical service needs based on available data inputs, such as enrollment, medical claims, pharmacy claims, and lab results. These predictive modeling analytics are integrated within provider distribution processes, such as the CMAT and other online resources.

RMHP and Reunion health understand the power of technology and the hard work that is required to transform clinical and business processes to take full advantage of it. RMHP has been an innovator in this realm, and has and will continue to embrace the challenges posed by using technology to realize its benefits.

PRACTICE TRANSFORMATION

RMHP Practice Transformation: Locally Based, Nationally Recognized

RMHP has earned national recognition for its comprehensive Practice Transformation Program. The Practice Transformation Team at RMHP partners with primary care and specialty practices to develop an active learning community to foster quality improvement with a focus on team-based, patient-centered primary care. A state-of-the-art approach is integrated into the medical neighborhood through care management processes, primary and specialty care partnership and social risk factors interventions.

For more than 16 years, the Practice Transformation Team at RMHP has fostered relationships with clinicians, helping them provide patient-centered, coordinated, team-based care to the residents of Western Colorado. The RMHP team provides a suite of evidence-based tools and talent, including Quality Improvement Advisors, Clinical Informaticists, an Integrated Behavioral Health Advisor, and other practice transformation specialists. Participating primary care practices advance through curricula based in large part on the Bodenheimer building blocks of high-performing primary care:

- Engaged leadership
- Data-driven improvement
- Empanelment
- Team-based care
- Patient-team partnership
- Population management
- Continuity of care
- Prompt access to care
- Comprehensiveness and care coordination

- Integration

The RMHP team takes the time to understand each practice, its workflow and its goals, and develop a customized, hands-on approach to meet those specific needs. Because practices and practice team members are unique, RMHP offers a variety of training modalities, designed to fit each learning style. Expert team members guide the practice each step of the way, providing the tools necessary for success, whether it is integrating new technologies or effectively collecting and reporting results. RMHP's sequential, targeted approach to transformation gives physicians and their teams the opportunity to fundamentally redesign their practices and prepare for value-based payments.

Participating practices receive educational support tailored to their particular needs and learning goals. This support includes:

- **Face-to-face practice coaching**: Quality Improvement Advisors and Clinical Informaticists meet with practice staff onsite to coach, train and share resources.
- **Learning collaboratives**: These day-long, face-to-face learning opportunities feature noted subject-matter experts and thought leaders. They also give practices the opportunity for peer-to-peer learning.
- **Targeted training:** Day-long face-to-face events targeted to meet the practice's specific learning and skill needs
- **Additional Tools**: Webinars, content-specific modules, clinical quality measure (CQM) tool kits and an extensive library of templates, tools and other resources are made available to practices.

Participating practices have access to the 17-member multidisciplinary Practice Transformation Team, which currently includes a physician, a PhD behavioral health expert, Registered Nurses (RNs), MBA-trained business consultants and information technology experts with advanced degrees. Their job is to guide and support practices as they step up to advanced primary care. The ten Quality Improvement Advisors and three Clinical Informaticists are deployed to practice sites to provide hands-on guidance to practices, helping them stay on task and report data so they can achieve their own goals.

- *Clinical Informaticists* assist practices with optimizing health IT and the use of electronic medical records (EMRs) and data mapping, data reports, report building, registries and other tasks. They provide face-to-face coaching on the meaning and application of the practice's data.
- *Quality Improvement Advisors* provide hands-on support to guide providers through workflow analysis, efficiency, effectiveness and other areas. They also teach quality improvement techniques.
- The *Integrated Behavioral Health Advisor* helps practices develop the skills, processes and infrastructure support needed to deliver integrated behavioral health in primary care settings.

Practice Transformation Program Module and Learning Tracks

Currently, the RMHP Practice Transformation team has engagements with 80 primary care, behavioral health and specialty practices throughout Region 1. RMHP developed multiple program modules and learning tracks, with the recognition that practices are at different points in the practice transformation continuum, necessitating a customized approach. Current RMHP Practice Transformation Program offerings are as follows:

Foundations

Foundations is an introductory level course in which participants learn basic quality improvement skills at the practice level to include Plan, Do, Study, Act (PDSA) quality improvement cycles, process mapping, and data used to improve/develop and implement skills, processes, and infrastructure to support ongoing improvement and the delivery of effective and efficient primary care.

Foundations Program Objectives

- Develop functioning quality improvement team within the practice
- Implement proven models for delivering clinical guideline-driven care
- Develop accurate, timely and actionable reporting for quality improvement
- Empanel entire active patient population

Foundations Practice Deliverables

- Create a practice quality improvement (QI) team that meets twice monthly to: implement the Program Change Package, implement the Care Model, and implement the Model for Improvement and Plan Do Study Act (PDSA) Cycles
- Meet with Quality Improvement Advisor and Clinical Informaticist
- Submit quarterly narrative reports to RMHP for the purpose of assessing progress by highlighting best practices and challenges
- Submit quarterly clinical quality measures to RMHP for entire patient population
- Participate in at least two learning collaboratives
- Share lessons learned and best practices, through informal, verbal sharing, at the Learning Collaborative Series

Specialty Practice Foundations is a new introductory level course for specialty practices, in which participants learn basic quality improvement skills at the practice level to include Plan, Do, Study, Act (PDSA) quality improvement cycles, process mapping, and data use to improve/develop and implement skills, processes, and infrastructure including enhanced coordination between specialty and primary care.

Masters Level 1

Master Level 1 practices focus on care management of high-risk patients and coordination of care across the medical neighborhood. This body of work includes empanelment (also known as patient-driven attribution), identification of high-risk patient populations and embedding processes for care management. Work is completed on care coordination as it relates to the

medical neighborhood to include avoidance of unnecessary hospital and emergency department visits and timely follow-up after discharge.

Master Level 1 Program Objectives

- Provide care management for high risk patients
- Demonstrate active engagement and care coordination across the medical neighborhood

Master Level 1 Program Deliverables

- Written process for empanelment of all active patients
- Written process for risk stratification of all RMHP patients
- Written process for care management including the use of a complete needs assessment of high risk patients, and patient-specific care plans
- Examples of completed high risk patient care plans and assessments
- Written process for care coordination across the medical neighborhood addressing emergency room visits and hospital discharges
- Quarterly narrative reports for the purpose of sharing progress, best practices, and challenges, as well as assessment of progress towards reducing risk and lowering costs utilizing reports generated monthly to practices
- Quarterly submission of quality measures to RMHP for entire patient population
- Participation in at least two learning collaboratives

Masters Level 2

Masters Level 2 practices expand their focus on care management of high risk patients and care coordination across the medical neighborhood and bring the patient experience into their QI processes through the use of shared decision making, the incorporation of patient surveys or patient family advisory councils (PFACs), and through the use of the Patient Activation Measure (PAM).

Masters Level 2 Program Objectives

- Provide care management for high-risk patients including implementation of the Patient Activation Measure and Coaching for Activation tool
- Demonstrate active engagement and care coordination across the neighborhood
- Assess and improve patient experience of care
- Shared decision making

Masters Level 2 Practice Deliverables:

- Ongoing implementation of empanelment and risk stratification process for care coordination and care management of high risk patients including the use of a complete patient needs assessment and patient specific care plans
- Examples of care plans and completed total needs assessments
- Update written process for care coordination across the medical neighborhood focusing on emergency department visits and hospital discharges

- For the selected item:
  - Written process to survey patients, copy of survey, and findings and changes addressed
  - Written process for implementing PFAC, and meeting agendas and minutes
  - Written process of shared-decision making and implementation of the use of a shared-decision making tool
- Quarterly narrative reports for the purpose of sharing progress, best practices and challenges, as well as assessment of progress towards reducing risk and lowering costs utilizing reports generated monthly to practices
- Quarterly submission of quality measures to RMHP for entire patient population
- Participation in at least two learning collaboratives

RMHP and its partners support quality improvement and assist practices achieve the quadruple aim of health reform in many other ways. Some of these are described below.

CO–EARTH (Colorado is Expanding Access to Rural Team-based Healthcare)

CO-EARTH is a practice transformation program designed to support rural practices and smaller practices (1 to 6 providers) in larger communities as they implement behavioral health integration. The program directs resources to participating practices so they can develop and implement the skills, processes, and infrastructure necessary to support the delivery of integrated behavioral health in primary care settings. CO-EARTH is a collaborative effort between St. Mary's Family Medicine Residency, RMHP, Caring for Colorado Foundation, and the University of Colorado Department of Family Medicine.

Colorado is at the cutting edge of behavioral health integration, with many health care systems boasting advanced, high functioning integrated models. Our state also benefits from a four-year federal grant (the State Innovation Model) that aims to expand integrated behavioral health services to the primary care offices of 80 percent of Coloradans. CO-EARTH's sponsors aim to ensure that these benefits are relevant and accessible to all types of practices, with a specific emphasis on assisting smaller practices or those from rural communities.

CO-EARTH offers three levels of training and support uniquely tailored to the needs of participating clinics and communities:

- **Coordinated Care Track:** For clinics wanting to improve their existing staff's ability to address behavioral health issues and to collaborate with behavioral health clinicians in the community (three to four months for completion)
- **Co-Located Care Track:** For clinics wanting to embed a behavioral health clinician (six to eight months for completion)
- **Integrated Care Track:** For clinics who already embed behavioral health clinicians and now want to create a fully integrated model—clinical services, payment, documentation and leadership (12+ months for completion).

The CO-EARTH team works with clinics to identify strengths, resources and a vision for practice transformation. Services include a one-day training visit, monthly support phone calls, and a one-day multi-site learning collaborative. Additional services can include one- to three-week rural rotations with family medicine residents trained in integrated care and assistance in applying for the SIM program.

CO-EARTH Program Objectives (vary between tracks)

- Screening and tracking psychiatric conditions in primary care
- Primary care counseling and behavioral intervention skills
- Basics of coordinated care
- Basics of co-location
- Basics of integration
- Care management
- Business practices
- Human resources and leadership
- Health information technology (HIT)
- Quality improvement and change management

CO-EARTH Practice Deliverables:

- Initial self-assessment upon entrance into the program
- Attendance at an annual CO-EARTH learning collaborative, usually in June
- Monthly internal quality improvement meetings pertaining to CO-EARTH work
- Monthly team conference calls with St. Mary's and RMHP Quality Improvement Advisor
- Narrative to summarize progress and plans for continued growth upon completion of the program

Patient Centered Medical Home (PCMH/PCSP) Recognition

Patient Centered Medical Home (PCMH/PCSP) Recognition practices review and improve current processes and develop and implement new processes to build and maintain an infrastructure that supports ongoing improvement for the delivery of effective and efficient primary care, as recognized and in accordance with NCQA's standards for PCMH Recognition. The goal is to attain Level 3 Recognition from NCQA. Currently, 10 practices are enrolled in the PCMH Recognition course.

Comprehensive Primary Care Plus (CPC+)

CPC+ is a five-year nationwide initiative administered by the CMS Innovation Center (CMMI). CPC+ is a partnership between payer partners from the Center for Medicare & Medicaid Services (CMS), state Medicaid agencies, commercial health plans, self-insured businesses and primary care providers. The goal of CPC+ is to strengthen primary care by focusing on high quality and high value care with an advanced care delivery and payment structure to achieve better care, smarter spending and healthier people. This program will allow for practices to be innovative in care delivery and payment redesign. Practices will receive financial support that

will change the way they deliver care via care management fees (CMF) and performance-based incentives.

Practices will participate in two different tracks based on their readiness for transformation. Each track will have different payment methodologies and care delivery requirements. Practices in Track 1 will build capabilities to deliver comprehensive care and better meet the needs of their patients. Practices in Track 2 will have additional requirements and will enhance their comprehensive care delivery. Each track will focus on the five Comprehensive Primary Care Functions:

- **Function 1**: Access & Continuity
- **Function 2:** Care Management
- **Function 3:** Comprehensiveness & Coordination
- **Function 4:** Patient & Caregiver Engagement
- **Function 5:** Planned Care & Population Health

Practices in all tracks have access to national and regional learning communities, individual and small group coaching and actionable data. CPC+ qualifies as an advanced alternative payment model (APM) through the Medicare Access and CHIP Reauthorization Act (MACRA). The practice transformation team at RMHP has been selected to provide practice facilitation services to practices in the CPC + in the Western Colorado region. RMHP is part of a larger CPC+ Regional Practice Network that is led by the Lewin Group in direct partnership with TMF Health Quality Institute and HealthTeamWorks.

Colorado State Innovation Model (SIM)
The focus of SIM is to facilitate the evolution from the fee-for-service medical model of care to comprehensive primary care models that include behavioral health integration. The SIM program includes practice transformation support, payment reform, regulatory reform, and consumer and community engagement. The Colorado Department of Health Care Policy and Financing funds SIM with money from CMMI. Practices selected for SIM cohorts work with a Practice Facilitator to progress toward implementing the ten practice milestones related to the Colorado framework for whole person care. Cohort 1 began in February 2016 and we expect Cohort 2 to launch in September 2017. RMHP is an approved SIM Practice Transformation Organization, and our practice transformation staff is currently working with 17 SIM practices.

Transforming Clinical Practice Initiative (TCPi)
The primary goal of TCPi is to prepare clinicians to be successful with new models of value based payment reform requiring new approaches of care delivery, effective care coordination and demonstrated value of care. The initiative is open to specialists and primary care providers. Cohort 1 began in fall 2016. Currently, there are 29 practices enrolled with RMHP practice transformation staff.

TCPi helps providers and care teams prepare for value-based payment and achieve the Quadruple Aim – improved care, reduce costs, improved patient experience, and restore the joy of practice. This 4-year program is open to clinicians in both specialty and primary care.

Within the program, there are three primary drivers that will help guide practice transformation:

- Person and Family-Centered Care Design
- Continuous, Data-Driven Quality Improvement
- Sustainable Business Operations

TCPi helps teams implement impactful changes to improve care for patients, families, and communities by utilizing quality improvement tools and strategies, collaborating with similar practices, and access to resources, such as presentations, journal articles, toolkits and one on one coaching with a Practice Facilitator and a Clinical Health Information Technology Advisor (CHITA).

The Value and Demonstrated Success of RMHP Practice Transformation

RMHP has developed robust data collection and reporting capabilities to integrate Clinical Quality Measure (CQM) and total cost performance data from practices participating in our Practice Transformation initiatives. We use this integrated data to track performance and improvement over time, and to complete comparative benchmarks that demonstrate the value of the work. Total cost trend performance is significantly better for practices that engage in RMHP practice transformation work, as shown in the graphs below.

Six key Clinical Quality Measures (CQM) improved as practices progress toward advanced primary care status.

Depression screening and follow-up is one of the six most common measures that practices focused on for their quality improvement work. The depression screening and follow-up measure includes 28 *Foundations* program practices, 51 *Masters* program practices, and 13 practices participating in CPC.

Screening for Clinical Depression and Providing a Follow-up Plan

The graph below shows Clinical Quality Measure NQF0418, the percent of Members in practice transformation practices screened for clinical depression and provided a follow-up plan. Performance improved from 17 percent in 2014 to 47 percent in 2016.
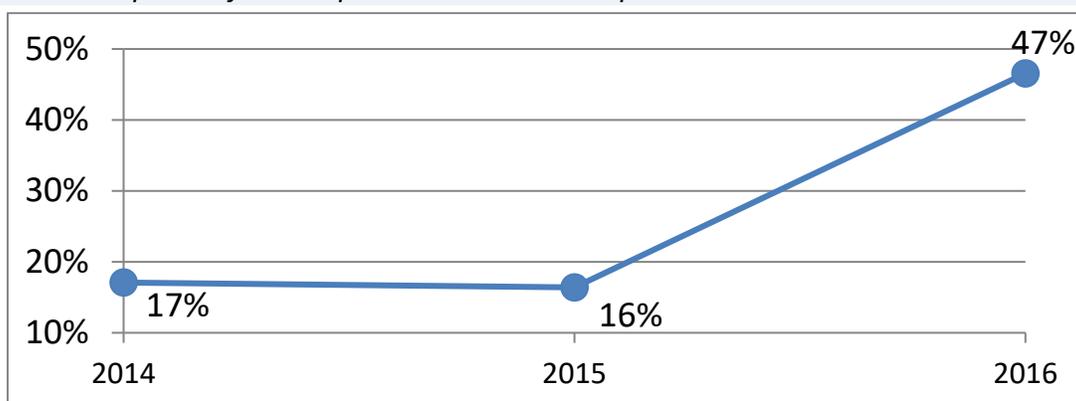
Practices improved on crucial medical functions of the patient-centered medical home.

Practices participating in RMHP's CPCi practice transformation program completed a self-rating performance of Patient-Centered Medical Home key concepts and delivery models. Twelve of the 13 participating practices received a rating at or above the 75th percentile regional benchmark, and self-reported scores increased dramatically over the period of performance.

Participation in practice transformation programs allows practices to test, prepare for and implement payment reform opportunities. These efforts are critical to the success of RMHP Prime and the Department's direction with Alternative Payment Methodology (APM).

RMHP asks providers to tell us what is working – and what is not – about the practice transformation program. What they tell us demonstrates that practices are changing the way they have always done things and that while it is sometimes difficult, they find it is worthwhile work. Providers understand the goal and are implementing activities that will enable them to achieve the better satisfaction in practice. Some of the comments we received are below.

Provider Testimonial
"In addition to improving on some of our measurements and costs, we have also been able to increase services that we are now providing. These include counseling visits with our care coordinator, group education visits with our nurse practitioner, ED and hospital follow-up contacts, care plans with self-management and establishing personal goals, shared decision making, etc. Most patients have indicated that they appreciate the added attention and service they are currently getting. I believe that the increased engagement by all of our staff, along with the patients themselves has improved overall satisfaction across the board. We are truly becoming a 'team'".
Peach Valley Primary Care

Provider Testimonial
"Our QIA provides insight and direction for our clinical quality measures, for upcoming deadlines and is a tremendous support. When we "get stuck" with the need to improve a certain Clinical Quality Measure, our QIA supplies our clinic with unique strategies that other clinics have used. This insight is important to our success. RMHP has organized several CPC Learning collaboratives that have consistently been a value to our clinics. The main thing is RMHP listens to clinic feedback and incorporates suggestions for improvement. The Learning collaboratives build on each other and provide instrumental collaboration between clinics. This collaboration is the infrastructure that is needed as clinics involve themselves with innovative ideas. Learning from each other is vital for successful and sustainable innovation. In addition, RMHP put on Learning collaboratives for care coordinators for specific training around care management. RMHP has also provided us with webinars that promote not only learning but collaboration between clinics as well. RMHP has been amazing as our support and resource. "
Mercy Family Medicine

Provider Testimonial

When I first heard about the Practice Transformation with Rocky Mountain Health, I was less than thrilled. Our practice was in the middle of Meaningful Use incentives, PQRS requirements, ICD-10 changes, Clinical Quality Measures, QHN programs, and on top of all that, forced computer-platform upgrades. Everything seemed to be putting pressure on the practice. And here was RMHP with yet another quality program, making even more demands on our practice. We seemed to be stretched to the limit already, and the last thing I wanted was more work to do.

When we first met with the Quality Improvement Advisor, I was annoyed with all the three-letter acronyms, the 1980's approach to quality improvement, and what I perceived as phony enthusiasm for the program. I went to the first Learning Collaborative, and it was only then that I realized what a great program it was. Here is an insurance company that is interested in the long-term health of patients. So rather than trying to make us see patients quickly and cheaply, Rocky Mountain is an insurance company that cares about the patients and the quality of care we provide.

So we, as a team, started to work on the quality improvements. At first, a large part of the effort was working on why the computer program was not counting the data correctly. We had so solve such questions as, "Where is the glitch that is making our data record incorrectly? What do we have to do to get the software to accept our inputs?" I worked on this whole-heartedly because I knew we were better than what the numbers were telling us. This involved updates, corrections, data-entry changes, and training. We changed the templates, added proper shortcuts, and worked with our EHR vender. While this was a lot of work, we now know we have reliable data coming out of our system about our patients.

While all this computer work was challenging for me, this is not what our nurse wanted to work on. "I want to do more than just figure out why the computer is giving us the wrong numbers, I want to help the patients get better!" So we worked together on many Quality Measures, for example, encouraging our patients to get mammograms. Together we created a letter, complete with eye-catching graphics, to send out to our patients, encouraging them to get their mammograms. I figured out how to generate the list of patients and how to create a batch mailing list. The nurse mailed them out, followed up with a phone call, and got the mammograms scheduled. Now we both feel good that we are helping our patients get this important screening. We know that we are making a difference in the long-term health of our patients with this effort.

Sopris Family Practice

FINANCIAL SUPPORT FOR PCMPS AND HEALTH HOMES

RMHP and partnering organizations within Reunion Health have been involved in numerous innovative and successful administrative/ performance payment arrangements with network providers over the course of many years. Most of these payment arrangements are tied to and dependent upon measureable improved outcomes. The methods the Partners use to incentivize and assist providers in achieving their goals, including our sophisticated practice transformation programs, have been described previously in this response. Next, the Partners will discuss specific activities we have undertaken in the past, and will embark on in the future,

to further support improved outcomes by making payments that will either supplement or replace standard per member per month (PMPM) payments.

Many of our current and planned payment arrangements are grounded in Thomas Bodenheimer's "building blocks" framework. This framework recognizes that achieving the health reform is dependent upon high-performing primary care. The framework also recognizes that while many of the building blocks are under the control of the practice, Alternative Payment Models (APMs) are necessary to achieve and sustain higher level competencies within the framework.

Dr. Bodenheimer's conclusions are echoed by the National Commission on Physician Payment Reform, which in their March 2013 report called for "drastic changes to the current fee-for-service payment system and a five-year transition to a physician payment system that rewards quality and value-based care."

We recognize that providers and practices are on a wide spectrum of being able to demonstrate improved outcomes and thus able to succeed in the practice transformation and payment reform environment. The Partners propose using the following four levels of PCMP resource allocation and funding to advance the goals of payment reform:

- **Level 1 – Basic:** Practices that are in the early stages of learning but who have demonstrated a willingness to change and improve
- **Level 2 – Foundations**: Practices that are participating in entry-level practice transformation tracks
- **Level 3 – Advanced**: Practices with demonstrated success in many of the advanced concepts of practice transformation
- **Level 4 – Comprehensive**: Practices on the leading edge of transformation with accreditations and technologic sophistication

The goal is to work with practices and provide the assistance and support they need for practice transformation that will allow them to move up to the next level of proposed reimbursement. The profile of each level, as well as the proposed reimbursement, is detailed below.

Level 1 – Basic

Practice Profile	Building Block Progress	Proposed Reimbursement and Resources
• Has not yet participated in any RMHP progressive learning tracks	Practices described by Dr. Judy Zerzan, Department Chief Medical Officer and Client and Clinical Care Office Director, as being on the "subfloor" of the Bodenheimer building block model	• Will receive the $2.00 PMPM or equivalent based PCMP participation reimbursement • Eligible for performance pool distributions • Will receive basic attribution and feedback reports

Level 2 – Foundations

Practice Profile	Building Block Progress	Proposed Reimbursement and Resources
• Demonstrates competencies from RMHP Foundations curricula or the SIM equivalent • Participated in and completed RMHP entry-level transformation tracks • Maintains certified EHR dashboard and reporting capability	Demonstrates competencies in "foundational" building blocks: • Engaged leadership • Data-driven improvement • Empanelment • Team-based care	• Eligible for $5k to $10k "participation incentive" for entry, progress, and successful completion of Foundations curricula or SIM equivalent • Will receive $2.00 PMPM or equivalent base PCMP participation reimbursement • Eligible for performance pool distributions for KPI performance • Will receive basic attribution and feedback reports

Level 3 – Advanced

Practice Profile	Building Block Progress	Proposed Reimbursement and Resources
• Demonstrates competencies from RMHP Masters curricula, CPCi, or SIM equivalent • Participation and good standing in CPC+ (either Track) or Department APM equivalent • Care Compact executed with at least 1 major specialty – PCMP choice • Maintains certified EHR dashboard and reporting capability	Demonstrates second and third level competencies: • Patient-team partnership • Population management • Continuity of care • Prompt access to care • Comprehensiveness and care coordination	• $3.00 PMPM or equivalent enhanced PCMP participation reimbursement • Eligible for performance pool distributions for KPI performance • Eligible for CommunityCare, Impact Pro and/or EasyCare telehealth application access and related technical support • Eligible for HET/CHW participation and targeted cohort support • $5k to $10k sign on bonus for AHCM social needs screening participation

Level 4 – Comprehensive

Practice Profile	Building Block Progress	Proposed Reimbursement and Resources
- Achievement and maintenance of full PCMH accreditation (aka "Level III") from NCQA curricula - Participation and good standing in CPC+ Track 2 or Department APM equivalent - Maintenance of certified EHR dashboard and reporting capability - Care Compact executed with at least 3 major specialties – PCMP choice	Practice is at the top level and is helping to design the high performing practice of the future	$3.50 PMPM or equivalent enhanced PCMP participation reimbursement - Eligible for performance pool distributions for KPI performance - Eligible for CommunityCare, Impact Pro and/or EasyCare telehealth application access and related technical support - Eligible for Health Engagement Team/Community Health Worker participation and targeted cohort support - Eligible for RMHP Behavioral Health Global Payment Agreement, pending completion of RMHP Readiness Assessment and COACH budgeting tool (or equivalent) - Eligible for RMHP Community Integration Agreement, pending acceptance for regional population accountability ("Community Anchor Status") and budgetary approval by RAE Executive Committee $5k to $10k sign on bonus for AHCM social needs screening participation

Shared Provider Network Resources

Practices will be given the option to invest some of their allocated PMPM in Shared Community Resources. Shared resources can include personnel, equipment, technology or other resources, such as a shared behavioral health clinician, community care team (CCT), or clinical pharmacist, that supports multiple practice sites. Our experience has shown that locally governed multidisciplinary CCTs can complement and support both high-functioning PCMPs and practices that have limited in-house resources. RMHP will use RAE funding to match / enhance practice-contributed funding.

The anchor organizations or community Health Alliances will oversee the use of funds to support Shared Community Resources, subject to Executive Committee approval.

Payment for Colorado Health Neighborhood Providers

The Colorado Health Neighborhoods (CHN) program is a whole person, team approach to medicine. The CHN health care team is comprised of primary care, behavioral health, specialty services, urgent care, diagnostic services, occupational health, hospitals, and other providers, through an integrated delivery system.

As part of its commitment to health care transformation through innovative financing, the Partners will make strategic investments that support Colorado Health Neighborhood capacity building. Examples of previous RMHP capacity building efforts have included:

- As the Region 1 RCCO, RMHP helped fund a mobile oral health clinic for Mountain Family Health Center in Glenwood Springs to help address an identified shortage of dental care for the Medicaid population.

- RMHP has made EasyCare Colorado, a state of the art telehealth tool, available to practices, at no cost, with a long-term goal of increasing primary care capacity.

- RMHP has invested in the pilot of Liberty Mobile, a ride share concept like Lyft and Uber, in rural areas not served by public transportation, NEMT, or taxis.

- RMHP has supported a "braided staffing" model in La Plata County, which provides integrated staffing for both SEP and RCCO services.

- RMHP has entered into Community Integration Agreements with multiple Local Public Health Agencies (LPHA) to assist with the provision of supports that benefits residents across geographic area served by the LPHA.

- RMHP has been a long-time supporter of Quality Health Network, the health information exchange for the Western Slope. Many of the projects performed by QHN on behalf of RMHP have had wide-ranging benefits across the Western Slope.

- RMHP has been an active member and supporter of the Community Resource Network (CRN), a shared technology platform that is fully integrated with QHN. CRN will act as a Social Information Exchange (SIE), connecting community resources that support reduction of social disparities (food and housing insecurity, transportation, interpersonal violence, etc.).

Describe how the Offeror will administer the Capitated Behavioral Health Benefit within the broader Accountable Care Collaborative while ensuring the continued delivery of sufficient Behavioral Health services and successfully managing the financial risk. Specifically address how the Offeror will:

a. Administer the Capitated Behavioral Health Benefit according to the principles outlined in Section 5.12.4.

b. Deliver services in multiple community-based setting.

c. Ensure compliance with federal managed care regulations.

A. ADMINISTER THE CAPITATED BEHAVIORAL HEALTH BENEFIT
Experience

Rocky Mountain Health Plans and Reunion Health have the expertise, tools and resources necessary to assume financial risk for the behavioral health services rendered under the Regional Accountable Entity (RAE), as well the experience necessary to manage the complexity inherent in capitated payment models. The partnership between RMHP and Reunion health will promote seamless continuity of care as the Behavioral Health Organization carve-out model transitions to the integrated Accountable Care Collaborative (ACC) RAE model. The Partners will facilitate information exchange and support all Members receiving services throughout the transition process.

Reunion Health CMHCs have been successful in managing the risk associated with BHO sub-capitation payments for nearly 20 years. CMHCs strive to provide the right services at the right time and place for each individual, in order to prevent higher costs associated with unmanaged acuity. Our Partners know that managing subcapitation is not about restricting access to care, but being proactive in providing timely and clinically appropriate care the meets Members' needs and aligns with their choices. Reunion CMHCs are motivated to create upstream strategies for prevention, early identification and intervention in order to avoid the higher costs associated with delayed treatment. The Partners take a population health management approach to risk and opportunity, by focusing upon primary and secondary prevention of behavioral health conditions.

Reunion Health, which includes Community Mental Health Centers and Federally Qualified Health Centers (FQHCs), creates an Essential Community Provider "backbone" throughout Region 1. Axis Health Systems, an FQHC and CMHC provider based in Durango, has not elected to join Reunion Health with the other centers, but will be afforded an opportunity to participate on an equitable basis in the RAE Network at the outset of Phase 2 program operations.

CMHCs, FQHCs and PCMP practices with integrated behavioral health play complimentary roles in the medical neighborhood by serving as providers who offer a continuum of care with the ability to ramp up service intensity based on the Member's presentation and to work seamlessly with the Member. The depth and commitment of these interdisciplinary partnerships presents a unique opportunity to align incentives and best practices that engage Members with a continuum of services. RMHP will maintain an integrated, statewide network

of medical and behavioral health providers, and will work with Reunion Health to support treatment of mild to moderate behavioral health conditions in PCMP settings as follows:

- Make psychiatric consultations available to primary care providers for shared patients, with the support of efficient "e-consult" and telehealth technology whenever possible.

- Provide CMHC and reciprocating FQHC educational services on site. This may include a diabetes education group at a CMHC provided by an FQHC nurse educator, a FQHC dietitian with a regular schedule at the CMHC to provide information about nutrition, or the CMHC offering psychotropic medication management training to the FQHC medical staff.

- Use the Project ECHO[102] model to link behavioral health specialists within an academic 'hub' with primary care clinician "spokes" in local communities. Together, they participate in weekly teleECHO clinics, which are like virtual grand rounds with CME credit combined with mentoring, collaborative learning and patient case presentations.

- Integrate decision supports for behavioral health conditions into the EMR

The administration of the capitated behavioral health benefit requires dedication to continuous process improvement so that foundational principles of recovery, resilience, trauma-informed care, least restrictive environment, cultural responsiveness, prevention, early intervention, and Member- and family-centered care can be consistently applied in practice. To that end, quality of care will be routinely monitored through tracking of all required performance measures and through the implementation of the Quality Improvement Plan. Analytics and outcomes will be disseminated to providers for regular review to inform process improvement. Innovative payment models and provider contracts within the CMHC network, as well as with high performing non-CMHC providers, will create incentives for better quality, better Member experience, efficient documentation and operations.

We believe that techniques for engaging people in their treatment are critical to supporting sustainable recovery from mental illness and substance abuse. People are often ambivalent about starting or continuing treatment for various reasons. It is the responsibility of the RAE to promote a culture of engagement at the point of care and throughout the system. This includes integrated approaches to both primary care as well as care coordination from the time of the first outreach and assessment. We will build on our current Member engagement strategies which start with building the relationship with the Member upon intake, supporting Members with a team-based care model, and incorporating peers into treatment plans. We customize treatment plans to meet the Member's needs, offering a wide range of tools and methods to support recovery.

We will follow up with Members who have dropped out of treatment so that we can assess their interest in re-engaging. Reunion CMHCs have a number of tools to support self-management the lead to more consistent engagement. For example, if we discuss that relapse can happen among individuals who are recovering from an alcohol use disorder, a Member may

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[102] http://echo.unm.edu/about-echo/model/

be more readily prepared to reengage in treatment after a relapse. Tip sheets for coping skills, health and wellness resources, and self-management tools are also available to Members.

Successfully Managing Financial Risk

Successful financial risk management entails a complex array of planning, analytic, monitoring and course correction activities. It is a *continuous* process in which specialized expertise and accurate analysis much be integrated in a disciplined management structure, and led by proactive executives who ensure adherence to strategic objectives and community values in all decision-making activities. RMHP has decades of experience, as well as the systems, expertise and leadership to succeed with management of the RAE capitated benefit structure. RMHP's Chief Financial Officer has extensive experience in the field of Medicaid managed care, and robust systems and processes to fulfill these functions. RMHP's Chief Financial Officer will oversee the budget, accounting systems, and financial and risk management operations for the RAE. Financial reports will be shared with the Department and within the Region 1 community governance structure for transparency and accountability.

Additionally, RMHP will manage behavioral health capitation with advice and input from the Reunion Health partners. CMHCs will receive subcapitation payments, and share financial risk within appropriate parameters set by RMHP as the licensed entity. Reunion Health CMHCs have years of experience managing subcapitation, and are uniquely positioned to move people to the most appropriate, safest and least restrictive level of care based on available resources and responsible use of the public dollar while valuing consumer choice. RMHP also has the backing of UnitedHealthcare, which will provide their additional tools, professional insights and enterprise-wide accountability systems that sustain Medicaid managed care and behavioral health programs in 26 states.

Key Principles Guiding the Administration of the Capitated Behavioral Health Benefit

The following pages provide an overview of the Partners approach to administering behavioral health benefits, including examples that demonstrate how we have historically incorporated each of these principles and they will be applied within the RAE program structure.

Recovery and Resilience Model

Sharing information, building skills, and empowering Members to make changes by leveraging individual strengths and protective factors are best-practice strategies for achieving sustainable and positive changes. The comprehensive programs, services, policies, and procedures offered by the Partners embrace an overall commitment to the recovery and resiliency model. Our recovery philosophy is grounded in the belief that recovery from mental health and substance use disorders is more likely to be practiced and incorporated in real life settings than in clinical treatment. Recovery is a process, not an outcome, and the Member defines his or her own version of recovery building upon their resources and strengths. An individual's ability to move successfully towards recovery is impacted both by the presence of a behavioral health condition and by the effects of social determinants of health, physical health or chronic co-occurring conditions, substance use, and the availability of a desired support network. Social determinants of health, including access to transportation, employment, food security and housing play a critical role. Recovery is predicated on the availability and accessibility of

community supports and resources to address the needs of the whole person, according to the individual's unique culture, values, and goals. From this perspective, our service philosophy embraces the notion that persons living with mental health or substance use disorders can effect positive change in their lives when they have access to the necessary information, skills, and supports to initiate this transformation.

For children and their families, our commitment to resiliency begins with the delivery of a continuum of services that are located as close as possible to the natural environment of the child and family. These services range from prevention and early intervention services delivered in schools to intensive home-based treatment and short-term stabilization in a residential facility. The child and youth programs in Region 1 build upon the strengths and resources available within the child, family, and community. The goal is to intervene as early as possible in emerging mental health and substance use conditions and to prevent secondary conditions from developing. The Partners will continue to develop internal capacity to coordinate care with pediatric primary care providers, schools, social service, early childhood centers and child welfare agencies, and the criminal justice system. Coordination across community systems is an essential component of meeting the unique needs of a child and family in their preferred service setting.

Reunion Health - Examples of Recovery and Resilience

Mind Springs Health (MSH) employs a large peer workforce, about 10 percent of its total staff. These staff members offer peer support groups and peer mentoring, all with a focus on recovery and resiliency. Some peers are people who have a mental illness and/or a substance use disorder (SUD) and are in recovery, while others may be parents of children who have a mental illness. The peer workforce is a valuable part of the organization, and "peer magic" occurs daily. Some examples of peer magic are set forth below:

- "Jim": An adult male with a brain injury began drinking and causing difficulties at a local residential facility for individuals with brain injuries where he has lived for years. MSH peer respite staff met with him every night at his temporary residence for respite and support, which helped him avoid drinking and find new ways to cope with cravings and anxiety. Within a month he was able to return to the facility, joined an outpatient SUD treatment group and began attending Alcoholics Anonymous on a regular basis.

- "Hope": A peer met with the family of a young person who experienced his first psychotic break. While this young adult was in a psychiatric hospital, the peer was able to share about her experience in the hospital and what the family could do to be helpful. The family commented that it was tremendously helpful to talk to someone who had actually been through a psychiatric hospitalization who could tell them what to expect. They said it provided so much hope to them that their young son could recover, just as the peer had, and lead a productive, happy life.

- Incredible Years: 71 people were served through the SummitStone Health Partners (SHP) Incredible Years early childhood development program in 2016. This program gives parents, caregivers and teachers the skills to support children in social and emotional learning, emotion regulation and problem solving.

- Choices *Café:* The Café is a drop-in center, which is client run and staff supported. It is a safe place for Members to go for social interaction and fun.

A new enhancement to the resilience model of care in Region 1 will be based on the University of Pennsylvania's *Penn Resilience Program*,[103] which is a train-the-trainer program based on empirical research that can be deployed in primary and secondary schools to teach children techniques for resilience. The Partners will to work with at least two schools to implement the resilience curriculum comprised of Positive Psychology skills. The research from the University of Pennsylvania demonstrates that even one semester of youth learning these skills in their school environment can improve their grades, attendance, and overall success in school.

Trauma-Informed Care

The Partners are committed to supporting treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences. Trauma is pervasive among individuals with mental health and SUD, in addition to those experiencing the extremes of poverty or social disparities. The Adverse Childhood Experiences (ACEs) Study[104], conducted by the Centers for Disease Control and Prevention and Kaiser Permanente shows that 90 percent of individuals seeking services at a mental health agency have experienced trauma. Therefore, Reunion Health CMHCs will practice "universal precautions" as prescribed by trauma-informed systems of care.

This awareness of the potential of behavioral health interventions to facilitate healing and to prevent inflicting further harm informs the way the Partners and our providers approach clients and their families. Screening for the effects of trauma occurs at every entry point into the system. For example:

- Members are engaged in meaningful partnership in service planning.

- Peer support is available to confirm that Members have the information they need to make informed decisions about their care and the support to communicate their preferences to the professional staff involved in their care.

- The Partners routinely take steps to avoid re-traumatizing the patient by avoiding the use of restraints, over-stimulation and highly confrontational approaches in the delivery of care.

- The client drives the treatment planning process to meet their identified needs and goals.

Unlike trauma-specific services, trauma-informed care places more emphasis on *how* services are provided, and less on the specific service. The Partners are committed to not only supporting trauma-informed care, but also creating a trauma-informed network through policies, formal training, and learning collaboratives available to providers and established through the Advisory Councils, including Member, Performance Improvement and Provider Advisory Councils. Trauma-informed care and communication training will be required for all staff and providers that interact with Members, including OneCall Support call center staff, and

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[103] https://ppc.sas.upenn.edu
[104] https://www.cdc.gov/violenceprevention/acestudy/about.html

all RAE care coordination program staff as well as CMHC behavioral health providers. All levels of staff are trained on ways to work with people who have experienced trauma, including how to ask sensitive questions and how to implement techniques such as motivational interviewing in the delivery of trauma-informed care.

Partner Examples of Trauma-Informed Care

SHP and MSH were selected by the National Council for Behavioral Health to participate in a yearlong learning collaborative to integrate Trauma-Informed Care (TIC) throughout the entire organization. As a result, the CMHCs reviewed and modified policies, paperwork and forms to align with TIC. Additionally, the CMHCs developed a TIC tip book provided at employee orientation and made modifications to their buildings, including updating lighting as well as providing quiet spaces and private meeting places. A typical modification that is supportive for people who have experienced trauma is a "quiet waiting room" which allows for a less chaotic environment for more sensitive individuals.

SHP and MSH have quarterly Staff Resiliency and TIC trainings for all employees. A Steering Committee drives the maintenance of the TIC culture and they offer weekly TIC tips for all staff. SHP and MSH have also shared TIC training and materials with primary care practices and county Department of Human Services (DHS) partners. Regardless of their role within the CMHC, employees are trained on this topic, and how they can contribute to the culture of a trauma-informed system of care. Both SHP and MSH have brought their TIC skills to the community - SHP has been a key partner with Larimer DHS in the Child Welfare IV-E Waiver Trauma Assessment project. Similarly, MSH has partnered with the Eagle County child welfare program.

- Trauma-Informed Parenting/Trauma Impact Parenting (TIP) is a program offered by SHP and MSH specifically designed for parents and caregivers of children and adolescents who have experienced trauma. There is a simultaneous children's group offered as well.

- Trauma and Resilience Assessments are comprehensive assessments for children who are referred by county DHS agencies. These children have experienced multiple and complex traumas and are screened by DHS using a trauma screening checklist. The assessments are strength-based, collaborative in nature and reflect the impact of trauma on a child's neurodevelopment, relationships, self-concept and day-to-day functioning.

With the support of UnitedHealthcare, RMHP will offer trauma-informed health education for staff and providers to take and earn free CMEs/CEUs. Additionally, the provider directory will have a searchable category for providers knowledgeable in trauma informed care.

Least Restrictive Environment

The Partners are committed to ensuring that Members receive behavioral health services in the least restrictive environment that meets the Member's needs and is expected to promote positive outcomes. From a person-centered care perspective, this approach is defined as thinking and behaving in ways that respect and value individual preferences, strengths and

contributions.[105] From a recovery and resilience perspective, this means caring for Members in their natural environment in a manner that promotes recovery and person-centeredness. While the Partners have access to inpatient hospitalization resources for individuals experiencing acute exacerbations of mental illness, the plan upon admission is to minimize the number of inpatient days needed to stabilize the individual, and support a step-down process for safe and supportive reintegration into the most appropriate and sustainable home environment.

Policies and procedures are in place to make sure that providers' assessments are thorough and consider the most effective treatment in the least restrictive environment. In order to do this, the assessment will include consideration of the individual's diagnosis and presenting problem, level of autonomy and functioning, safety concerns regarding harm to self or others, level of acceptance and engagement, current status related to physical health and social needs, social/familial supports and finally, the available treatments and resources.

Partner Examples of Supporting Individuals using Least Restrictive Settings

Reunion Health CMHCs are well versed in this concept, and strongly believe that the best chance for sustained recovery is for individuals to receive treatment in or close to their natural environment.

The Partners currently provide an array of community-based treatment and service options in Region 1 in the least restrictive environment. These are described below.

- Mind Springs, the Center for Mental Health and SummitStone are all participating in the Intellectual/Developmental (I/DD) Cross-System Crisis Response Pilot Program (the I/DD Pilot), which is discussed in detail in Offeror's Response 3. The Pilot, which started in August 2016, addresses the needs of individuals with intellectual or developmental disabilities (I/DD) who have a co-occurring SMI and who are in crisis. When an individual presents in crisis to either a participating Community Centered Board (CCB), CMHC, another community organization or local law enforcement, the CCB and Crisis Center staff evaluate and support them in the least restrictive environment possible, using outpatient therapeutic support, in-home therapy, site-based therapy in community-based home settings or brief inpatient support. The Pilot has mobile crisis teams that are integrated, with behavioral health providers and I/DD specialists. A range of therapeutic environments is available through the Pilot, so that individuals experiencing a crisis can transition to the safest and least restrictive setting for therapeutic support when indicated.

- Psychiatric hospital recidivism at its West Springs facility—9 percent of clients return to the institution-- is half of the national average of 19 percent. Outpatient follow-up after discharge from West Springs Hospital averages 65 percent at seven days and 89 percent at 30 days in the last six months. They attribute this success to using peers to help "bridge" the transition from inpatient to outpatient care.

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[105] From: HCPF "Person- and Family Centered Approach: Creating a Culture of Collaboration with Clients" Presentation February, 2016. Given by: Carrie Cortiglio and Colleen Daywalt. https://www.colorado.gov/pacific/sites/default/files/StakeholderMeeting_PresentationSlides.pdf, retrieved on 06/04/17.

- *Assertive Community Treatment (ACT)*: ACT is an evidence-based practice provided by each of the Partner CMHCs with the goal of helping people recover through community treatment. A multidisciplinary team works closely together to provide assistance and treatment to meet peoples' needs. ACT team members go into the community and peoples' homes to provide services, such as treatment, rehabilitation, and case management. The ACT program is unique in that any member of the team can see any client; treatment is flexible and specific to the clients' needs at the time. All mental health services are provided through the ACT team, and are provided for as long as needed. While the typical ACT client is highly complex, treating in the least restrictive environment promotes sustained recovery.

- *Community Dual Disorder Treatment (CDDT):* CDDT is provided in coordination with SHP, Housing Catalysts (Fort Collins Housing Authority) and the Health District of Northern Colorado. It provides services for adults who have both serious mental illness and serious substance use disorders. This program provides for all the treatment needs of the participants, as well as all basic living needs. The program is based upon the Integrated Dual Disorder Treatment and ACT models. The majority of this work is conducted in Member's homes and in the community, which is not only least restrictive, but also provides the natural environment needed for sustained recovery.

- *Adult Home-based Services:* SummitStone has a team that works specifically with homebound individuals to support continuity of therapy. Other CMHCs provide this service when possible and appropriate for the Member.

- *Crisis Stabilization Unit:* Colorado Crisis Services uses several evidenced-based modalities for the stabilization of mental health crises. Services are provided in Crisis Stabilization Units for people with high mental health needs and low physical health needs. Modalities utilized include psychiatric medication management, group therapy and individual psychotherapy interventions. They are designed for maximum therapeutic effectiveness for a short-term crisis stabilization stay of three to five days. The Crisis Stabilization Unit is less restrictive than an inpatient mental hospital stay. Currently, Region 1 has two Crisis Stabilization Units, one in Grand Junction, operated by Mind Springs Health, and one in Fort Collins operated by SummitStone Health Partners. There are plans to open two more Crisis Units in Region 1 in 2018. The Center for Mental Health will operate one in Montrose County and Mind Springs Health will run another in Summit County.

- *Permanent Supportive Housing Integration:* SHP and MSH have mental health therapists assigned to supportive housing initiatives and local homeless shelters. Redtail Ponds, a permanent supportive housing (PSH) apartment complex owned by Housing Catalyst has a SummitStone therapist on site. This individual provides mental health services including brief therapy, case management and crisis management to the 60 residents, many of whom are SHP clients. There are 40 units for people needing supportive housing, and 20 units for low-income individuals. Those in supportive housing units are chronically homeless before admission. Individuals in PSH are often at risk for hospitalization or incarceration. PSH allows the individual to function well in a less restrictive environment. At Mind Springs, a therapist has regular hours at a shelter for

homeless teens. The House in Grand Junction and three other homeless shelters offer housing vouchers for 90 people. MSH owns an apartment complex of 20 units for people with mental illness who otherwise would be homeless.

- *Family Care Coordination (FCC)*: This is an intensive in-home therapy program designed to serve children of all ages who are at risk for out-of-home placement or for whom there are safety or behavior concerns. FCC therapists are flexible in terms of how each family is served, and may incorporate both individual and family therapy in the treatment process, with much of the emphasis typically being on caregiver education and support. Cognitive behavioral therapy (CBT) and trauma-focused CBT, solution-focused therapy, attachment therapies, play therapy, art therapy and behavior modification are utilized. Treatment duration is planned to average six months, with the therapist in the home 1-2 times per week for 60-90 minute sessions depending on the child's and family's needs. Meeting families in the home enables the therapist to quickly understand family dynamics and family culture, and to build strong rapport with the family. It also enables family members to practice new skills in the setting where they will need to use those skills.

- *Court programs:* SHP and MSH participate in several court support programs, including Family Court for families with DHS involvement due to safety issues for the children and Drug Court for individuals whose SUDs resulted in criminal behavior. SHP and MSH are part of the court's multi-disciplinary teams, which include the judge, district attorney, defense attorney, treatment providers, therapists and law enforcement. When the program is successful, individuals at risk for a more restrictive level of care, like incarceration, are successfully served in community-based and home settings.

Culturally Responsive Care

The Partners are committed to maintaining an integrated PCMP and behavioral health network of culturally competent and culturally responsive providers for all members. The Partners will have policies in place using the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as guidance for cultural responsiveness. Cultural responsiveness is woven into every aspect of our administrative structure and in the support of Members. Member materials, surveys, educational materials and services will be provided in a culturally responsive manner. In addition, the Partners will engage in ongoing internal awareness building around cultural competency and areas for improvement. We will train staff in cultural awareness and sensitivity and expect the same of our network providers. Annual trainings for the Partners' staff will include didactic discussion and media to raise awareness and educate staff about cultural sensitivities to avoid hurtful or inappropriate behavior, and how to improve cultural responsiveness within the organization and in engagement with Members, providers and stakeholders. We strongly believe that cultural responsiveness does not stop at having bilingual providers, which all of the Partners employ. Cultural responsiveness must account for the environmental context in which the Member lives, works and plays.

We will provide formal training opportunities on culturally responsive practices to build competency across the entire behavioral health and PCMP provider network. Training will include how to embed the CLAS standards into all aspects of care delivery through policy, staff

training, practices and allocation of resources. Cultural Responsiveness/Competency Committees teams are currently in place in the Partner CMHCs to promote and advocate for health equity for minority groups, including persons who may be marginalized due to their LGBTQ status, age, religion or physical ability. The Partners will also offer training in working with culturally specific populations, including individuals with disabilities, and Bridges Out of Poverty training, which identifies the barriers and cultural norms that are often part of the experience of poverty.

Our workforce is knowledgeable about working with Members with limited English proficiency. The majority of staff members who engage with patients at our Partner FQHCs are English-Spanish bilingual. All clinical staff at behavioral health partner organizations have 24/7 medical interpretation available, including American Sign Language, so that clients have access to health care services in their preferred language. If not available directly through the provider, the Partners will follow policies and procedures to make sure that interpretation services are available for all Members regardless of the provider serving them, and that providers are aware of how to access these services through the RAE. Additionally, RMHP offers Contegos at seven sites in Fort Collins, Loveland and Estes Park through a partnership with Colorado Daylight Partnership. Contegos are encrypted personal hearing-assistive technology devices that amplify audio for people with mild to moderate hearing loss.

All of the Partners' FQHC, CMHC and care coordination staff are trained in culturally responsive approaches to supporting the needs and beliefs of individuals and families, and are able to access interpreter services when needed.

All treatment staff complete cultural responsiveness training annually. Additionally, trauma-informed care and person-centered care principles are core to providing culturally responsive care. All staff are respectful and nonjudgmental of every individual and ask questions to help understand where they are on the continuum of personal health engagement and self-awareness so that they can determine the most appropriate treatment using evidence-based guidelines. As evidenced by their commitment to recovery and resiliency, their aim is to create a true partnership with clients so that they are empowered to take responsibility for directing their own care. Culturally responsive staff respect that every individual is different and individuals know themselves best.

Partner Examples of Supporting Culturally Responsive Care

The Partner CMHCs offer multicultural services where staff members assist the agency through intra-agency training opportunities and the appreciation of diversity in communities. Programming includes a 12-week parenting class called *Strengthening Latino Families* as well as support groups in Spanish and interpretive and case management services on- and off-site.

SHP offers an annual staff development series of two-hour classes to assist behavioral health professionals in developing basic intercultural competency skills to improve the effectiveness of their work with culturally diverse clients and their interactions with co-workers. This is research-based curriculum developed by SummitStone. The series will be available to all of the Partners' staff and Network. The curriculum includes:

- *The Complexity of the Dimensions of Cultural Diversity:* This lesson helps participants explore the complex nature of cultural diversity that helps avoid stereotypes and labels that encapsulate people into limiting categories.

- *Exploring the Dynamics and Importance of One's Culture:* This lesson explores the definition of culture, assists participants in identifying their own cultural learnings and examines how the levels of the "Cultural Iceberg" affect interactions with others.

- *The Process of Learning a New Culture:* This lesson teaches the steps involved to successfully become aware of a culture different from one's own, including the impact of cultural shock and internal resistance strategies used to avoid the discomfort of change.

- *Facing Our Own Conscious and Unconscious Biases:* This lesson helps participants bravely explore their own biases and how these biases affect client and co-worker relationships. Topics include the concept of "White Privilege."

- *Moving from a Culture of Oppression to a Culture of Well-Being and Empowerment:* This lesson examines a process of moving from being oppressed to becoming empowered and includes obstacles to change and strategies for overcoming the obstacles. Topics include the concept of "learned generational helplessness."

- *Creating a Culturally Skillful Agency:* This lesson outlines the components of a culturally skillful agency, including creating a welcoming environment, cultural differences that influence staff interactions, and an evaluation checklist to measure progress toward becoming a culturally skillful agency.

Prevention and Early Intervention

The Partners focus prevention and early intervention on two primary strategies:

- Screening for commonly occurring behavioral health conditions including trauma
- Aligning and engaging in health literacy campaigns, community education and outreach to normalize the need for "emotional hygiene" and reduce the stigma associated with seeking behavioral health services

Screening for Common Behavioral Health Conditions including Trauma

Screening for early intervention in behavioral health conditions is essential to reducing costs and improving outcomes in physical and behavioral health. Approximately one in three Medicaid Members with a chronic physical health condition has a mental health condition, and one in five has an SUD. Individuals with a combination of physical and behavioral health conditions are more likely to be hospitalized and have higher health care costs than individuals with either a physical health or behavioral health condition alone.[106] Further, the impact of childhood trauma has been well-documented in the Adverse Childhood Experience (ACE)[107] study, demonstrating that childhood trauma increases the risk for a multitude of physical and

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[106] Boyd, C., et al., Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. 2010, Center for Health Care Strategies Inc.: Hamilton, NJ.
[107] https://www.cdc.gov/violenceprevention/acestudy/about.html

behavioral health concerns in adulthood, including chronic pulmonary disease, heart disease, liver disease, depression, and SUDs.[108]

For these reasons, the Partners will leverage the strong partnerships between the behavioral health provider network, primary care providers, county human services and public health agencies to implement a process of screening for depression, substance use, and trauma as well as physical health care access and access to resources for social needs. Partners and agencies may use a variety of screening tools based on their own requirements and protocols, but all tools will be validated. This screening process is already in place as part of Region 1 care coordination assessments, where the PHQ-2 is used. We will expand our screening to include the Child Stress Disorders Checklist-Screening Form (CSDC-SF) and other evidence-based tools built in to the care coordination platform, Community Care. The Region 1 Partners will participate in the newly awarded Accountable Health Communities Model (AHCM) from CMMI to provide screening and care navigation to resources for housing, interpersonal violence, food, utilities and transportation, among other potential needs. The Community Resource Network (CRN) will support that process by serving as a community-wide platform for communication and referral tracking across the medical, behavioral health and social support system.

The Partners will continue to engage in broad, communitywide efforts to reduce the impact of mental health and SUD on individuals and communities that include the following:

- Improving public understanding of risks, signs and symptoms of mental illness and SUD
- Normalizing mental health and SUD as genuine and treatable health issues
- Actively promoting mental health/emotional hygiene and resilience
- Promoting education and public awareness of mental health and substance use disorder symptoms
- Increasing access to effective treatment and supporting individual recovery

The Partners' Quality Committee will determine outcome measurements to evaluate the impact of these population health programs in the community. We will seek opportunity to replicate and scale proven programs, particularly in rural and mountain communities, to increase access to high-impact prevention and early intervention strategies.

Partner Examples of Preventive Care and Early Intervention
- *Youth and Adult Mental Health First Aid (MHFA):* Reunion Health CMHCs provide training to community members, including law enforcement, schools, CCBs and FQHCs throughout the Region and will continue to make available and promote MHFA and Youth MHFA to community partners and care coordinators.
- *Zero Suicide* is a commitment by health and behavioral health providers to relentlessly pursue a reduction in suicide deaths. To implement this initiative, the Partners will promote adoption of Zero Suicide and assist providers by offering training in using and responding to screening tools to all network providers. The intention of all Zero Suicide

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[108] Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACE) Study Major Findings. 2013 [cited 2013 December 2]; Available from: http://www.cdc.gov/ace/findings.htm

activities is to have early identification of those at risk of suicide, to support those in suicide crisis, to apply effective suicide intervention strategies with those in suicide care, and ultimately to reduce the number of Member suicide deaths to zero.

- *"Multiply Your Happy" (MYH) Calendars:* MYH calendars highlight that May is National Mental Health Month. The calendars offer daily activities, rooted in Positive Psychology concepts, for a variety of age groups: preschool, school age, teens and adults. They are distributed at each of the 13 Mind Springs sites, at West Springs Hospital, and as an insert in newspapers across the 10-county service area. Calendars are also distributed at local meetings and provided to partner agencies.

- *My Strength*: My Strength is a website and associated mobile app self-billed as the "health club for your mind." It provides adults and adolescents with personalized information to enhance the therapeutic process and learn about topics including symptom reduction, stress management, coping skills, trigger avoidance, distraction, parenting, feelings identification and spirituality. Activities and information are based in CBT ideals and provided in both English and Spanish. Mystrength.com is promoted at all locations of MSH and CMH outpatient sites and West Springs Hospital. Information is available on Mind Springs Health website and is distributed to agency partners. Anyone, regardless of his or her status as a patient of Mind Springs Health, is welcome to this service.
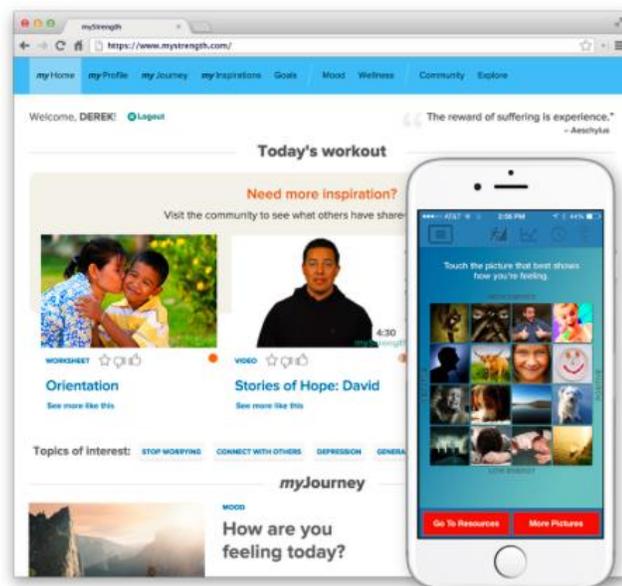
- *Mind Over Mood (MOM)*: MOM is an evidence-based CBT modality aimed at offering skills to enrich clients' lives by addressing and disproving their own negative thoughts. While MOM is often used in groups, it can also be used for individual therapy to reinforce skills the clients learn in their group.

- *Love & Logic*: Love & Logic is a practical and effective set of strategies to help parents support the emotional and behavioral growth of their children. The Love and Logic approach to parenting is built around the science of crafting caring and respectful

relationships using an authentic, loving connection between parents and their children as the root of a healthy, thriving relationship built on trust and understanding.

- *School-based curriculum*: The Partners are excited for a new school-based prevention initiative involving the principles of Positive Psychology. Positive Psychology is a new way to think about one's emotional well-being and focuses on resiliency. It is supported by a large body of research from the University of Pennsylvania.[109] Positive Psychology is less about treating mental illness and more about a focus on cognitive and resilience strategies to reframe thinking. The Partners plan to pilot a Positive Psychology curriculum in two middle school home rooms. They intend to, with the appropriate permissions, video document the changes the students experience and their newfound resiliency. This documentation can be used subsequently to evaluate and improve the training.

Additionally, through its affiliation with UnitedHealthcare, RMHP has access to evidence-based applications that help members identify their strengths, and use Cognitive Behavioral Therapy techniques to develop action plans and help identify, cope with and plan for situations that may trigger their depression, anxiety or trauma sensitivity. RMHP will work with the Region 1 Person and Family Advisory Committee and Performance Improvement Advisory Committee to identify the applications that are most promising from an evidence based and user perspective to offer to members.

Member- And Family-Centered Care

Member- and Family-Centered care is at the heart of all services delivered by the Partners. We provide all services within the context of the individual's support system, including family. The Partners have adopted the definition of *person-centered care* developed by the Department of Health Care Policy and Financing: "thinking and behaving in ways that respect and value individual preferences, strengths, and contributions."[110] The Partners' approach is to support the Member or family to direct the process, focusing on strengths, capacities, preferences, needs and desired outcomes.

We believe that the Member is the expert about their health goals and the strengths they have to help them achieve those goals. We will use a Member-directed approach to understand each Member's goals, circumstances and barriers to achieving good health. This approach will be supplemented by exchange of information between providers for a data-driven picture of how Members use the service system. Based upon this understanding, our role is to connect the Member to their appropriate and desired services in order to provide the support that leads to improved well-being. To achieve this, the Partners will:

- Recognize the unique needs of each individual within the context of the individual's health care needs, cultural values, family and community resources, utilizing available data, Member-reported health information, and community forums.

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[109] http://ppc.sas.upenn.edu/
[110] https://www.colorado.gov/pacific/sites/default/files/StakeholderMeeting_PresentationSlides.pdf

- Improve the Member's ability to successfully advocate for themselves and to cope with challenges through Member engagement, self-management skills, and voice in the RAE leadership.

- Promote prevention and wellness in whole health care through alignment with community initiatives, delivery of high-value healthcare, and targeted population health interventions.

- Encourage member choice in health care providers and treatment options by developing a broad and diverse provider network and range of treatment choices.

- Facilitate recovery from mental health and substance use disorders through wraparound services, self-management and relapse prevention skills, and community-based services.

- Build resilience through creation of trauma-informed care system.

- Support the navigation of the Member through the health care system through aligned coordination of care, supported by technology to streamline referral processes.

- Family support includes support groups for children, adolescents and adults. For families of children and adolescents, we provide parenting support and attendance at individualized education planning and other community meetings, and groups for those dealing with extreme behaviors.

Partner Examples of Supporting Member- and Family-centered Care

- *Facility Design*: Past patients at West Springs Hospital were deeply involved in the planning and design for the psychiatric hospital expansion. As West Springs discusses their architectural renderings for future expansion, past patients proudly point out how their input was incorporated into the final design.

- *Consumer engagement:* All CMHC Partners meet regularly with consumer groups. Region 1 CMHC consumers influence everything from administrative processes, like improving the process for obtaining medical records, to building remodels, where consumers were consulted for advice on waiting room layout and color scheme.

- *Consumer Advocates*: All CMHCs have a consumer advocate who provides ongoing support and limited psycho-education groups for family members of children who have been diagnosed or receive selected services. The advocate typically has personal experience with a child with mental illness, and can empathize with families. The advocate can provide support for parents who need help with an Individualized Education Plan (IEP) for their child. They also connect members to other consumer organizations like the National Alliance on Mental Illness.

- *Family Supports*: Each of the Partner CMHCs offers family support programs, family treatment court mentors and a grand-family support program as part of their child and adolescent suite of services.

B. Deliver Services in Multiple Community-Based Settings.

The Partners are excited about the opportunity to truly transform the care delivery system by "meeting people where they are." This means care transforms to being even more community-

based and integrated. Providing access to community-based care that meets the preferences and needs of Members requires that services be available within multiple community-based venues. Meeting the Member in their location enhances utilization and satisfaction with care and can prevent escalation and the subsequent need for higher levels of care. We value the inclusion of providers in the network who are able to care for Members in a variety of community-based settings, including: primary care practices or integrated health homes, homeless shelters, skilled nursing and assisted living facilities, schools, jails, community corrections facilities, community resource centers and Members' homes. The Partners will collaborate with community-based services providers to achieve greater access, quality of care and member satisfaction with services.

The Partners will enable access to care for all Members in need of medically necessary covered mental health and substance use disorder services in accordance with state regulation by providing access in multiple community settings. Providers within the partnership have experience and established relationships to deliver behavioral health services, care and advocacy for Members in all of these settings, including integration of substance use programs. Programs are in place for individuals reintegrating into the community from inpatient care or criminal justice incarceration, as well providing comprehensive assessment and linkage to care for children and families involved in child welfare. Behavioral health professionals are co-located or provide services alongside both nursing home teams and assisted living teams. A number of housing programs, from vouchers to placement in Partner-operated housing, seek to intervene and prevent homelessness while others provide care, advocacy and alternatives for the homeless population.

RMHP will support PCMPs with training via our Practice Transformation program, detailed in Offeror's Response 17, so that they understand how a licensed BH provider can deliver brief interventions in the primary care setting using six sessions of short-term BH services per episode of care. We will also support care coordinators with the tools they need to triage behavioral health issues and help the Member obtain the appropriate resources when needed. As part of its Practice Transformation program, RMHP hired a Behavioral Health Provider in 2016 to support practices as they integrate a new behavioral health provider into their practice.

The Partners, many of whom are part of the infrastructure that supports the Cross-System Crisis Response Pilot Program established by House Bill 15-1368 (I/DD Pilot), will incorporate lessons learned from the Pilot and share our lessons learned with all other RAE regions. One of the most beneficial components of the I/DD Pilot was cross-training for the CCB and CMHC staff. CMHC staff were trained to support communication strategies for non-verbal individuals diagnosed with I/DD so they would understand behaviors that are indicators of stress, discomfort or other issues that need attention. CCB staff received training in Mental Health First Aid and other therapeutic communication and treatment techniques to support individuals experiencing a behavioral health crisis.

Some highlights of the community-based settings where services are provided in addition to the services listed earlier in this response include the following 1915 (b)(3) services offered by the Partner CMHCs:

Vocational Services

- Supported Employment Services: Supported Employment is a unique opportunity for employers to hire a pre-screened, motivated employee with ongoing mentorship and support at no cost. For Supported Employment employees, a job provides an especially meaningful role in individual self-sufficiency and the power of community partnerships. Supported Employment is designed to assist people with mental illness find and keep meaningful, competitive jobs in the community. This is an evidence-based practice to support recovery and is evaluated annually for outcomes and fidelity.

Clubhouse/Drop—in Centers

- Choices *Café:* The Café is a drop-in center, which is client run and staff supported. It is a safe place for Members to go for social interaction and fun.

- *Sister Mary Alice Murphy Center for Hope:* The Murphy Center is designed to be a "One Stop Shop" for services for families and individuals who are homeless or at risk of homelessness. Case managers connect Members with local agencies providing community resources on-site. Services available include employment resources; housing assistance; financial counseling; transportation assistance; job training and educational opportunities; mental health and SUD counseling; phone and computer access for employment contacts; medical room; washer/dryer, kitchen, showers and storage facilities; and play areas for children.

- *Oasis* Clubhouse*:* **The** Oasis Clubhouse was created with community integration in mind. When learning to manage a mental illness, it can be difficult to navigate everyday occurrences like keeping a steady job or socializing. The Oasis Clubhouse is a place where anyone with a mental illness can go to socialize, receive support and reassurance and engage in meaningful work. Clubhouse activities include skill groups, support groups, work groups, recreational activities and outings. Located in a Classic Victorian house in Grand Junction, the Oasis Clubhouse is the perfect place for recovery, empowerment, fun and friendship.

- *Spirit* Crossing *Clubhouse and Vocational Support Programs:* Crossing Clubhouse is a certified Model of Rehabilitation with the International Center for Clubhouse Development. Vocational support includes transitional employment, supported employment and job development, career counseling, supported education and job-seeking skills training. Clubhouse members and staff operate the facility jointly. Clubhouse work-ordered day activities include preparing and serving lunch daily, clerical and retail work, computer and data entry, newsletter publishing and facility maintenance. Recovery oriented activities include weekly socials and recreational outings, wellness classes, fundraising, client advocacy, community education and program development responsibilities.

Recovery Services

- *The Women's Recovery Center:* The Women's Recovery Center is a 90-day intensive drug, alcohol and transitional living program specializing in holistic recovery. It is the only program just for women on the Western Slope and one of the few in Colorado where women may have their children with them during residential treatment.

Other Programs Delivered in Community Based Settings

- *Projects for Assistance in Transition from Homelessness (PATH):* This grant-funded program provides care coordination and clinical intervention to homeless individuals. MSH works with local housing authorities and supported housing programs to provide site-based services for individuals to help them maintain housing according to the guidelines of Housing First, which is a nationally recognized model. Housing vouchers are also available through partnerships of the housing authority and CMHCs to support individuals to find independent housing in the community. MSH helps Members look for available housing options and work with the individual to maintain their housing through home-based case management. They also work with the local homeless shelter programs to coordinate care.

- *School- based services:* Each of the network CMHCs either provide services as part of a school-based health clinic or provide pediatric behavioral health services in school-based settings. Both MSH and SHP host intensive Outpatient Alternative Day programs in schools for children with severe emotional disturbance who are at-risk for placement outside the home.

- *Whole Health, LLC:* Repeat unnecessary emergency room visits can be costly and disruptive to patients, providers and community members. Whole Health, LLC is a subsidiary of Mind Springs Health, Inc., and was created to support those who repeatedly use the emergency room unnecessarily by modifying their behaviors to reduce unnecessary visits and hospitalizations. Whole Health, LLC connects Community Health Workers (CHWs) to patients it identifies as repeat users with assistance from RMHP. Patients are then provided with services they need, community education, informal mentoring and social support. CHWs serve as a vital link between patients and providers to confirm thriving relationships and provide care in PCMP and other community-based settings. CHWs report that when driving Members to appointments, they have some of the most therapeutic conversations while in the car with the member. As a result of this program, emergency room visits have reduced and patients are connected to preventative care.

- *Colorado Crisis Services:* Mind Springs Health, SummitStone Health Partners, and the Center for Mental Health are providers within the Colorado Crisis Services system and can provide short-term respite care in a safe, peer-managed environment as well as mobile crisis services that meet patients in the community to assess their urgent needs.

C. Assure Compliance with Federal Managed Care Regulations

RMHP has successfully operated a risk management program in its Prime, Medicare, ACA Exchange and commercial behavioral benefit programs for many years. Along with Reunion Health CMHCs, which have operated their own risk management programs, we will comply with all applicable federal managed care regulations, which were updated in 2016. All of our employees are trained on relevant policies and procedures as well as state and federal laws, including the managed care regulations, so that they understand how these laws impact their work. Each Partner maintains a robust compliance program that includes all of the elements

recommended by the Office of Inspector General (OIG) in its voluntary compliance program guidance. We describe our approach to compliance in detail in Offeror's Response 24.

The Partners will work together to achieve consistency in our approaches to compliance with federal managed care regulations. Within each Partner organization, the Compliance Officer works with all departments to provide appropriate educational content for training and we disseminate periodic updates to laws and regulations, such as the revised federal managed care regulations, HIPAA updates, 42 C.F.R. Part 2 and any other changes to state or federal laws. Within the RAE, the RMHP Compliance Officer will oversee monitoring activities designed to evaluate compliance with applicable laws, regulations and policies, including the federal managed care regulations. Any material compliance issues detected during monitoring will be reported to the RMHP Compliance Officer and Compliance Committee. The RMHP Compliance Officer will report serious compliance issues to the Chief Program Officer and the RAE executive committee in addition to following all applicable reporting requirements to the Department, state Program Integrity Office, Medicaid Fraud Control Unit or other governmental agencies.

Offeror's Response 19

Describe the Offeror's process for providing or arranging for the provision of each Covered Service and how 1915(b)(3) Waiver services will be used in conjunction with State Plan services to maximize available resources and outcomes for its Members. The response should specifically include the following:

a. Comprehensive list of the Offeror's package of 1915(b)(3) Waiver Services using the table in Appendix S. This comprehensive list shall include the type of services, the capacity/number of Members to be served, the number and location of service sites, and any special population(s) to which these services shall be offered.

b. Description of the Offeror's utilization management program and procedures.

c. Description of how the Offeror will meet the service planning, care coordination, and transition of care requirements.

d. Description of how the Offeror will leverage and coordinate with other agencies, particularly the Colorado Crisis System, Managed Service Organizations, and the Department of Child Welfare, to maximize available resources and outcomes for its Members.

OUR APPROACH TO THE PROVISION OF COVERED SERVICES

The Colorado Department of Healthcare Policy and Financing (HCPF) has, through the State Plan and 1915(b)(3) Waiver, developed a robust behavioral health benefit for Health First Colorado Members.When coordinated properly, these benefits create a continuum of services from prevention to treatment to recovery. They further support community health promotion and many related principles outlined in this proposal, such as capacity building Health Neighborhoods and proactive planning for whole population health.

The Partners are committed to sustaining and strengthening this continuum of services, within an inclusive service delivery system that supports proactive interventions at the earliest possible opportunity. We have the expertise, resources and community-oriented culture necessary to build upon the talent and resources present in Region 1. Our current community integration activities reflect this commitment in our capacity as a Phase 1 RCCO:

- **Prime payment model** – PCMPs are motivated to work with CMHCs so that their Members receive the support they need to keep their patients out of the hospital and emergency room.

- **Commitment to SIM** -- RMHP and partnering CMHCs participated in the original design of the State Innovation Model (SIM) and have collaboratively invested in supporting behavioral health integration and community based initiatives, such as Health Engagement Teams.

- **Rural strategies** – Many RMHP Community Care Teams (CCTs) include behavioral health professionals as well as certified addiction counselors, which allows for rapid response and navigation support for many Members who might otherwise not effectively be able to take advantage or Waiver or State Plan services.

Access to quality behavioral health services, at the right time and through a provider team of the Member's choosing, is our commitment as the RAE for Region 1.

The Substance Abuse and Mental Health Services Administration, SAMHSA, promotes the Behavioral Health Continuum of Care Model shown below. The Partners' strategy to provide or arrange for the provision of all covered State Plan and 1915(b)(3) waiver services is consistent with this model.
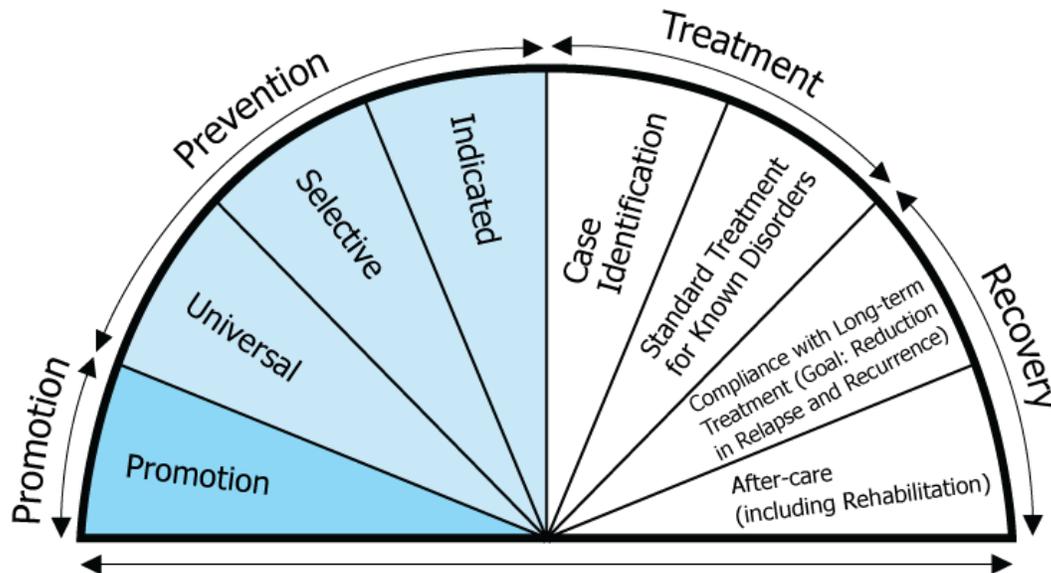
Promotion includes the creation of "environments and conditions that support behavioral health and the ability of individuals to withstand challenges," which the Partners foster through the established relationships of community providers, alliance with county public health agencies and the collective focus on behavioral health integration at the point of care.

Prevention activities and services "prevent or reduce the risk of developing a behavioral health problem." Prevention and early intervention services are supported in Colorado through the 1915 (b)(3) waiver services. A detailed description of prevention and early intervention services are included in Appendix S.

Treatment services for Members diagnosed with a mental health or substance use disorder fall primarily under the State Plan. Treatment consists of a range of medical, behavioral and social interventions including assessment, counseling, group therapy and pharmacotherapy.

Recovery "supports individuals' abilities to live productive lives in the community." The Department has demonstrated commitment to recovery services for individuals to maintain functioning and quality of life that allows for Members to thrive in their recovery through the provision of 1915(b)(3) waiver services.

The Partners will utilize the strength of our partnership and build on the existing network of providers contracted through Rocky Mountain Health Plans (RMHP) and the Substance Use Disorder Managed Services Organizations (MSOs), North Range Behavioral Health and West Slope Casa. Our statewide network of highly skilled providers will deliver medically necessary,

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[111] SAMHSA, "Prevention of Substance Use and Mental Illness." https://www.samhsa.gov/prevention

evidence-based care for covered mental health and substance use disorder services to enrolled Members within the guidelines established by the Department. We are committed to providing timely access to quality services under the State Plan through the provider of a Member's choosing. The Partners will offer contracts on a value-based model-- as defined in Offeror's Response 11-- to 472 mental health providers and 50 SUD providers. In addition, there are 100 psychiatrists and other psychiatric prescribers that are currently contracted and credentialed within the RMHP statewide network, who have been revalidated for Medicaid participation by the Department.

With our network, we will exceed the time and distance standards established by the Department for all Members in Region 1. We will also engage Member-requested, licensed behavioral health providers in the contracting and credentialing process when necessary to ensure choice and continuity. We will provide both capacity and diversity within our network, ensure timely access to behavioral health services and respect the Member's provider and treatment preferences.

The Partners have adpoted SAMHSA's definitions and principles of recovery[112], and resilience[113], which are built on 10 guiding principles: Hope, Person-Driven, Many Pathways, Holistic, Peer Support, Relational, Culture, Addresses Trauma, Strengths & Responsibility and Respect. As we describe the State Plan and 1915(b)(3) services the Reunion Health CMHCs provide, we have woven these principles throughout.

A. PROVIDING STATE PLAN COVERED SERVICES

State Plan Services

The Partners' experience has taught us that well-coordinated integration of State Plan services and 1915(b)(3) waiver services works to address the continuum of behavioral health needs in the covered population. We have several resources at our disposal to ensure that State Plan services are accessible and delivered to all Members. These services span the therapeutic continuum from education and prevention services to emergent stabilization and post-stabilization services. These include:

- **Access:** A robust, statewide provider network with clear standards for performance.
- **Person-centered delivery:** Services are accessible in a diverse array of settings, such as schools, shelters and other community-based settings, as well as through multiple encounter modalities, including face-to-face, telephone, telehealth, secure chat and smart phone applications.
- **Choice:** Member engagement is predicated upon responding to their direction regarding the care plan and service delivery. With the robust combination of State Plan and 1915(b)(3) services we offer, the Member can choose the services and settings that best meet their needs.

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[112] SAMHSA, "SAMHSA's Working Definition of Recovery." https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf
[113] SAMHSA, "Recovery and Recovery Support." https://www.samhsa.gov/recovery

The Partners will provide or arrange for all the covered services in 5.12.5.7. A complete description of each service and highlights of how these services are delivered is found in Additional Appendix A – Covered Behavioral Health State Plan and 1915(b)(3) Waiver Services. Below is a list of some of the State Plan Services covered under behavioral health capitation with basic information about how they will be provided in the RAE network.

Brief Summary of State Plan Services and How they are Provided

For more detailed information, see Appendix A of this proposal.

State Plan Service	Process for Provision	Highlights
Individual Psychotherapy	Provided in all CMHCs	Also provided by independent provider network
Individual Brief Psychotherapy	Provided in all CMHCs	Also provided in integrated PCMP practices
Group Psychotherapy	Provided by all CMHCs	
Family Psychotherapy	Provided by all CMHCs	Also provided by independent provider network & integrated PCMP practices
Behavioral Health Assessment	Provided by all CMHCs	
Medication Management	Provided by all CMHCs	
Outpatient Day Treatment	Provided by Mind Springs Health, SummitStone Health Partners	CMHCs will arrange for Outpatient Day Treatment for Adults when clinically appropriate, if not available at the CMHC
School-based Services	Provided by all CMHCs	Provided throughout the region, services vary by school
Targeted Case Management	Provided by all CMHCs	
Rehabilitative Services	Provided by all CMHCs	
Substance Use Disorder Assessment	Provided by all CMHCs	
Alcohol/Drug Screen Counseling	Provided by all CMHCs	
Medication Assisted Treatment	Provided by all CMHCs	
Social Ambulatory Substance Withdrawal (detoxification)	Provided by all CMHCs	
Outpatient Hospital Services	Provided or arranged for by all CMHCs	West Springs Hospital is an inpatient mental health facility affiliated with Mind Springs Health that serves the Western Slope and that can provide Outpatient Hospital Services

State Plan Service	Process for Provision	Highlights
Emergency and Post Stabilization Care Services	Provided or arranged for by all CMHCs	All Region 1 CMHCs support Colorado Crisis Services, and 2 CMHCs host short-term crisis stabilization units. Additionally, emergency room visits and post-stabilization care are paid for under the BH capitation
Inpatient Psychiatric Hospital Services	Provided or arranged for by all CMHCs	West Springs Hospital is an inpatient mental health facility affiliated with Mind Springs Health that serves the Western Slope

Inpatient Psychiatric Hospital Services

A strength of the partnership between RMHP and Reunion Health in Region 1 is that Mind Springs Health owns and operates West Springs Hospital, the inpatient mental health hospital that serves the Western Slope. SummitStone Health Partners has a long-established collaborative relationship with hospitals in the northeastern part of the state, as well as with Denver-area hospitals. RMHP contracts with hospitals inside and outside Region 1 to provide inpatient care for Members of all ages with covered primary psychiatric diagnoses. In addition to hospitals, the Partners' statewide provider network includes a range of other community supports such as state plan-covered intensive case management programs like Assertive Community Treatment and hospital alternatives like Acute Treatment Units and crisis residential placements for youth. These alternatives provide an opportunity to avoid hospitalizations and to re-establish safety quickly in settings that are in closer proximity to the community.

When Members of any age require hospitalization, CMHC care transition staff work in partnership with the Member, hospital staff, family members and community treatment providers to develop a transition plan for discharge. The transition plan includes coping strategies for the Member and their support system, comprehensive and holistic outpatient follow-up services, scheduling needed outpatient behavioral health services and assistance with other services such as transportation, coordination with other service agencies, housing, medications, and physical health care appointments. To facilitate smooth transitions and timely outpatient service access, the Reunion Health CMHCs have systems in place that will arrange clinician and prescriber access within seven days of discharge from the hospital.

Twenty-four-hour psychiatric services for Members under the age of 21 with a covered mental health diagnosis are provided by licensed and specialty psychiatric units. Inpatient hospital services are available to all members under the age of 21 when medically necessary. We understand that Members who are inpatients on their 21st birthday are entitled to receive inpatient benefits until discharged from the facility or until their 22nd birthday, as outlined in 42 C.F.R. § 441.151.

The Partners will be responsible for all inpatient hospital services with a primary covered psychiatric diagnosis that requires an inpatient level of care and is being managed within the

treatment plan of the Member. We are financially responsible for the hospital stay when the Member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures, such as labs and ancillary services. We are not financially responsible for inpatient hospital services when the primary diagnosis is physical in nature or is a substance use disorder that is evident at the time of admission.

RMHP, in its capacity as the licensed, risk-bearing entity that manages the behavioral health capitation benefit, may contract with an Institution of Mental Disease (IMD) to provide inpatient and SUD treatment. West Springs, owned by MSH, is a state-approved IMD. SummitStone Health Partners has close relationships with IMDs in the northeast part of the state and the Denver metro area. These existing relationships will allow for continuity of care when the Member is discharged to a step-down unit or outpatient services. In all cases, we strive to manage inpatient facility stays to allow for stabilization while arranging for services and treatment in a less-restrictive setting that is as close as possible to the Member's natural environment in order to facilitate and sustain progress.

The Partners understand that they are financially responsible for a Member's admission to any free-standing inpatient psychiatric facility, provided the Member presents with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment. In the case of a SUD as the primary diagnosis, the Partners will not be responsible for continued acute stabilization, safety and assessment services associated with that admission. If a mental health disorder is the primary diagnosis, the Partners understand that they are financially responsible for the remainder of the hospital stay as medically necessary in accordance with 10 CCR 2505 10 8.076.1.8. The assessment phase to determine the exact nature of the problem shall generally not exceed 72 hours.

Non-State Plan 1915(b)(3) Waiver Services

The CMHCs and partners will provide or arrange for all the covered services in 5.12.5.8. A complete description of each service and highlights of how our CMHCs provide or arrange for these services is found in Appendix A. Below is a list of all of the 1915(b)(3) Services covered under the behavioral health capitation with basic information about how they are provided.

In compliance with Department requirements, the Partners will regularly evaluate the effectiveness of the 1915(b)(3) Waiver services throughout the term of the contract. Suggested changes will be proposed to the Department for approval prior to implementation. The Partners will submit the 1915(b)(3) Waiver services Report quarterly and will follow all Department regulations for the report.

Non-State Plan 1915(b)(3) Waiver Services Plan

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Vocational	Individual Placement and Support (IPS)	8am-5pm	Frisco	360 Peak One Drive, Suite 110	Summit	10 at a time	SPMI, SUD
Vocational	IPS	8am-5pm	Grand Junction	450 Ouray Ave., Grand Junction	Mesa	70 at a time	SPMI, SUD

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Vocational	IPS	8am-5pm M - F	Fort Collins	125 Crestridge St, Fort Collins	Larimer	20 at a time	SPMI, SUD
Vocational	Supported employment	8am-5pm	Grand Junction	450 Ouray Ave., Grand Junction	Mesa	10 at a time	SPMI, SUD
Vocational	Supported employment	8am-5pm	Fort Collins	125 Crestridge St, Fort Collins	Larimer	20 at a time	SPMI, SUD
Intensive Case Management	Intensive Case Management	8am-5pm	Aspen	0405 Castle Creek Road, Suite 207	Pitkin	100 per month	SPMI, SUD, SED
Intensive Case Management	Intensive Case Management	8am-5pm	Craig	439 Breeze Street	Moffat	100 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm M-Thur 8-2 Friday	Eagle	137 Howard Street	Eagle	100 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Frisco	360 Peak One Dr., Suite 110	Summit	100 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Glenwood Springs	6916 Highway 82	Garfield	100 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Granby	480 E. Agate Ave.	Grand	50 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Grand Junction	515 28 ¾ Road	Mesa	1,000 per month	NA
Intensive Case Management	Intensive Case Management	11am-8pm M 8am-5pm T-Thur	Meeker	267 6th Street	Rio Blanco	50 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm M, T, Thur, Fri 11-9:30 Wed	Rangely	17497 W Highway 64	Rio Blanco	50 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Rifle	796 Megan Ave, Suite 300	Garfield	100 per month	NA
Intensive Case Management	Intensive Case Management	8am-5pm	Steamboat Springs	407 S Lincoln Ave.	Routt	100 per month	NA

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Intensive Case Management	Intensive Case Management	8:30am-5pm M-Thur, 9am-2pm Fri	Vail	395 E Lionshead Circle	Eagle	100 per month	NA
Intensive Case Management	Intensive Case Management	7am-5pm M-Thu	Walden	350 McKinley St	Jackson	50 per month	NA
Intensive Case Management	Intensive Case Management	8am-7pm M-Thur, 8am-5pm Fri	Fort Collins	Multiple Service Locations	Larimer	300 per month	NA
Intensive Case Management	Intensive Case Management	8am-7pm M-Thur, 8am-5pm Fri	Loveland	Multiple Service Locations	Larimer	150 per month	NA
Intensive Case Management	Intensive Case Management	8am – 5pm M-F	Estes Park	Multiple Service Locations	Larimer	20 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Aspen	0405 Castle Creek Road, Suite 207	Pitkin	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Craig	439 Breeze Street	Moffat	100 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm M-Thur 8am-2pm Fri	Eagle	137 Howard Street	Eagle	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Frisco	360 Peak One Dr., Suite 110	Summit	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Glenwood Springs	6916 Highway 82	Garfield	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Granby	480 E. Agate Ave.	Grand	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Grand Junction	515 28 ¾ Road	Mesa	1,000 per month	NA
Prevention/ early intervention	Prevention/ early intervention	11-8 Monday 8-5 Tues-Thur	Meeker	267 6th Street	Rio Blanco	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8-5 M, T, Thu, Fri 11-9:30 Wed	Rangely	17497 W Highway 64	Rio Blanco	50 per month	NA

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Rifle	796 Megan Ave., Suite 300	Garfield	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am-5pm	Steamboat Springs	407 S Lincoln Ave.	Routt	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8:30am-5pm M-Thur9am-2pm Fri	Vail	395 E Lionshead Circle	Eagle	50 per month	NA
Prevention/ early intervention	Prevention/ early intervention	7am-5pm M-Thur	Walden	350 McKinley St	Jackson	25 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Fort Collins	Various sites throughout the city	Larimer	100 per month	NA
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Loveland	Various sites throughout the city	Larimer	70 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Estes Park	Various sites throughout the city	Larimer	15 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Delta	Various sites throughout the city	Delta	100 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Montrose	Various sites throughout the city	Montrose	300 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Gunnison	Various sites throughout the city	Gunnison	75 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Telluride	Various sites throughout the city	San Miguel	30 per month	
Prevention/ early intervention	Prevention/ early intervention	8am – 5pm M - F	Norwood	Various sites throughout the city	San Miguel	25 per month	
Clubhouse/ Drop-In Center	Drop in Center	8am-4pm	Oasis	450 Ouray Ave., Grand Junction	Mesa	40	NA

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Clubhouse/ Drop-In Center	Drop in Center	2 times per week	Fort Collins	214 S. Whitcomb St, Fort Collins	Larimer	35	Adults
Clubhouse/ Drop-In Center	Drop in Center	2 times per week	Loveland	1250 N Wilson Ave, Loveland	Larimer	35	Adults
Clubhouse/ Drop-In Center	Clubhouse (Internationally Certified)	8am-5pm M-F, Saturday and Holiday hours	Fort Collins *transport provided for Loveland members	125 Crestridge St, Fort Collins	Larimer	40	SPMI, SUD
Clubhouse/ Drop-In Center	Empower-ment Center	8am-6pm M-F	Delta	107 W. 11th Street, Delta	Delta	50	Adult
Clubhouse/ Drop-In Center	Empower-ment Center	8am-6pm M-F	Montrose	605 E. Miami Rd., Montrose	Montrose	50	Adult
Assertive Community Treatment	ACT	8am-5pm	Grand Junction	515 28 ¾ Road	Mesa	40	NA
Assertive Community Treatment	ACT	8am-5pm M-F	Fort Collins, Loveland & surrounding area	2001 S Shields St, BLDG G, Fort Collins	Larimer	30	SPMI
Recovery Services	Peers	8am-5pm	Aspen	0405 Castle Creek Road, Suite 207	Pitkin	50	NA
Recovery Services	Peers	8am-5pm	Craig	439 Breeze Street	Moffat	150	NA
Recovery Services	Peers	8am-5pm M-Thur 8am-2pm Fri	Eagle	137 Howard Street	Eagle	25	NA
Recovery Services	Peers	8am-5pm	Frisco	360 Peak One Drive, Suite 110	Summit	50	NA
Recovery Services	Peers	8am-5pm	Glenwood Springs	6916 Highway 82	Garfield	50	NA
Recovery Services	Peers	8am-5pm	Granby	480 E. Agate Ave.	Grand	50	NA
Recovery Services	Peers	8am-5pm	Grand Junction	515 28 ¾ Road	Mesa		NA
Recovery Services	Peers	11am-8pm M 8am-5pm T-Thur	Meeker	267 6th Street	Rio Blanco	25	NA

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Recovery Services	Peers	8am-5pm M, T, Thu, Fri 11am-9:30pm Wed	Rangely	17497 W Highway 64	Rio Blanco	25	NA
Recovery Services	Peers	8am-5pm	Rifle	796 Megan Ave, Suite 300	Garfield	50	NA
Recovery Services	Peers	8am-5pm	Steamboat Springs	407 S Lincoln Ave.	Routt	50	NA
Recovery Services	Peers	8:30am-5pm M-Thu, 9am-2pm Fri	Vail	395 E Lionshead Circle	Eagle	25	NA
Recovery Services	Peers	7am-5pm M-Thur	Walden	350 McKinley St	Jackson	5	NA
Recovery Services	Peers	8am-7pm M-Thur, 8am-5pm Fri	Fort Collins	525 W Oak St, Fort Collins	Larimer	45	NA
Recovery Services	Peers	8am-7pm M-Thur, 8am-5pm Fri	Loveland	1250 N Wilson Ave, Loveland	Larimer	35	NA
Recovery Services	Peers	8am – 6pm	Delta	107 W. 11th Street, Delta	Delta	50	
Recovery Services	Peers	8am – 6pm	Montrose	605 E. Miami Rd., Montrose	Montrose	70	
Recovery Services	Peers	8am – 6pm	Gunnison	710N Taylor St., Gunnison	Gunnison	15	
Respite Services	Facility based Respite	8am-5pm	Frisco	360 Peak One Dr., Suite 110	Summit	2 at a time	NA
Respite Services	Facility or in home respite	8am-5pm	Steamboat Springs	407 S Lincoln Ave.	Routt	1 at a time	NA
Respite Services	In home respite	8am-5pm	Aspen	0405 Castle Creek Road, Suite 207	Pitkin	1 at a time	*NA*
Respite Services	In home respite	8am-5pm	Glenwood Springs	6916 Highway 82	Garfield	1 at a time	NA
Respite Services	In home respite	8am-5pm	Rifle	796 Megan Ave, Suite 300	Garfield	1 at a time	NA

Service Description	Service	Availability	Location	Location	County	Member Capacity	Special Populations
Respite Services	In home respite	8:30am-5pm M-Thur 9am-2pm Fri	Vail	395 E Lionshead Circle	Eagle	1 at a time	NA
Respite Services	In home respite	8am-5pm M-Thur 8am-2pm Fri	Eagle	137 Howard Street	Eagle	1 at a time	NA
Respite Services	In home respite	8am-5pm	Grand Junction	515 28 ¾ Road	Mesa	3 at a time	NA
Respite Services	Facility based Respite	Two Saturdays per month 9am-1:30pm	Loveland *transport provided for Fort Collins members	221 E 29th Ave, STE 101, Loveland	Larimer	10	Children
Respite Services	In home respite	24 hours per day	Delta	107 W. 11th Street, Delta	Delta	1 at a time	
Respite Services	In home respite	24 hours per day	Montrose, Naturita, Nucla	605 E. Miami Rd, Montrose	Montrose	2 at a time	
Respite Services	In home respite	24 hours per day	Gunnison	710 N. Taylor St, Gunnison	Gunnison	1 at a time	
Respite Services	In home respite	24 hours per day	Lake City	710 N. Taylor St, Gunnison	Hinsdale	1 at a time	
Respite Services	In home respite	24 hours per day	Norwood, Telluride	1175 Grand Ave, Norwood	San Miguel	1 at a time	
Respite Services	In home respite	24 hours per day	Ridgway, Ouray	1175 Grand Ave, Norwood	Ouray	1 at a time	
Respite Services	In home respite	24 hours per day	Montrose	605 E. Miami Rd, Montrose	Montrose	2 at a time	

B. UTILIZATION MANAGEMENT PROGRAM AND PROCEDURES

RMHP and Reunion Health will implement a seamless Utilization Management (UM) process, which includes state-of-the art clinical guidelines and system support to determine the most appropriate level of care. This is augmented by the human intelligence of CMHCs, crisis response, Member assessments and ongoing care management. Our UM process will ensure that Members in need of behavioral health care services access the most effective clinical pathways to recovery and resiliency while also improving clinical outcomes and controlling costs.

RMHP will apply evidence-based behavioral health clinical guidelines to support all UM decision-making. We will employ a highly qualified Utilization Management Director, who will consult peers as needed prior to generating a denial for sign off by the Chief Medical Officer or other qualified physician designee. All immediate after-hours requests will be supported by RMHP to ensure 24/7 coverage for timely UM decisions.

Reunion Health CMHCs, serve as the front line for service requests and as the local clinical experts, and will provide relevant background, history, and recommendations on service requests when appropriate. They adhere to evidence-based guidelines to guide the assessment process, and will make recommendations to the RAE based on the Member's clinical history, current clinical status, availability of resources, desires of the Member, clinical guidelines and other available information. In many cases, the CMHC can work with the Member and support systems to find an alternative to the requested service that better serves the Member.

For example, the parents of a minor Member may request that their daughter be placed in a Regional Treatment Center. However, after discussion with CMHC staff about alternatives that are less restrictive and more therapeutic, the family may choose an alternative, less restrictive option for treatment. CMHCs do not issue denials; denials are only issued by the RAE in accordance with Utilization Management guidelines for denial of service. If there is a request for approval of a service, the CMHC will share their recommendation with RMHP, and continue to provide services for the Member, in the requested setting, until another course of treatment is authorized.

Appropriately licensed practitioners from the CMHCs will be involved in the development, adoption and review of clinical policies adopted by the RAE. Additionally, medical or behavioral health practitioners with relevant clinical expertise will have an opportunity to comment on development, review, adoption and application of UM criteria.

All individuals involved in the behavioral health UM process will apply criteria accurately and consistently in the assessment of needs and clinical appropriateness of requested treatment, subject to inter-rater reliability reviews during new employee training and annually thereafter, in accordance with RMHP standards. We will identify opportunities for improvement by evaluating process and outcomes data, including the volume and characteristics of any overturned denials, and implement updates and corrective actions when necessary.

RMHP will apply written, evidence-based criteria to evaluate the appropriateness of behavioral health care services. We will not expand or contract the scope of services beyond what is covered within the defined Behavioral Health Capitation based on clinical policy. Coverage based solely on a specific diagnosis will not be expanded to include diagnoses not covered by Medicaid.

Application of UM criteria occurs throughout the preauthorization, concurrent review and retrospective claims review processes. The RMHP reviewer will verify Member eligibility and the benefit structure prior to application of clinical criteria for decision-making. Requests for services rendered by a nonparticipating provider are reviewed for medical appropriateness prior to review for allowance of out-of-network services.

The Partners' Utilization Management process for behavioral health services utilization is illustrated below:

Utilization Management Decision Tree
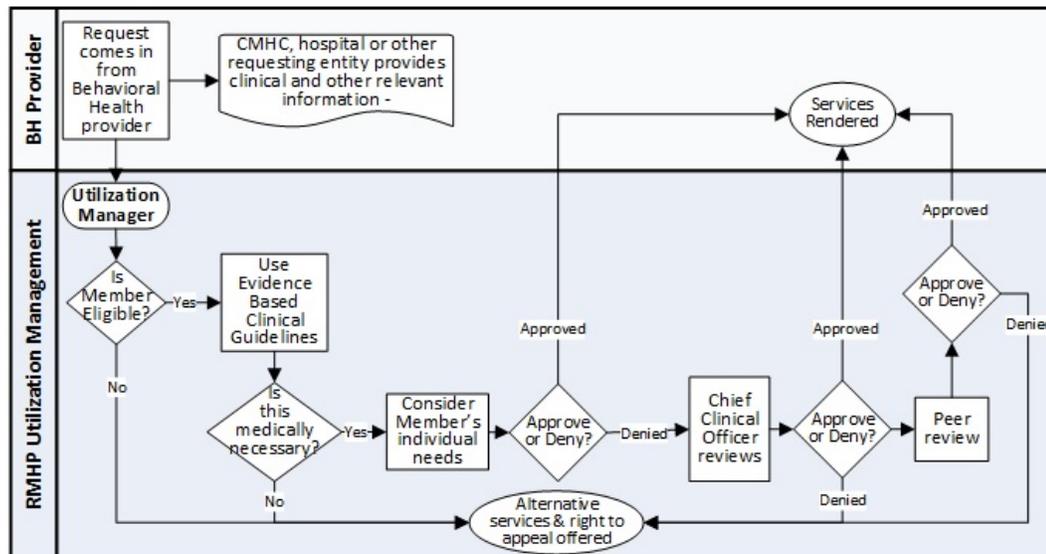
Reviewers compare relevant behavioral and physical health information to the appropriate criteria for each case. This is comprised of clinical and other relevant information including:

- Provider and hospital records
- A history of the presenting problem
- Behavioral health assessment findings, and/or LOCUS evaluation results
- Diagnostic testing results
- Treatment plans and progress notes
- Member psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care and BH practitioners and providers
- Any operative or pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, social supports and other relevant information
- Information from family members

In making a determination, the reviewer considers individual Member needs, such as:

- Member's choices
- Member Age
- Comorbidities

- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable
- Social disparities the member may be experiencing, like housing or transportation issues
- Ability to perform activities of daily living (ADLs)
- Cognitive functioning
- The reviewer considers the characteristics of the local delivery system including:
- Availability of inpatient, outpatient and transitional facilities.
- Availability of outpatient services in lieu of inpatient services
- Availability of highly specialized services

The reviewer selects review criteria in the following order (where they exist):

- Procedures designated as "Not a Benefit" per Colorado Medicaid Fee Schedule or other HCPF documentation are denied
- Medicaid Directives and Bulletins
- RMHP Clinical policies for UM decisions and medical necessity
- Evidence-based clinical guidelines for reviews

RMHP Behavioral Health UM Committee

The RMHP Behavioral Health UM Committee provides oversight of clinical behavioral health programs and activities.

UM activities include:

- Oversight of development, evaluation, review and approval of clinical programs and program criteria. Program criteria is based upon peer reviewed clinical literature, randomized clinical trials, pharmacoeconomic studies and outcome studies as applicable.
- Maintain a comprehensive program, describe activities and ensure an annual review and evaluation of criteria to ensure clinical programs are achieving desired results. The RMHP Pharmacy and Therapeutics (P&T) Committee provides oversight and final approval for clinical programs.
- Report to the respective quality management committees and have a dotted line relationship with the UHC P&T Committee.

The UM Committee will review UM criteria and the procedures for applying them at least annually and revise them as needed. We notify practitioners in writing that criteria are available upon request. We publish UM criteria and review processes on the website in the provider materials section. Any denial letter issued states that UM criteria used to make the decision is available upon request. Members may request written UM guidelines and criteria by calling our OneCall center.

The Partners continuously assess the inter-rater reliability with which physician and non-physician credentialed clinician reviewers apply UM criteria during the initial employee on-boarding process, and annually, according to the NCQA Health Plan Accreditation standard. At least annually, an inter-rater reliability study is conducted to assess variation in decision-making, and identify areas for improvement and training. Staff members receive feedback on incorrect responses immediately. RMHP UM Managers will evaluate whether a particular employee — or group — is correctly applying the guidelines. Staff members interact with guideline content throughout testing for inter-rater reliability, just as they would during actual case reviews. Additionally, we have standard established treatment guidelines.

The RMHP UM department will safeguard and honor Member rights and requests, and respond to concerns or inquiries in an appropriate and timely manner. The UM Director works in collaboration with the RMHP Quality Improvement (QI) Department, and the behavioral health Provider Network to collect data for program evaluation and outcome measures.

Timeliness of UM decisions

Pre-authorization: Some services will require preauthorization and the requesting entity (CMHC, hospital, etc.) will contact RMHP's UM Department for authorization of these services prior to beginning service provision. Some of the types of services that will require preauthorization for Members include inpatient, Acute Treatment Unit (ATU), residential, intensive outpatient and respite care.

Inpatient, Emergent and Subacute Admissions: The RMHP UM Department is available seven days a week, 24 hours a day, to review requests for inpatient and subacute care for a Member. Once admission occurs, the RMHP UM department remains involved for concurrent review and authorization determinations for continued stay as well as to assist with discharge planning. The CMHC Transition Care Coordinators and hospital liaisons from the CMHCs will assist with discharge planning. RMHP and the discharge planners will remain actively involved until the member is safely and successfully discharged.

With respect to standard service authorization decisions that deny or limit services, we will issue decisions as expeditiously as the Member's health condition requires or within 10 calendar days following receipt of the request. If the Member or Provider asks us to extend the timeframe, or if we think an extension of time to submit additional information is in the Member's best interest, we will grant an extension for up to 14 additional days. We will provide the Member with notice about the extension and their right to file a grievance if they disagree with our decision to extend the timeframe.

In those cases where we or a Network Provider believe that following the standard authorization timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, we will make an expedited decision as soon as possible and no later than 72 hours after receipt of the request for service. If the Member or Provider asks us to extend the expedited timeframe, or if we think an extension of time to submit additional information is in the Member's best interest, we will grant an extension for up to 14 additional days.

We will issue service authorization decisions on the date that the applicable timeframe expires if we are unable to reach a decision for either a standard or expedited request.

Monitoring Utilization Trends

Under- and over-utilization of care is monitored through the comparison of specific performance indicators against established benchmarks to assess when utilization falls outside of defined practice patterns. Here are some examples of how we identify under- or over-utilization:

- Monitoring appropriate hospital utilization by tracking average length of hospital stay and rates of hospitalization/1,000 Members
- Defining and monitoring best practice for amount of outpatient follow-up after hospital discharge
- Monitoring a specified number of services within a certain period of time to assess Member engagement
- Monitoring emergency department utilization/1,000 Members to evaluate adequacy of outpatient, non-hospital-based crisis services

The Partners' Quality Improvement and Utilization Management Committees review under- or over-utilization trends with the option to recommend a performance improvement project, provider training or review of decision criteria. In addition, RMHP UM program management may take steps specific to identify individual providers of services, including Reunion Health CMHCs, to remedy identified patterns. These remedies may include a discussion of practice patterns and utilization concerns, specific training programs or a corrective action plan.

Reporting

RHMP, an MCO with full NCQA Medicaid accreditation, has extensive experience with reporting on all aspects of utilization management. We will generate the following reports, as well as any others requested by the Department, according to Department specifications and timeframe.

- UM Program and Procedures
- 1915(b)(3) waiver services report
- Third party identification report
- Third party recovery report
- CMHTA Report

c. Service Planning, Care Coordination & Transitions of Care

The Partners have developed and will implement a comprehensive approach for each of the behavioral health service planning, coordination and care transitions activities listed in section 5.12.7 of the RFP. We envision an aligned and integrated delivery system in which there is no wrong door for a Member to enter for their whole health needs to be assessed and the appropriate services to be determined. When Member is in need of behavioral health services, the RAE will determine the appropriate level of care and service plan to meet his or her unique needs. Additionally, the behavioral health intake and service planning process takes into account the impact of physical health conditions and social determinants of health on the

Member's mental health and substance use disorders and as factors impacting the recovery process.

Intake and Assessment

Intake and assessment is a formal and ongoing process of collecting information about a Member for planning, treatment and referral. Periodic re-assessments are necessary to determine if a change or discontinuation of services is warranted.

RMHP and Reunion Health will provide access to services for Members through an Open Door system, meaning that the Health Neighborhood will be equipped to guide a Member to needed services, which encompasses multiple sites across the Region 1 area, including the Reunion Health CMHCs, SUD service providers, and independent providers. Members can access behavioral health services through a range of community settings, including PCMPs with behavioral health integration, FQHCs, schools, family resource centers, TANF workforce centers, nursing homes and assisted living residences (ALRs). In cases where a Member is unable to travel, Network providers can complete intake and assessments at a Member's place of residence such an ALR or nursing home. Regardless of the location, Members receive a standardized and thorough evaluation that includes screening for mental illness, SUDs, past and current trauma, engagement with a primary care provider and any unaddressed social determinants.

Intake Process

The Partners will ensure a uniform but flexible process for intake and assessment, based on the individual needs and preferences of each Member. The key components of a complete intake are shown below:

Key Components of a Complete Intake

- Demographics including cultural and racial affiliations
- Language and reading proficiency
- Personal health and developmental history
- Personal health habits
- Family health history
- Transportation
- Substance Use
- Social supports
- Member's description of problems
- Factors contributing to the presenting problem
- How the Member has tried to resolve the problem
- Advanced directives
- Safety (suicide risk, homicide risk, self-harm)

During the assessment, clinicians review how the Member experiences the problems they describe, factors contributing to the problems, and how they have previously tried to resolve these problems. An assessment of the Member's strengths, abilities and resources is at the heart of creating a strength-based and Member-directed service plan in the next phase of initial

treatment. Another essential component of the initial session is the assessment of transportation, cultural, and linguistic needs and other barriers to access. Once all of the relevant information has been gathered, the intake also includes a discussion of service options based on the presenting symptoms, level of need, treatment goals and Member preferences.

Reunion Health CMHCs offer an expansive range of services, and can customize the services to prioritize Member preferences. The information solicited for each Member during intake is recorded in the clinical record. The assessment results in recommendations about the type and setting of care that is likely to be the most effective and meet the unique needs of the Member. Recommendations are also provided at this time about how additional referrals, such as a primary care provider, or services, such as WIC, could support the Member's overall health.

While many features of the intake are standard across all Members, we tailor the process to specific populations and their individual needs and preferences. Intake clinicians, including bilingual staff, are experienced and knowledgeable in mental health and SUD assessment and the broad range of services offered through the Reunion Health CMHCs. The intake clinician works with the Member to gather relevant information in an efficient and welcoming manner, clarifying the problems or symptoms that led the Member to seek services and jointly establishing the Member's treatment objectives. CMHCs have psychologists and psychiatrists available to staff complex cases, including Members who present with co-occurring SUDs, trauma histories, medical problems, intellectual and developmental disabilities or neurological conditions. Family members or other significant persons in the lives of Members may serve as key informants in the intake process. Members have a choice of geographic service location and providers.

Assessment and Evaluation Process
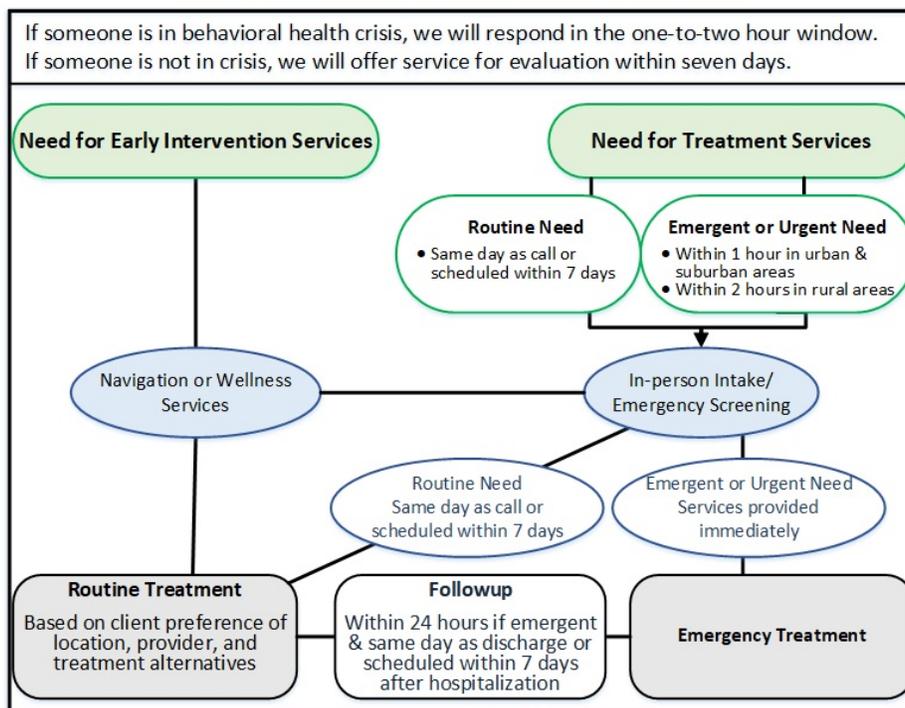
Clinical staff will triage all calls as routine, urgent, or emergency. In those instances in which the call appears to be an emergency, staff transfers the Member directly to an emergency clinician. Members who call or walk in to a Reunion Health CMHC during business hours with a routine need are assessed on the same day when possible, unless they prefer to be seen on another day during the week. Members who call or walk in to an SUD service provider or another Network provider are scheduled for an appointment within seven days, or if in crisis, are seen immediately through Crisis Services. During this initial appointment, clinicians complete a clinical assessment that results in recommendations for follow-up that include an appointment, referral, or other follow-up care. In addition, same-day appointments are available for individuals with covered mental health diagnoses who are transferring from another RAE or Members who are moving from higher to lower levels of care.

In addition, access is available through a variety of service co-locations and partnerships described throughout this proposal, as part of our Open Door approach. Clinicians at the CMHCs or SUD service providers may conduct assessments at other community sites such as nursing homes, jails, and homeless shelters as requested by the partner organization or Member. Behavioral health clinicians also are integrated at physical health sites such as FQHCs and school-based health clinics in Region 1. At these sites, screening for depression and SUDs is conducted using standardized instruments such as the Patient Health Questionnaire (PHQ)-2 and Screening, Brief Intervention, and Referral to Treatment (SBIRT) process. Individuals who screen positively for a behavioral health need in integrated PCMP settings may be treated by the PCMP, if measured improvement or remission can be reasonably expected within a defined period of time. Otherwise, they can be referred directly to the CMHC if more intensive treatment is necessary, in accordance with the parameters outlined in Offerors Response 20.

Services in the Member's Preferred Language

Intake staff interacting with Members with a language preference other than English arrange for a bilingual clinician, an in-person translator or a telephone translator service to facilitate a thorough intake. The Partners will maintain current information about all Network providers, documenting those who are fluent in languages other than English. All providers in the RAE Region 1 network are required to arrange for telephonic interpreter services when an in-person interpreter is not feasible. Additionally, they are required to have a TTY line and provide staff training in Relay Colorado. For smaller providers, the Partners will provide access to telephonic interpreter services.

Service Planning

The Partners will maximize recovery by partnering with Members to develop *comprehensive, individualized service plans that reflect the individual's strengths, needs, and preferences*. Reunion Health CMHCs develop service plans through an interactive, collaborative process involving the Member, parents, families and others with legal custody. In addition, professionals and other individuals are involved as appropriate and approved by the Member, including social services caseworkers, care coordinators and PCMPs. The service planning process encompasses a review of the current status, needs and strengths in major life domains for each Member. Service planning links to the level of need and may include information about interpersonal, legal, psychiatric, educational, vocational, residential, physical, behavioral health,

substance use, social, dental, family, activities of daily living, cultural, spiritual, and linguistic factors.

This extensive information collection is the underpinning of the *Member care plan* that is individualized and culturally appropriate. It specifies diagnoses of problems and disorders but also the strengths and assets of each Member. The care plan supports the Member and family and fosters the values of resiliency and recovery by setting measurable goals aimed at resolving the problems and concerns highlighted during the assessment. Additionally, timeframes and discrete steps are articulated to achieve these goals, including the points at which the care plan is to be evaluated and modified. At the minimum, service plans are reviewed every six months and also whenever there is a change in the Member's level of functioning and service needs or preferences. Advance directives, recovery-oriented self-care plans and crisis plans are incorporated into the service plan. The Member and the clinician sign each care plan; if a Member elects not to sign the care plan, this fact and the Member's reason are documented in the Member's medical record.

The Partners encourage creative service planning that can include non-traditional services, such as participation in self-help groups, volunteer work, wellness classes, clubhouses and drop-in centers. As with more traditional services, care is prescribed in written, measurable objectives using the Member's own goals and language. In partnership with the Member, staff develops care management plans expressed in terms understandable for Members.

Service planning for members with co-occurring mental health and SUD disorders
Service planning for Members affected by co-occurring mental health and SUDs centers on an integrated model of care that is provided in tandem by our CMHCs and SUD providers. Screening for co-occurring mental health and SUD commences with the very first contact with the Member at the CMHC, and extends throughout treatment, modified as appropriate depending on the changing nature of each disorder. We assess and treat co-occurring mental health and SUD disorders in an integrated way, and focus on the needs the Member has on that day. Our providers and treatment modalities are aligned with the evidence base for treatment for both mental health and SUD. Clinicians are trained to identify co-occurring conditions using a developmentally appropriate, standardized protocol.

We rely on Motivational Interviewing and build on the individual's readiness for change. Service planning and the best setting for continued treatment are determined by factors that include the severity of the Member's mental health or SUD, the Member's motivation to change, immediate risk factors, and the Member's and family's preferences. Clinical practice guidelines on the treatment of co-occurring SUD and MH conditions will be available to clinicians throughout the network.

Service planning in collaboration with Criminal Justice Systems
Over a period of years, the Reunion Health CMHCs and RMHP have developed effective collaborations with local jails, prisons, and detention facilities. The Partners' service planning policy will specifically address care coordination with the criminal justice system. The basic elements follow:

- The Care Coordinators and CMHCs will coordinate with jails in their respective jurisdictions, when possible, to assure continuity of care for Members, including medications, during jail stays that do not exceed 30 days and upon the Member's release from a criminal or juvenile justice facility.

- Members released from criminal justice facilities have access to services with the identical standards that are afforded other Members for routine, urgent, emergent care, including the same access to outpatient appointments and access to prescribers. In some cases, Members may be directly transferred from jail to the mental health center for a prescriber appointment or emergency crisis evaluation.

- Care coordination with parole or probation includes record sharing as allowed by Member release and state and federal privacy and confidentiality laws.

- Members involved with the criminal justice system are provided with a referral to a PCMP if they have no provider.

- Members involved with the criminal justice system are assisted in accessing physical health, specialty care or community resources as indicated.

- RMHP has designated a single point of contact to ensure that care is coordinated through transitions to and from the criminal and juvenile justice systems and to troubleshoot problems.

Service Planning in Collaboration with Human Services Departments

The Partners have close working relationships with many of the twenty-two county human or social services departments in Region 1, which is essential to effective service planning for children and families. For example, in Larimer County, SummitStone Health Partners has a defined process for collaboration with the DHS to assure that all children in foster care have access to the appropriate level of behavioral health treatment. On the Western Slope, county DHS agencies are highly collaborative with RMHP Care Coordinators and the CMHCs to provide service planning for children involved in the system. We have a strong understanding of best practices paired with strong community relationships throughout Region to continue building on this work.

Service Planning for Members Involved in Child Welfare

Reunion Health CMHCs, FQHCs and RMHP coordinate behavioral health referrals and services with each county human services department and county caseworkers. This includes communication on individual cases as well as on systems-level coordination. With individual cases, the Partners will coordinate with county caseworkers regarding significant events that occur for child, adolescent, and adult members in treatment who have been referred from the human services or child welfare systems. This will be facilitated by the connected HIE and shared, integrated Care Coordination documentation system, CommunityCare. CMHC documentation systems will have a bilateral Application Programming Interface (API) connection to CommunityCare, so that discrete, prioritized, structured information can be securely shared across systems, despite variation in EHR systems.

The Partners will facilitate behavioral health screening and assessment for children who are at risk for out-of-home placement within seven days of a request from the caseworker or the

adoptive or biological parent. Our network providers offer clinician home-based programs that provide consultation, treatment, case management, evaluation for residential treatment and parent education services in foster homes. In addition, these home-based assessments include family and youth advocacy and mentoring. The CMHCs focus their services to meet the broad goal of preserving families and facilitating stable placements.

Complex Care Coordination meetings are an established means by which members of the child's care team, including representatives from the county child welfare departments, the CMHC, and the Partners' community-based care coordination staff review the needs of the Member and determine the appropriate follow-up care. In many cases, without this coordinated effort, children would have gaps in service and be at greater risk of out-of-home placement.

Service Planning for Individuals with Intellectual and Developmental Disabilities

The Partners will build upon strong working relationships with the Community Centered Boards (CCB) in Region 1, including Strive, Mountain Valley Developmental Services, Community Options and Foothills Gateway. RMHP, the Reunion Health CMHCs and these CCB partners are currently managing the *Cross-System Crisis Response Pilot Program* for people with Intellectual/Developmental disabilities (I/DD) and a co-occurring behavioral health condition.

This pilot allows the Partners to look beyond covered behavioral health diagnoses and work side-by-side to provide intensive crisis stabilization and follow-up care for a person with I/DD who is experiencing a behavioral health crisis. For these individuals, service planning starts with the individual calling the Colorado Crisis Services line or presenting at the Crisis Services unit in either Fort Collins or Grand Junction. The I/DD Pilot also provides Mobile Crisis Services. The individual is assessed by both a behavioral health provider and a skilled staff member from one of the participating CCBs, and the comprehensive service plan is developed with both behavioral health and I/DD needs addressed. Both organizations provide the services and follow up planning so that the full range of needs is met. We will continue to grow the relationships established as part of the pilot to better serve the I/DD population.

Transitions of Care and Care Coordination

Effective transitions of care begin with collaborative service planning between systems to meet the overall health needs of the Member. In addition to our care coordination and care navigation teams, there will be designated CMHC staff serving as Transition Coordinators, whose role is to ensure that Members with behavioral health needs who are also involved with other systems of care have the support they need to transition effectively. The CMHC Transition Coordinators will work with transition staff from each system or provider to align and coordinate services. A few examples of transitions that the Partners will focus on are:

- Incarceration and community corrections into community-based services
- Inpatient hospitalization to lower levels of healthcare – both medical and psychiatric inpatient
- Transitions between behavioral health and primary care

Transitions of Care with Criminal Justice Systems

Our CMHC Providers have developed effective *collaborations with local jails, prisons, and detention facilities*. Our Transitions of Care policy will specifically address care coordination with the criminal justice system, the basic elements of which are inclusive of the Service Planning activities detailed earlier in this response. The Partners will have designated care coordination staff to support criminal justice care coordination to ensure that all of the needs of these complex members are addressed.

RMHP will hold behavioral health providers accountable to ensure that Members released from jails and prisons are offered an appointment within seven days of release. We will have procedures in place to monitor appointment follow-up for these Members within seven and 30 days of jail release using CommunityCare, the Partners' care coordination platform. We have developed strong relationships with the parole offices and community corrections in Larimer, La Plata and Mesa Counties, and will continue to build these relationships throughout Region 1.

Because offenders released from jail, prison, or other correctional settings generally face numerous barriers in making a successful transition to the community, Reunion Health CMHCs and SUD service providers have several specialized programs to assist in the transition. These programs typically combine treatment services, intensive case management, navigation to benefit programs, and peer support so that Members have access not only to the treatment they need, but also other services and supports to assist them with housing and employment. Current transition programs facilitated by CMHCs in partnership with criminal justice partners include:

Transition Program	Description
Parole Orientation Presentation	In Mesa and La Plata Counties, members of our Community Care Teams have been invited to the monthly Parole Orientation, which is mandatory for newly released individuals. The presentation covers the basics for health literacy – how to find a primary care or behavioral health provider, how to make an appointment, what to bring, etc. They also offer care coordination services and give them a wallet card with phone numbers to use if they choose to engage with care coordination services.
Care Coordination for Criminal Justice Involved (CJI) individuals	The good relationships we have developed in Larimer, La Plata and Mesa Counties mean that the CCTs in those regions are a trusted resource for Parole Officers, who generate referrals to the CCTs frequently. Once engaged, our priority is to enroll the CJI individual for Medicaid services and find a primary care provider and help them access behavioral health services. Once the Member is assessed and the care coordinator and Member collaborate on a plan, our care coordinators will support the Member to navigate services, ensure the Member has transportation to appointments and, on some occasions, care coordinators will accompany the Member to their appointment.
Larimer County and La Plata County	In both Larimer and La Plata Counties, the CCTs have developed relationships with the local community corrections residential facilities.

Transition Program	Description
Community Corrections Health Clinic	CCTs attend a health clinic to take blood pressures, address issues and introduce them to care coordination services. In Larimer County, the CCT staff sometimes use the Easy Care app, which allows for a real-time consultation with an Emergency Medicine physician, who can assess and assist with immediate concerns. The Larimer County Community Corrections program reports fewer emergency room visits since the health clinic program started.
Recovery Court Services	Our CMHCs are partners in their local Recovery Courts in judicial districts that offer the option. CMHC behavioral health providers collaborate with the District Attorney's Office, the county probation office, and the Judicial District. This is a voluntary program to deliver intensive outpatient substance use services to individuals on probation.
Adult Mental Health Court	Our CMHCs are partners in their local Adult Mental Health Courts in judicial districts that offer the option. CMHC behavioral health providers collaborate with the District Attorney's Office, the county probation office, and the Judicial District. This is a voluntary program to deliver intensive outpatient mental health services to individuals on probation.
Jail-Based Behavioral Health Services (JBBS) in Larimer, La Plata and Mesa Counties	A partnership supported by the Office of Behavioral Health with the local County Jails, and the CMHC. The program provides screening, assessment, individual/group therapy, case management and transition to community supports to incarcerated adults who have a co-occurring mental health-substance abuse disorder.

The Partners look forward to expanding our current relationships with the continuum of corrections services and will support the enhancement of existing programs by providing access to additional data sources and predictive data analytics through our custom data warehouse to better alert providers about transitions out of incarceration, offering our suite of technology-based Member engagement tools like EasyCare telehealth and collaboratively developing clinical guidelines for the appropriate health interventions for this population. We will also help to increase the competence and capacity of the independent behavioral health network to deliver evidence-based interventions to this population, and offer transition support from the Partners' care coordination team.

Transitions of Care from Hospital Settings

The National Quality Forum has established that care coordination across a Member's treatment team is essential to ensure acceptable health outcomes including reducing preventable hospital readmissions, medication errors, and emergency room visits.[114] The Partners will develop a robust model so that transitions from inpatient hospitals are personalized, timely, and clinically appropriate. Transitions from inpatient, sub-acute,

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[114] National Quality Forum. Integrating Behavioral Healthcare Performance Measures Throughout Healthcare. 2005, Author: Washington, D.C.

psychiatric residential treatment facility, or a mental health institute commence on the day of admission and are driven by five guiding criteria:

- Member safety
- Member and family choice
- Member's individual recovery goals
- Continuity of care
- Less restrictive environment

If the Member is not already receiving transition care from their routine behavioral health provider, the Transition Coordinators will be assigned to all adult and child Members entering inpatient care either within or outside the RAE catchment area to facilitate discharge planning and transition to a lower level of care. The UM team receives regular updates on the clinical condition of Members from the hospital utilization management (UM) department or hospital social workers, providing outpatient treatment plan information to promote continuity of care. Information from the hospital as well as routine ADT data is documented in CommunityCare, which generates an alert to the CMHC Transition Coordinators to assess discharge planning needs of Members, in collaboration with the UM team so that care authorizations meet the aftercare needs of the Member. The transition staff immediately initiates discharge planning through a face-to-face session, and the Member is followed for a minimum of one month following discharge.

Through coordination between the hospital and the Partners' UM and transition staff, a discharge plan is initiated at admission, working with the Member and family to identify needed supports and post-hospital treatment resources. In addition, potential barriers to the discharge plan are reviewed to prevent avoidable delays in the Member moving to a clinically appropriate lower level of care. Flexibility is always maintained so that the Member's follow-up care is comprehensive and reflects the Member's individualized needs and goals at the time of actual transition. Because transition staff works on a regular and often daily basis with the hospitals in the network, relationships between the transition staff and the hospitals are well-coordinated. The refinement of the transition process by the Partners is ongoing.

Transition planning includes identification and arrangement for the following key elements:

- Availability of a safe, appropriate living environment (independent living, with family or provider, hospital alternative facility, assisted care residence, 24-hour residential, nursing home)
- Access to a continuum of clinical services that support the Members' individual recovery goals, build resiliency, and optimize functioning within the community (individual/group/family treatment, medication management, case management, clubhouse, residential services, vocational/pre-vocational services, peer services)
- Crisis or self-care planning, preparing the Member for the transition from the hospital

- Additional community services, resources and supports (physical healthcare, dental care, housing, childcare, benefit acquisition, vocational rehabilitation, faith community support)
- Post-discharge follow up by the hospital liaison/transition coordinator/designated behavioral health provider staff to confirm the transition plan is in place and does not require modifications

The coordination and integration of clinical services with additional community services, resources and supports are always a focus of transition step-down planning. The transition staff confirms all required elements of the discharge plan are in place and communicated to the discharging facility prior to actual discharge. The discharge plan includes, at a minimum, a face-to-face follow-up outpatient appointment within seven days and a prescriber appointment within 10 days unless a prescriber appointment is not needed.

Unless the Member transitions to a residential setting, CMHC care transition staff will make weekly contact with the Member and the inpatient staff while they are hospitalized to ensure completion of appointments and assist with rescheduling and overcoming barriers as needed. If the Member is re-hospitalized, a meeting with the Behavioral Health Medical Director, CMHC Medical Director and UM Director is held to discuss modifications to the treatment plan. Hospital Liaisons receive updates to any treatment plan modifications that need to be implemented.

Transitions of Care with Medical Providers
Integrated transitions of care are essential to align the whole health needs of the Member. To support information sharing and coordination of services without duplication, the Partners Care Transitions Policy will outline the expectation that behavioral health providers in our network encourage Members to sign a release of information for their primary care provider at the time of intake. To support good bi-directional communication, a Primary Care – Behavioral Health Specialty Provider Compact will be encouraged to make sure that the information exchanged is well defined, mutually useful and timely. The exchange of appropriate medical and behavioral health information, with the Member's consent, is critical to successfully coordinate care and promote better outcomes for the Member. In the event that a Member does not have a primary care provider, the Partners' care coordination team will assist the Member in identifying a primary care medical provider.

This coordination with the physical health care provider is of particular importance for individuals using psychiatric medications, children and youth covered by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, pregnant and postpartum women, and individuals with multiple and complex health conditions. In the case of children and youth, the information request specifically includes EPSDT screening information and provider-to-provider communication with the PCMP is completed to notify the PCMP that the youth is receiving mental health services. For Members who are receiving psychotropic medications, the behavioral health prescriber contacts the PCMP to notify the PCMP of the initial medication assessment including the diagnosis, medications list, and care plan, and invites the PCMP to participate in coordination of care.

Our CMHCs will promote the following coordination strategies, which have been successfully utilized by CMHC behavioral health providers:

- Ask Members at intake about their PCMPs and encourage Members to follow up with their existing providers or link them with the provider of the Member's choosing
- Provide care coordinators to help Members identify and schedule with a PCMP
- Secure releases of information to facilitate coordination of care across the physical and behavioral health provider
- Screen Members during medication reviews for health risk factors and providing referrals, based on their preference, to PCMPs
- Coordinate care with PCPs when EPSDT screens are available from these physical health care providers

Continued Services to Members

The Partners will commit to the Statewide Continuity of Care Policy, to make sure that all state-funded agencies are held accountable for continuity of care. The Partners commit to being collaborative resources for RAEs and CMHCs in other regions, by providing courtesy evaluations and emergency services for any Members experiencing a need in our counties. The Partners will assume responsibility for covering the Medicaid benefits for Members attributed to Region 1 until such Member becomes enrolled in a new RAE. We commit to working with the Member and the receiving RAE to ensure a smooth transition of coverage and services and minimize any disruptions to care. To facilitate the Member's transition, and with the Member's consent, the Partners will transfer care coordination and intake, service planning and treatment records in their systems to the new RAE. For Members with complex needs transferring to a new RAE, care coordinators may exchange additional information with the Member's new RAE by phone or secure email to facilitate a seamless transition without a break in service.

We will work to integrate the Colorado Client Assessment Record (CCAR), and other appropriate service planning and treatment data from CMHCs into CommunityCare, within the bounds of 42 C.F.R. Part 2 and with consent from the Member.

d. How We will Leverage and Coordinate with Other Agencies, Particularly the Colorado Crisis System, Managed Service Organizations (MSOs), and the Department of Child Welfare, to Maximize Available Resources and Outcomes for Members

Members sometimes have complex needs and receive benefits and services through multiple agencies. Indeed, multiple system involvement is an indication of complex social needs and higher level stratification in Partners' logic model. The Partners recognize the need to share information and coordinate Member interactions within the RAE Network, Health Neighborhood and Community in order to reduce duplication, waste and missed opportunities while improving Member experience.

Members involved in multiple systems are often assigned multiple care coordinators including CMHC care managers, Single Entry Point (SEP) care managers, nursing home or assisted living

providers, Community Centered Board care coordinators, EPSDT Healthy Communities coordinators, PCMPs, and others. The Partners will utilize their existing relationships, community governance process and shared care planning technology to designate a "lead" coordinator. This lead will serve as the primary point of contact with the Member or designated representative, but receive timely information and support from a "virtual team" of coordinators who are involved in other aspects of the Member's care plan. The rights and permissions framework within CommunityCare will improve the effectiveness of this process where it is adopted. Other stakeholders can develop and agree to coordination protocols and additional data sharing agreements as necessary within the Partners community governance framework.

For example, a single care coordinator will be designated for children in wrap-around programs or individuals in waiver programs. When an individual has a serious and persistent mental illness and is on a Community Mental Health Supports waiver, the CMHC care manager will work closely with the SEP care manager to identify a single or lead care coordinator. The designation of a single care coordinator occurs through telephone conference meetings or staffing sessions with representatives from the other systems involved in the care for the Member and in conjunction with the Member and/or the Member's family.

In cases where medically necessary services are not covered under the behavioral health capitated benefit, the Partners' Care Coordination team will initiate care planning for the member or identify the appropriate lead care coordinator to actively coordinate with appropriate alternate systems of care to access additional benefits or resources. This could include, at a minimum, coordination with CCBs, SEPs, child welfare, Health Communities, and MSOs. The Partners have a strong local presence in all of the Region 1 counties and have developed valuable relationships and partnerships with all of these entities. These relationships will be formalized into structured care coordination agreements and processes to link Health First Colorado Members to the array of necessary benefits and services.

Coordination with Other Agencies and Services

Criminal Justice System: SHP and MSH are both Offender Mental Health Services Initiative providers under SB07-97, and Jail Based Behavioral Services providers. This allows them to connect with Criminal Justice-Involved individuals who are Medicaid-eligible before their release, and they can provide continued care after their release. As detailed above, opening a dialogue with CJI individuals prior to release can forge personal connections as well as address any urgent physical symptoms.

In addition, RMHP Community Care Teams (CCTs) in the Southwest Counties of La Plata, Dolores, Archuleta, San Juan, Montezuma and San Miguel, provide health literacy presentations as part of parole orientation and resources for the individual to get behavioral health care, primary care, and other needed services through care coordination. The CCTs are closely connected to the CMHC that serves the area and will coordinate care across systems to ensure the Member's behavioral health and other needs are met. Mesa County has a similar program where RMHP CCTs are connected with the Parole office and provide health literacy presentations and resources for the individual to get behavioral health care, primary care, and other needed services through care coordination. In Larimer County, the CCT, supports a clinic

on Monday evening hosted by Larimer County Community Corrections. When Care Coordinators come to the Community Corrections residence, they are meeting CJI individuals where they live to make it easier for them to access services.

A simple blood pressure check can turn into a conversation about behavioral health or medical concerns, and the care coordinator can make the appropriate referrals, appointments and warm hand-offs. RMHP CCTs also have access to EasyCare, which is an on-demand secure telemedicine modality. If, while the care coordinator is present, a Community Corrections resident has a non-emergent medical concern, The Care Coordinator can use Easy Care with the individual to consult with a medical provider in real time, gather assessment information and treat simple non-emergent conditions as needed, thereby avoiding an emergency room visit.

Interagency Care Coordination is provided throughout Larimer County for adults who are intensive utilizers of community services (not just for CJI, but any identified adult with complex needs in the community), including emergency departments, police services, jail, adult protective services, nursing facilities, fire and rescue services and others. Multiple Larimer County agencies regularly assess and plan for intervention on behalf of individuals who are perceived as over-utilizing community resources or at risk of jeopardizing themselves or others.

Child Welfare: All of the CMHCs in Region 1 have close communication channels with their county DHSs to support children in the child welfare and foster care systems. Many of these children experience Serious Emotional Disorder (SED) and need comprehensive behavioral health care. One example of formalized interagency relationships developed in Larimer County is the following:

- Family Assessment and Planning Team (FAPT) is a weekly scheduled interagency planning group in Larimer County that addresses high-risk children who are in danger of out-of-home placement, including residential treatment or commitment. These meetings include decision-making representatives from the local school districts, Department of Human Services Child Welfare, probation, SHP and Matthew's House Family Advocate. Parents, foster parents and children attend, if appropriate to participate in arranging the intervention plan. Community resources are recommended to divert from higher levels of care

Long Term Care Services and Individuals with Developmental Disabilities: The Partners' experience with the I/DD Crisis Services Pilot uniquely positions them to support coordination of LTSS and, specifically, CCB services for individuals with an I/DD. The I/DD Crises Center Pilot has resulted in systematic and organized communication across systems as well as cross training, which facilitates coordination of care. Additionally, the CMHCs work closely with their local SEP agency to support Members receiving behavioral health services and coordinated services.

Community-based Care for Members Transitioning from Institutional Settings: The network of CMHCs in Region 1 is closely connected to, and sometimes the operator of, community housing settings where individuals may live after transitioning from an institutional setting. These are complex transitions that require attention to needed behavioral and physical health care, as

well as the non-medical and social supports to help someone live successfully in the community. Region 1's integrated CCT model is uniquely suited to support these transitions. In tandem with CMHC care coordinators, they work to assist the Member in receiving all needed services. CMHC professionals will have access to the CommunityCare care coordination documentation platform, and the CCTs will have access to the appropriate parts of the Member's CMHC records through the same system. This allows for better coordination and non-duplication of services. The CMHCs in Region 1 communicate regularly with providers of LTSS in order to arrange for non-medical supports to enable the Member to thrive in their community-based setting.

Managed Service Organizations (MSO): MSH is one of the owners of the MSO in its region, called West Slope Casa. All of the CMHCs on the West Slope document in the same system and use that documentation system for MSO services, Crisis Services, intake and service planning. All MSO and CMHC services are closely coordinated across systems by behavioral health care coordinators affiliated with the CMHC.

SHP works closely with North Range Behavioral Health, the MSO provider in Larimer County, to coordinate MSO service records as needed. Since SummitStone provides several of the MSO services in Larimer County, Members who opt to do so can be seamlessly transferred into behavioral health treatment. All MSO and CMHC services are closely coordinated across systems.

Colorado Crisis System: The Partner organizations, including Mind Springs Health (MSH), the Center for Mental Health (CMH) and SummitStone Health Partners (SHP) host the Colorado Crises Services call-in, walk-in and mobile services in Region 1. On the Western Slope, documentation of crisis services is in the same system that all West Slope network CMHCs use for documentation of intake, service planning and service delivery. This preserves continuity of care, since records are visible to the Member's CMHC. All CMHCs on the West Slope use the same documentation system, so if a Member moves within that area, their records can be retrieved by the new CMHC. SHP works closely with North Range Behavioral Health to coordinate crisis services records as needed. Since SHP hosts Crisis Services in Larimer County, Members can be seamlessly transferred into the intake and service planning process, if they choose, when they have stabilized. All MSO and CMHC services are closely coordinated across systems.

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.

The Partners have a strong history of supporting integrated care, including behavioral health and primary care providers working in multi-disciplinary settings to deliver team-based care. Our experience, expertise, partnerships, existing programs and technology position us well to support Primary Care Medical Providers (PCMP) and track utilization of the six fee-for-service (FFS) short-term behavioral health sessions delivered in primary care settings.

We believe that early intervention and normalization of behavioral health modalities are critical to identifying and treating mild to moderate behavioral health concerns before they become severe and difficult to treat. The "six visits" innovation that the Department has developed will greatly enhance access to timely, preventive behavioral health care, thereby meeting needs upstream, before they disrupt a Member's ability to function optimally. This change in practice is especially important for children, as research shows that half of mental illness presents by age 14[115].

We will build upon our substantial experience with primary-care behavioral health integration to encourage and support PCMPs that pursue behavioral health integration in their practices, while aligning RAE services and broader delivery system functions to ensure smooth transitions to specialty behavioral health care when needed.

SUPPORTING PCMP PRACTICES DELIVERING BEHAVIORAL HEALTH SERVICES

RMHP and Reunion Health have extensive experience working collaboratively. We have successfully worked together on several initiatives, including, Comprehensive Primary Care Plus (CPC+), State Innovation Model (SIM) and the Medicaid Payment Reform Initiative ("Prime") that the Department implemented pursuant to Colorado House Bill 12-1281. To support practices in delivering integrated services and the six-visit benefit, the Partners will:

- Provide operational support for practice transformation, through RMHP's existing behavioral health integration curricula, related training, and data collection assistance
- Deploy and promote PCMP adherence to clinical practice guidelines for screening and identification of Member behavioral health conditions and risks
- Deploy and promote PCMP adherence to guidelines for communication and referral processes to Community Mental Health Centers (CMHC), other specialty behavioral health providers and RAE care management services when an individual needs more intensive treatment

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[115] https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml

- Align PCMP-based behavioral health outcome measures with major ongoing initiatives (e.g., Center for Medicare & Medicaid Services' (CMS)' Quality Payment Program) to avoid creating additional burdens upon PCMPs

The Regional Accountable Entity (RAE) PCMP Advisory Council and Directors Committee and Council will discuss guidelines for the six visit benefit, to solicit the broadest possible input and feedback on clinical screening, assessment, referral, documentation and reporting processes.

Practice Transformation– Training and Assistance for Successful Integration

In August 2016, RMHP hired a dedicated Integrated Behavioral Health Advisor to expand our practice transformation support. With PhD level training and experience in Community Mental Health Center settings, this advisor is providing specialized assistance to PCMPs pursuing behavioral health integration milestones. This individual develops practice curricula, conducts trainings, leads regional Learning collaboratives, and works one-on-one with practices to create tailored plans for integrated behavioral health. Additionally, this advisor serves as a resource for evidence-based guidelines and related tools. Another step RMHP has taken to expand our practice transformation support is to develop tool kits to assist practices in areas such as: (1) guidelines for *hiring* a behavioral health provider to work in primary care; (2) balancing *cultural and pragmatic* components of integrated behavioral health; and (3) tips for *effectively using the Patient Activation Measure* in primary care. As the six-visit benefit and other payment supports for sustained behavioral health integration evolve, RMHP's practice transformation team will further expand and refine this specialized training and assistance.

To date, RMHP financial and technical assistance initiatives for integrated behavioral health in PCMP settings have yielded exceptionally positive outcomes. Below are outcomes we have collected through our clinical reporting, practice survey and actuarial analysis processes:

- **Better quality:** In 2014, only 14 percent of patients in participating practices who were screened for depression and screened positively had a documented follow-up plan. In 2016, 47 percent of the patients who were screened for depression and screened positively had a documented follow-up plan.

- **Provider satisfaction:** When asked about a practice's greatest success in the past year, one pediatric practice reported "Hiring two full-time, fully integrated behavioral health professionals." Another practice reported "Depression screening and integration with behavioral health."

- **Lower costs:** RMHP routinely analyzes total costs trends for Members attributed to Advanced and Comprehensive tier PCMPs (as defined in Offeror's Reponses 17). Many of these high-performing Practices with integrated behavioral health providers have cost trends that are two to four percent lower in total on a risk adjusted basis than their lower-tier, non-integrated peers.

A practice interested in support for integrating behavioral health will have an assigned Quality Improvement Advisor and provided access to a Clinical Informaticist and RMHP's Integrated Behavioral Health Advisor. These professionals will work with the practice to develop a quality improvement team, understand the various levels of integration, and develop an integration

plan. These individuals will also support practices in implementing their plan through use of Plan, Do, Study, Act (PSDA) quality improvement cycles and small tests of change to develop improved work flows. A more detailed description of Practice Transformation is found in Response 17. We will have Quality Improvement Advisors who specialize in integrated behavioral health who will support practices in maximizing the role of integrated behavioral health providers, and integrating as full members of the team. This includes:

- Supporting culture change related to difference in expectations about what "should" be handled in medicine/primary care, since some primary care providers are uncomfortable addressing behavioral health concerns.

- Workforce development related to providing specific training for behavioral health providers who practice in a primary care setting

- Supporting the behavioral health professional in team-based care models, including how to support particular patients, provide in-service education to staff, participate in daily huddles and "sell" their role in supporting patients and providers.

Screening and Identification of Members

Participating PCMP practices with integrated behavioral health professionals will routinely screen patients for common behavioral health conditions using validated tools, including the Patient Health Questionnaire 9 (PHQ-9 for depression, Generalized Anxiety Disorder 7-item (GAD-7) for anxiety disorder, the Pediatric Symptom Checklist (PSC) screener for children and youth (Y-PSC) and National Institute for Children's Health Quality's (NICHQ) Vanderbilt Assessment Scale. If the screening is positive with relatively high scores, indicating a moderate to severe condition, the Member will be referred directly for specialty behavioral health services under the behavioral health capitation. If a screening is positive, but with relatively low scores (implying lower acuity), behavioral health professionals within the practice will provide brief treatment, measure progress made over the course of six sessions with re-screening, and then re-analyze the situation with the patient to see if any additional care is needed. If, after six visits, additional services are needed due to lack of progress towards goals, this may include referral to specialty behavioral health or a request for additional sessions in the primary care setting which will require approval from the RAE. Any sessions beyond the initial six will be paid for out of the behavioral health capitation.

The Partners, with assistance from the Directors Committee and Advisory Councils, will adopt appropriate clinical assessment criteria practice guidelines to identify whether Members would benefit from brief or longer-term behavioral health support. The assessment criteria will include a shared care planning component and, when necessary, a referral process for Network behavioral health providers. The initial assessment goal will be to appropriately identify the scope and likely duration of Member needs and determine the whether or not the behavioral health services needed should be offered within the PMCP clinic. However, at any time, PCMP may determine that a more intensive level of treatment is needed and refer to the specialty behavioral health network.

Screening tools will be evidence based, age appropriate and pertinent to common behavioral health conditions that present in the primary care setting. Additionally:

- In addition to the PHQ, GAD, PSC and NIHCQ Vanderbilt Assessment Scale instruments, Primary Care Practices will receive training on evidence-informed tools to screen for behavioral health conditions such as drug and alcohol use, suicide risk, and trauma. Some of the validated screening tools that can be used in primary care settings include: the CAGE questionnaire[116], Screening, Brief Intervention and Referral to Treatment (SBIRT)[117] and Adverse Childhood Experience (ACE)[118].

- Once screened, the behavioral health provider located at the primary care office can conduct a further assessment of need, and also request assistance from the care coordination team within the RAE.

- The behavioral health assessment may result in a decision to refer to more specialty behavioral health care, or to treat the needs within the primary care office. Acuity and chronicity will be the general factors in making this determination. If follow-up care can resolve the presenting behavioral health issues in six contacts, then follow-up care will occur at the primary care office. We will primary care settings with appropriate, evidence-based treatments such as, Problem Solving Therapy, Behavioral Activation, Motivational Interviewing, Solution-Focused Brief Therapy and family or group therapy.

We will provide training and protocols for practices to use when making a determination of the appropriate care plan. Training will include the clinical practice guidelines and approaches to brief interventions, as well as referral processes to complete a warm hand-off to the co-located behavioral health provider.

Treatment

A behavioral health provider with a PCMP practice will have proven tools for providing age-appropriate support for mild to moderate behavioral health concerns, such as anxiety, ADHD or depression. Our Practice transformation facilitators will work with PCMP practice behavioral health providers on to implement best practices in primary care settings. The list below is far from exhaustive, but provides insight into our approach to treatment modalities for primary care settings.

Effective Therapies for Mild to Moderate Behavioral Health Conditions

- **Solution Focused Brief Therapy:** SFBT is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought clients to seek therapy[119].

- **Motivational Interviewing:** Motivational Interviewing is a goal-oriented and client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. [120]

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[116] Ewing, J.A. Detecting alcoholism: The CAGE questionnaire. JAMA: Journal of the American Medical Association 252(14):1905–1907, 1984.
[3]SBIRT: Screening, Brief Intervention, and Referral to Treatment; https://www.integration.samhsa.gov/clinical-practice/sbirt
[118] ACE – Adverse Childhood Experiences https://www.cdc.gov/violenceprevention/acestudy/index.html
[119] https://solutionfocused.net/what-is-solution-focused-therapy/
[120] https://en.wikipedia.org/wiki/Motivational_interviewing

- **Anticipatory Guidance:** Providing guidance to parents about what to expect, or anticipate as their child develops. Recommendations are specific to a child's age at the time of a visit[121].
- **Cognitive Behavioral Therapy:** Cognitive Behavior Therapy (CBT) is a time-sensitive, structured, present-oriented psychotherapy directed toward solving current problems and teaching clients skills to modify dysfunctional thinking and behavior[122].
- **Brief Family Therapy[123]:** Often used for families with an adolescent with SUD.
- **Mindfulness Group Therapy[124]:** Best for small groups of adults who experience mild to moderate anxiety or depression. Shown to be as effective as one-on-one CBT.

Specialty Behavioral Health Network – Communication and Referral Protocol

The Partners will collaborate with integrated PCMPs to develop guidelines on when and how to complete a closed loop referral process to elevate care if and when more intensive treatment is needed. PCMPs and specialty behavioral health providers can tailor general expectations based upon individual provider relationships and agreed clinical parameters between the primary care practice and the behavioral health provider. In all cases, we will strive to accommodate Member's needs and choices throughout the referral process.

- PCMP staff can refer to the specialty behavioral health network at any time: at initial assessment, after several visits, or at the completion of the six visits.
- PCMP practices with integrated behavioral health will establish referral protocols in advance with their local specialty behavioral health providers, including local CMHCs and independent providers. Referral protocols will be modeled after Colorado Medical Society's Primary care – Specialty care Compact, and include agreed-upon guidelines for:
  - Assigning a point of contact for the PCMP and behavioral health specialist
  - Timeliness of evaluation and transmission of records after the Member's appointment with the behavioral health provider.
  - What types of information the PCMP and behavioral health specialist will share and what types information is not to be shared.
    - The PCMP may consider sharing screening results, any treatment provided in the PCMPs office, Member's level of engagement, additional considerations for treatment, and other relevant clinical and medication information.
    - The specialty behavioral health provider may consider sharing results of assessment and evaluation, diagnosis, course of treatment, medications prescribed and additional considerations for Member treatment
  - Methods for communicating and sharing information between providers (e.g. phone, fax, CommunityCare)

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[121] http://medical-dictionary.thefreedictionary.com/anticipatory+guidance
[122] https://www.beckinstitute.org/get-informed/what-is-cognitive-therapy/
[123] Brief Family Therapy https://www.ncbi.nlm.nih.gov/books/NBK64953/
[124] Mindfulness Group Therapy https://www.ncbi.nlm.nih.gov/pubmed/25431430

- Upon being referred to the specialty behavioral health network, the Member will be encouraged to sign a release form at the PCMP's office to enable collaborative management

- A referral form will be transmitted to the CMHC or other specialty behavioral health provider via fax or through the Community Resource Network (described in Offeror's Response 15), or our shared care management platform, CommunityCare.

- Members will be encouraged to make an appointment on their own, however, the referring PCMP practice care coordinator or behavioral health provider may offer to call the CMHC or other specialty behavioral health provider with the patient to make their initial appointment. Alternately, the referring practice may refer the Member to the care coordination program for help with scheduling and navigation. The CMHC or other specialty behavioral health provider will offer all non-urgent appointments within seven days, unless the Member requests a later appointment.

- The referring practice's behavioral health provider will follow up with the CMHC or other specialty behavioral health provider to determine if the individual kept the appointment within seven days of the appointment being scheduled. The PCMP will contact the CMHC or other specialty behavioral health provider via phone, fax or through CommunityCare and document this outreach in the PCMP practice Electronic Health Record (EHR).

Promote Use of a Single Coordination Platform

The Partners will promote use of an integrated care management tool and a community resource network referral system to exchange referrals and track referral receipt and closure for Members who require more than six behavioral health sessions. Through CommunityCare, PCMPs, CMHCs and other specialty behavioral health providers can view a Member's integrated care plan and communicate with other members of the care team, including the Member. While no provider will be required to use CommunityCare, all providers will have access to the platform and can use it to securely communicate with their local specialty behavioral health providers to share records and track appointments.

Tracking Utilization of the Six Short-Term Behavioral Health Sessions
What's an episode?
RMHP and Reunion Health acknowledge that the Department has not prescribed a specific, episodic time horizon to determine the appropriate duration of a six-visit course of treatment, nor criteria that distinguish treatment encounters that accrue in one episode from those that accrue in a subsequent episode. The Partners will work intently, monitoring all available CommunityCare records, clinical data, as well as BIDM support, to ensure that PCMPs with integrated behavioral health staff utilize and bill for the benefit appropriately. We will also make sure that that any outlier patterns or excessive provider interChange billing is reported and addressed by the RAE in a timely manner. Finally, the Partners will establish appropriate criteria to determine when payment by the RAE will be authorized for an ongoing course of treatment that must continue beyond the six-visit limit without disruption.

While data regarding use of the new benefit develops, the Partners will evolve and adapt appropriate criteria and monitoring processes. As a starting point, subject to change as data emerges, RMHP and Reunion Health will adapt criteria and screening periodicity present in aligned broad-based clinical quality measures (CQMs) to set appropriate parameters for use of the new benefit.

One such CQM is *Depression Remission and 12 Months* measure (CMS Measure ID: CMS 159v5), which has been adopted by CMS for primary care practice participating in the Quality Payment Program (QPP), as well as Alternative Payment Model (APM) initiatives such as CPC+. Specifications for this measure establish treatment for patients with a PHQ score of 9 or greater, with the objective of obtaining improvement to a PHQ score of less than 5 (remission) within 12 months of less.

Accordingly, the Partners will track brief intervention episodes of 12 months or less. Patients who do not achieve, or are not likely to achieve, a PHQ score of 5 or lower within this time horizon may be referred to a CMHC or another specialty behavioral health provider for extended treatment. The Director's Committee will develop a policy defining when Members should be transferred to a higher level of behavioral health care and other parameters to promote a high-quality continuum of behavioral health services.

Tracking Utilization

To track utilization of the six FFS short-term behavioral health sessions delivered in primary care settings, and assist Members who need services beyond what the PCMP practice can provide, the Partners will:

- Document and report Member care plans and treatment encounters in real-time via CommunityCare, as applicable for Reunion Health partners and other adopting PCMPs

- Provide Practice Transformation expertise (e.g., consultation with a Clinical Informaticist and Quality Improvement Advisor) as necessary to help practices develop workflow and systems to track and report upon these visits using their electronic health record

- Produce reports for integrated primary care practices that use claims data information extracted from BIDM to track the provision of behavioral health sessions. This is useful for longer-term tracking of the use of the benefit, including how frequently it is used, which PCMP practices are providing the benefit the most and how many of the six visits are used, on average, for a given episode.

We will work with the Department, our Network Providers and the other RAEs to troubleshoot issues related to tracking utilization as they arise, since this is a new program. For example, if a Member makes use of the six visits from multiple PCMP providers during one episode of care, we will need to determine how best to track the visits.

Evaluation

We will determine effectiveness of behavioral health care in the primary care setting through several key metrics. For example:

- Longitudinal improvements in the percentage of Members who are treated and achieve remission within a defined period of time, as documented in accordance with specifications for CMS Depression Remission Measure (CMS 159v5).

- Increased Member satisfaction, as measured through an RMHP Member satisfaction tool, focused on timeliness and access, provider collaboration, and health outcomes.

- Increased provider satisfaction, as measured through an RMHP Provider satisfaction tool focused on timely access to behavioral health provider support, collaboration in care planning, and successfully meeting the needs of the Member.

- Successful referrals to specialty behavioral health when needed, as measured by tracking the number of referrals followed by attendance of a behavioral health specialty visit.

- Increased number of practices supported by a behavioral health clinician, as measured by quarterly network adequacy reports and quarterly outreach to network PCMPs regarding services and hours of operations.

- Increased behavioral health penetration rates in primary care practices, as measured by the number of Members with behavioral health claims submitted in primary care practice locations out of the total Members with claims in primary care practices within Region 1.

- Clinical quality metrics will be tracked for some conditions (like depression) using the screening tools described earlier (GAD-7, PHQ-9) as pre/post tools to measure the effectiveness of a sample of the visits in the primary care setting.

The Partners' Quality Committee will review effectiveness of services and billing practices as a routine agenda item, and will also be informed by routine feedback from the Primary Care Provider Council and the Behavioral Health Independent Provider Council. Adherence of individual primary care practices and behavioral health providers to clinical quality guidelines and appropriate coding and billing of services also will be monitored through audit processes, which may include chart review and site visit. Additional follow-up support and training will be provided as necessary. We are committed to developing and maintaining a network of informed, high quality providers capable of effectively delivering short-term behavioral health sessions that improve Members' functional status.

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.

OUR COMPREHENSIVE DATA STRATEGY

Whole person care and community integration are not possible without a comprehensive strategy for data exchange, management and analysis. Traditional health care data strategies, which rely solely on administrative data collected in the payer sphere, or clinical data in siloed, disconnected, provider electronic health record (EHR) systems, are insufficient to fulfill the objectives set by the Department for Phase 2 of the Accountable Care Collaborative (ACC).

Data from traditional payer and provider sources must be integrated and assimilated with data from a wider array of partners in order to create a 360-degree view of each Member as a complete person -- and better anticipate personal health, behavioral, social and functional needs in a timely manner. Specifically, community data from four key domains must be utilized to *predict*, *prioritize* and *prevent* unnecessary health risks, functional losses and expenditures. These are: **Administrative, Clinical, Social** and **Member Reported** data sources.

To achieve this objective, the Partners will work to create and build capacity in a community-based *information network* — not rigid "platforms" or new information silos that extend only as far as the walls of a single organization or a limited group of providers. Moreover, the RAE will be as adept at *sharing* information as it is at *collecting* information. Rocky Mountain Health Plans (RMHP) and its partner organizations possess world-class expertise, national resources, aligned local leadership and relationships in this critical area of performance. Our data management strategy is differentiated from other offerors because we not only have best-in-class data management expertise and tools, but also a community-based, integrated service delivery structure that uniquely positions us *to act directly* on the opportunities identified in the data we analyze.

RECEIVING, PROCESSING AND MANAGING DATA

Data management is a core component of any population health strategy. In order to be effective, it will be important for the Regional Accountable Entity (RAE) to be established as a data driven organization from the start. As the RAE in Region 1, RMHP will accelerate our strategy to be able to gather important data on our patients that support smarter population health management, care coordination, predictive risk stratification, chronic disease management, and better clinical decision support. We use the data to create meaningful and actionable information, as well as performance feedback and opportunity analysis for providers, community leadership and the Department. We will build upon the significant investments made by the Department in the BIDM and broader interChange systems, and develop bilateral data sharing mechanisms for all data types, including clinical, social and patient reported.

Modern analytic tools and technologies help organizations analyze complex data and use it to benefit patients as well as their institutions. However, selecting and implementing these solutions requires specialized expertise to understand the underlying data while effectively applying systems that support the community. Additionally, the human element is critical in the development and maintenance of actionable data analytics. Superior insight and expertise is necessary to produce breakthrough results.

The Partners' strategy begins with a comprehensive, community architecture that aligns data sources with management infrastructure and use cases by participants in the ACC Network, Health Neighborhood and Community. Rather than focus on technology, however, our strategy *begins and ends with defined, practical, end-user needs*. Below is a framework for the development of real world solutions and information system use cases, which we utilize to focus our architectural design and technology development priorities:

The Partners' organizational structure is uniquely positioned to bring actionable **health, behavioral, social data and Member feedback together in a single strategy** –with the active support of all health and human services organizations within the ACC community.

Community Networks and Social Information Exchange

Health information exchange partners, such as *Quality Health Network* (QHN) and *Colorado Regional Health Information Organization* (CORHIO), as well as clinical data management

entities such as the *Colorado Community Managed Care Network* (CCMCN), have developed data sharing agreements with the Partners to support the RAE community integration strategy. Additionally, RMHP has also implemented new data sharing relationships with public sector partners such as county housing and human services agencies to promote the development of *Social Information Exchange* (SIE) – so that the team member needs described above can be met with a timely, efficient and actionable flow of information across a community network. This new dimension in integrated data exchange services is necessary to make whole person care a reality. Given their insight into real world, whole person needs, and opportunities for smarter care coordination, the Partners have developed a simplified data governance and architectural map for a community-wide data management plan that will support the use cases.

In the diagram below, end users and data sources – including the Department's BIDM resources and claims data processed by RMHP for behavioral health services -- are depicted on the far right and left of the graphic, while key health and social management data use cases, supported by HIE and SIE services, are shown for community team members in their respective domains. Access to the data reflects rights and roles of each team member, while data quality and matching technology (e.g., through *master person & provider index* ("MPI") and *natural language processing* solutions), is used to validate that unique Member and provider identities are accurately determined across disparate data sets.

Diagram: Governance and architectural map for community-wide data management plan
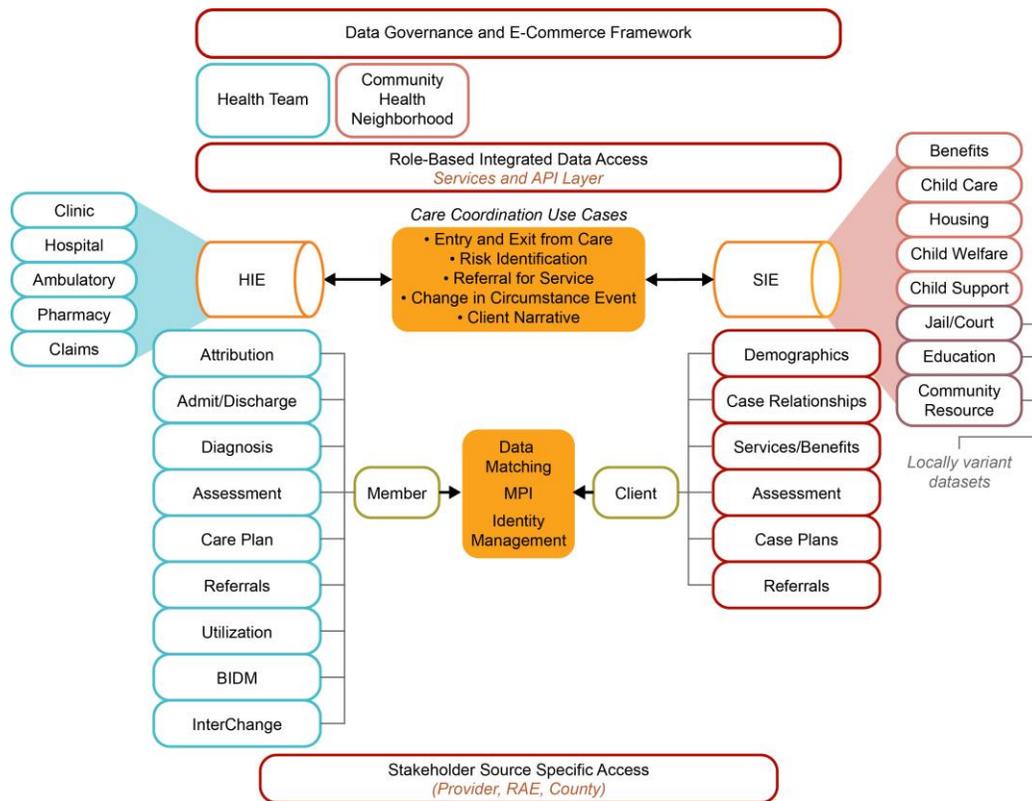
A comprehensive array of risk stratification and shared coordination, assessment and care planning functions is supported – within an overall governance, consent and regulatory compliance process established by the RAE.

UTILIZATION, COST AND RISK STRATIFICATION

Data analysis and shared population health intelligence in these domains are primarily supported by **administrative data** sources and use cases. Data types in this domain include:

- Member information including enrollment, demographics (HIPAA X12 834 Format Files) and attribution data (produced in the Department's BIDM)
- Claims and encounter data, procedures (HIPAA X12 837 Format Files), pharmacy data (NCPDP Format Files), diagnosis, utilization and total cost

The Partners will use these data to understand key cost drivers within the region, and identify where there is unexplained and warranted variation, in order to:

- Monitor utilization of low value services and analyze cost categories
- Analyze cost categories that are growing faster than expected
- Incorporate risk adjusted utilization expectations into analytic procedures as more complex conditions and needs are expected to use more resources

Administrative Data Resources

Primary data sources in this domain of data management and analysis include the following existing resources:

- The Department's Colorado interChange and BIDM system
- RMHP's claims processing systems, and solutions that produce outbound HIPAA X12 Format 837 encounters and NCPDP Format pharmacy claims data to the interChange
- Colorado's All Payer Claims Database

Key Technology Solution: Impact Pro

RMHP will deploy **Impact Pro**, an advanced analytic engine developed by UnitedHealthcare, within our own operations and through external deployments in Network Provider sites. Impact Pro continuously evaluates enrollment data to proactively identify health risks and intervention opportunities. This process incorporates and integrates a variety of data from claims, pharmacy and lab data and providers. Impact Pro algorithms forecast future health risk, stratify Members and provide information to help determine the intensity of care management interventions — crucial data analytic capabilities that assist in the production of targeted reports and, in turn, effective Member supports.

Variation in care and avoidable costs

Impact Pro will enable RMHP and participating network providers to complete the following actionable analyses:

- Identify overutilization, underutilization and related variation in the pattern of care

- Understand the clinical and utilization events affecting a Member's health risk, to prioritize care coordination activities

- Evaluate the ongoing effectiveness of clinical care management interventions

- Identify opportunities for improvement in the way we deliver services to Members

- Identify care improvement opportunities

- Evaluate the overall efficiency and appropriateness of service delivery

Impact Pro is a multidimensional, episode-based predictive modeling solution, supported by a Strategic Management Analytic Reporting Tool (SMART) data warehouse. These tools allow us to produce internal and external reports, dashboards and scorecards that interpret the data and provide guidance to providers, partners and the Department. The tools also support clinical, quality and care management analyses to monitor and evaluate medical and behavioral health utilization.

Impact Pro provides actionable Member data that we share with partnering providers as well as internal care teams. Impact Pro identifies specific diagnoses and synthesizes multiple comorbidities, including behavioral health issues and demographic information, to provide a more accurate risk analysis. It considers the relative benefits of various interventions in a Member's care, and promotes a holistic approach in setting priorities for health. Key components of the Impact Pro analysis include:

- Identifying Members with atypical utilization patterns, such as a Member with bipolar disorder with no regular behavioral health visit as indicated by claims or emergency room use without associated primary care follow-up

- Identifying Members who have a history of emergency room use, repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues or an indication of multiple providers of services that appear to lack coordination

- Providing clinical (medical and behavioral) insights into why an individual is at risk; predictions of future expenditures and the probability of one or more hospitalizations

- Identifying Members with behavioral health conditions, including Members with co-occurring, mood and psychotic disorders

- Identifying gaps in evidence-based care, which can be used to design and implement effective case management and provider engagement strategies

- Identifying Members with a full spectrum of diagnoses (e.g., diabetes, depression) and acute and chronic conditions that contribute to a Member's level of future risk

- Identifying cohorts of Members with multiple chronic diseases and behavioral health issues to support enhanced care coordination by targeting the highest risk Members and gaps in care

- Identifying Members with complex needs, behavioral health issues or comorbid conditions that contribute to a Member's level of future risk

- Understanding the risk of future expenditures, the risk of future hospitalizations and existing gaps in care, which we can use to design and implement effective case management and provider engagement strategies

Impact Pro creates an overall "future risk score" for each Member representing the degree to which care coordination has the opportunity to have an impact on the Member's health status and clinical outcomes. Impact Pro will compliment tools provided by the Department and other available resources to establish benchmarks and monitor provider performance across key cost and utilization metrics.

Timely Follow-up, Closing Gaps and Improving Quality at the Point of Care

Data exchange and use cases in these domains are primarily driven by **clinical data**. Key clinical types for population health management include:

- Labs and diagnostic information;
- Alerts regarding admissions, discharges and transfers (ADT);
- Health records and prescriptions;
- Clinical assessments, care plans and referrals;
- Colorado Client Assessment Record (CCAR) and Drug/Alcohol Coordinated Data System (DACODS)

Clinical data is an essential element in a comprehensive data management strategy. Unlike administrative data, which includes a broad, but limited, picture of the RAE population, clinical data provides a timely, in depth picture of Member health – albeit often in narrow and disconnected provider record systems. In this regard, administrative data can be "a mile wide but an inch deep" – while clinical data is "a mile deep but an inch wide." The Partners' integrated data management strategy addresses these limitations through shared technology and system interfacing solutions.

Clinical Data Resources

Primary data sources in this domain of data management and analysis include the following existing resources:

- Care management tools provided by the RAE in the Health Neighborhood.
- Health Information Exchange services, such as CORHIO and Quality Health Network.
- System interfacing, clinical analytics and performance scorecard services provided by community data aggregators, such as CCMCN.

These resources will enable Primary Care Medical Provider (PCMP), behavioral health and other network providers to partner efficiently with the RAE, reduce redundancies and "blind spots" that can hamper adherence to evidence-based guidelines, proactive treatment and planning, and timely respond to emerging Member needs.

Key Technology Solution: CCMCN Services and the Azara Registry

Colorado Community Managed Care Network (CCMCN) is a Membership organization consisting of 19 Community Health Centers (CHCs), encompassing more than 170 clinic

locations in Colorado. CCMCN provides data management, quality reporting, care coordination support, data analysis and performance improvement support on priority Key Performance Indicators (KPIs) to its members. This approach has allowed CCMCN to create economies of scale with high volume enterprise software licensing and shared expertise. Smaller organizations benefit from the specialized resources normally available only to large practices. All practices benefit from the reduced cost of enterprise solutions.

CCMCN will collaborate closely as a community-based technology provider for the Partners. In addition to sustaining a comprehensive clinical data management structure, CCMCN has established interoperability standards and interfacing services with PCMPs throughout Colorado to support a best-in-class, patient-centered data registry, Azara.

The Partners will adopt CCMCN's clinical data registry support in this area. We will work with CCMCN to generate "practice scorecards" and quality improvement target "dashboards" that will enable PCMPs, community mental health providers and the RAE itself to quickly target gaps and take action for improvement at the clinical point of care – see below:
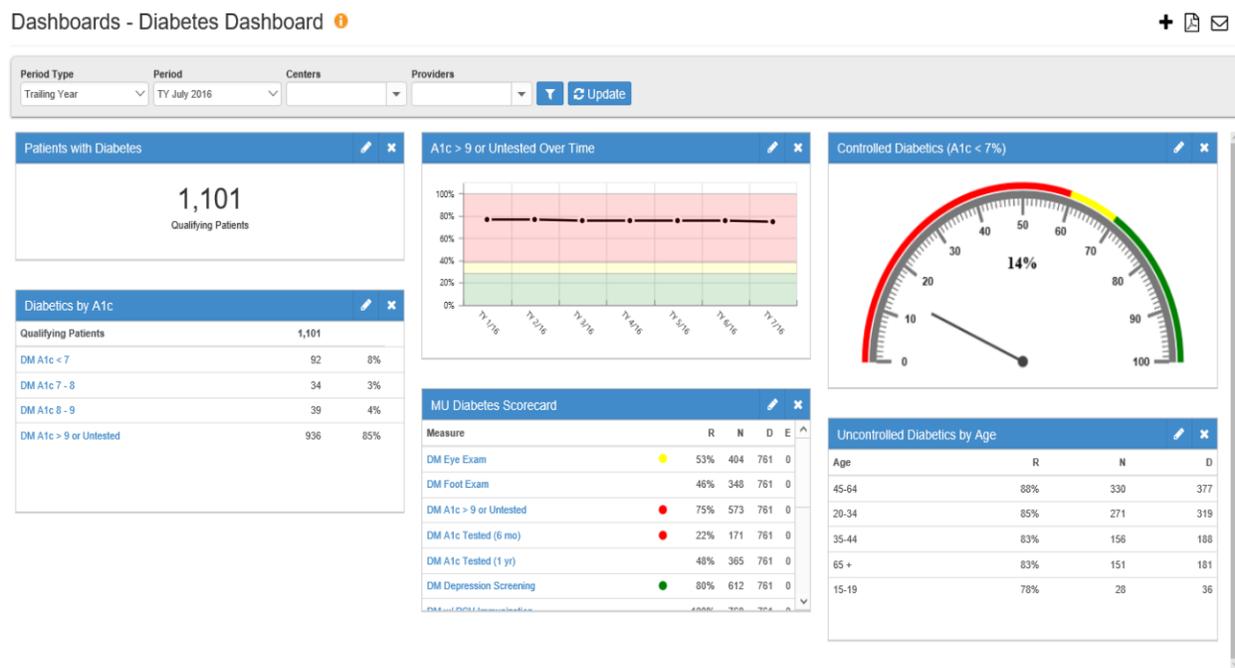
Azara Healthcare is a leading provider of clinical data-driven reporting and analytics for the Community Health marketplace. Azara's solutions empower Community Health Centers, Primary Care Associations and Health Center Controlled Networks to improve quality and efficiency in all aspects of their care delivery through actionable data. Azara's flagship product, the Data Reporting & Visualization System (DRVS), will help the Partners meet the objectives set by the Department for Phase 2 of the ACC.

With DRVS, a health center manager, RAE quality improvement director, and all other interested members of the care team can view and analyze their data through a set of well-defined reports and charts. DRVS provides performance insight regarding compliance with

federal and state mandates, aligns quality improvement initiatives, and examines trends on over 150 key care metrics such as smoking cessation or blood pressure control. DRVS will fulfill a critical role in the Partners' enterprise by enabling PCMPs, CMHCs and RAE personnel to focus efficiently upon achieving KPIs established by the Department. DRVS provides data to help practices understand the performance and compliance variations among different providers, locations and/or health centers. Since its inception, the information provided by the DRVS system has become increasingly valuable, driven by the requirements of health care reform and the programs built to support it. Examples include Meaningful Use and national healthcare programs like UDS Health Outcomes and Disparities reporting for FQHCs.

For Community Health Centers that have already invested in EHR software, Azara DRVS seamlessly integrates with their technology environment to present data in ways that are useful for efficient population and care management, and in driving operational improvement.

SOCIAL DETERMINANTS: USING DATA TO TAKE ACTION

Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, the physical environment, employment, and social support networks – as well as access to health care.[125] See table below. Lower education levels are directly correlated with higher likelihood of smoking and shorter lifespan. Children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health. There is also growing evidence that chronic, "toxic stress" negatively impacts health for children and adults across the lifespan.[126]

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to health options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks			Discrimination	
Medical bills	Playgrounds	Vocational training			Quality of care
Support	Walkability	Higher education			

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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[125] Harry J. Heiman and Samantha Artiga, "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." Issue Brief, November 2015. Kaiser Family Foundation.
[126] Heiman and Artiga.

The regional, community-based focus of the ACC Phase 2, as well as the flexible program structure designed by the Department, create an excellent opportunity for the RAE to build data-driven processes to link Members with community services that mitigate these risk factors. More important, the RAE can use data to serve as a change agent in the broader ACC Community. Given their local relationships, experience and expertise, the Partners are well-positioned to make the most of this opportunity to improve the "upstream" social factors that determine health outcomes. Accordingly, the Partners will use social determinants data for two, strategic purposes:

1. To proactively screen Members for chronic stress generated by gaps in community services, such as **housing, food** and **transportation**, and integrate access to these services in all care planning and coordination activities

2. To support **family, household** and **multi-generational** modeling to better align population health management resources with emerging risks, and work more effectively to "break the cycle" that gives rise to poverty and health inequities

Social Data Resources

Primary data sources in this domain of data management and analysis include the following existing resources:

- Social risk factor screening information collected in clinical and community settings, such as the PRAPARE tool, including assessments and referrals to services

- Community resource data collected and maintained in shared databases, such as 211

- Publicly available data such as census data, foreclosures, access to food, pollution sources, crime rates and other data with predictive value

- Stratified social risk scores for families and individuals, produced by partnering housing and human services agencies

RMHP's research on social determinants of health in Larimer County demonstrates how health need assessments, census data and other public data sources can be used to better understand and predict the health of Members.

Larimer County Social Determinants of Health

Effect of Social Health Determinants on Average Per Member Per Month Costs:

Being homeless — +78.5%

Feeling unsafe at home — + 43.1%

Living 3 minutes closer to a fast food restaurant — +22.0%

Living 3 minutes further away from a grocery store — +19.7%

Living in a neighborhood with 10% fewer college graduates — +14.6%

Per Member per Month costs based on SFY 15-16 data and adjusted for eligibility (adult or disabled), gender, age and physical/behavioral risk scores from the Medicaid Chronic Disability Payment System (University of California, San Diego). SDoH data comes from RMHP health needs assessments, US Census and the Larimer Health Department. Analysis by RMHP using data for 1,324 Members in Larimer County. Images from Icons8.com

The Accountable Health Communities Model

RMHP received and is actively supporting a Cooperative Agreement with the CMS Innovations Center (CMMI) for the *Accountable Health Communities Model* (AHCM), which entails developing a region-wide, integrated social risk factors screening and service coordination strategy. One AHCM initiative will operate in rural and frontier communities in ACC Region 1 while the other will be implemented in the broader Denver-metro area. Over the course of each 5-year, $4.5M Cooperative Agreement, medical and behavioral health providers working with RMHP and its community partners will screen over 200,000 Medicaid and Medicare beneficiaries for social risk factors in clinical settings – and produce measured referrals to food, shelter, transportation and other community services providers.

To support AHCM, RMHP has partnered with *Vision Link*, a community resource data solutions provider, to develop data interfacing connections with HIE partners and collect, process and deliver data from human services programs – including housing, child welfare, child support, community corrections, education and other social service non-profits. These new, HIE-based, *Social Information Exchange* interfacing solutions will securely collect and send data in a manner that meets the privacy requirements of each agency, and will provide the RAE with a spectrum of SDoH information – including alerts that are triggered whenever changes occur in Member housing, caregiver, program eligibility, incarceration or other major "social episodes or transitions."

Housing and Human Services Network Data

RMHP has also implemented a data sharing initiative with Boulder County Department of Housing and Human Services (BCDHHS) to develop interoperability and interfacing standards with major social service platforms, such as **Trails**, which includes access to statewide information – which will be useful in any community, including Region 1. Accessed by approximately 6,000 users through 87 unique interfaces, Trails integrates with 11 other state

systems that track child abuse and neglect cases, care provider licenses, children and youth in the youth corrections system, foster and adoptive services and data required to gauge program effectiveness and adherence with government safety standards. Additionally, RMHP will integrate data from the **Homeless Management Information System (HMIS)**. HMIS is a class of database applications used to confidentially aggregate data on homeless populations served in the United States. Such software applications record and store client-level information on the characteristics and service needs of homeless persons. An HMIS is typically a web-based software application that homeless assistance providers use to coordinate care, manage their operations, and better serve their clients.

Intergenerational Analysis: Family Risk Scores and Machine Learning

Emerging research affirms that health of individuals is closely correlated with the health of family members and other close relationships. Yet most current predictive models and care management programs only look at the health factors of individuals – not families or households. By using demographic data from BIDM, and other human services data from local partners, RMHP will conduct analysis to accurately identify changes in family and household relationships, which will improve the accuracy and impact of prioritized stratification for each RAE Member. For example, research conducted by BCDHHS indicates that a family's likelihood of being involved with child welfare increases by up to 59 percent if a family has gone through divorce or separation. Larger households and households that have experienced divorce or separation are also 23 percent and 25 percent more likely to be regularly involved in county provided services for food assistance, case management, child care, and/or housing. Proactive analysis of household relationships, and social transitions information, will enable the Partners to be more proactive in identifying Member risk factors and coordinating supports.

Additionally, RMHP has committed support to BCDHHS to design and implement the IBM Watson Cognition Project, a Colorado based data processing solution that will read case notes and develop predictive risk scores across health domains. Watson has been trained to identify risk in housing and homelessness, mental health and income domains through natural language processing and machine learning. RMHP will work with BCDHHS to expand this resource to:

- Support additional research that links social determinants of health to health and system outcomes
- Provide Watson generated risk scores to providers and community partners through secure, HIE-supported Social Information Exchange services to inform service strategies and interventions
- Incorporate risk scores from Watson to enhance existing stratification and predictive modeling

The Watson proof of concept provides a clear road map for expanding technology to screen for additional risk factors and develop smarter, more actionable stratification processes. A secure API interface will allow organizations like RMHP – throughout Colorado – to use the technology to better serve local communities.

Key Technology Solution: Healthify

In order to effectively integrate social risk factor screening and related, whole person care coordination activities, efficient application support must be provided in RAE, Network and Health Neighborhood workflows to the greatest extent possible. Healthify is fully integrated in CommunityCare (the care management solution provided by RMHP and adopted by partnering PCMP and CMHCs for shared care coordination, documentation, referral and loop closure) and supports the following critical functions with social risk factor screening, referral management and evaluation:

Search: Healthify *Search* provides staff and consumers with the ability to easily find the right resource for any social or behavioral health need. Rather than relying upon old paper binders and inaccurate internet searches, Healthify ensures quality through a database of highly vetted and constantly curated resources. Healthify Search integrates fully into day-to-day workflow allowing teams to edit, comment, favorite, and share information leading to accurate referrals resulting in an overall time savings and optimization.

Track: Healthify *Track* allows care teams to understand what needs are in a population and to report on what referrals are being made. With Track, teams can track referrals made and deploy integrated screening tools to assess for social needs. This allows care teams to fully understand the social determinants in a population and match people to the best services.

Measure: What doesn't get measured doesn't get improved. With Healthify, RMHP personnel and community partners can see trends in user engagement, heat map resources, and analyze referral success in the network to social service delivery and community health. These analytics will support evaluation of the following critical questions regarding social risk factor mitigation, such as:

- Who is looking for resources? How often?
- What resource is needed the most? What are the top needs in a community?
- Where are people going for help?
- Which organizations are successful with referrals?

Effective evaluation is essential to build and sustain a high performing, well-coordinated network of community service providers, which RMHP will complete on an ongoing basis.

IN THEIR OWN WORDS: MEMBER INFORMATION AND FEEDBACK

While the administrative, clinical and social data sets and analytic use cases described above are essential for proactive, whole person support, Member reported data is a priority in the Partners' strategy for the RAE. Members are in the best possible position to accurately and efficiently describe what they need, in their own words, if the RAE is organized efficiently enough to listen and act upon them.

Member-Reported Data Sources

There are several existing resources for Member data available to the RAE. The Partners will utilize these and several other sources for care coordination and planning activities. These include, but are not limited to:

- The Department's Health Needs Survey

- Other Member assessments and screens

- Additions and corrections to the care plan, either by communications through the care coordinator or via direct access via a Member's mobile device

Key Technology Solution: EasyCare and MyHealthLine

RMHP recognizes that telehealth is the single most promising way to quickly create capacity in the health and behavioral care services network, while making a direct, positive impact upon Member care. Easy Care Colorado is a best in class telemedicine application that supports secure messaging, video chat, scheduling, and image sharing between practitioners and patients.

With a single login, patients can gain access to each of the practices and services that are using the platform for their patients. That means a member will log in and potentially have access to their primary care physician, behavioral therapist, a virtual emergency room doctor in case they are in need of urgent care, and best of all, their familiar care coordinator. By providing access to all of their clinicians in one place, the hope is that patients will have better outcomes as a result of seeing the right provider at the right time, without the traditional barriers to care that come with living in a more rural community.

Free smart phone devices and data plan

One of the biggest barriers to the adoption of telehealth solutions within the Medicaid population is access to smart phone devices and data plans, which can be costly. RMHP will remove that barrier by making *MyHealthLine* available to all Members, by combining the national Lifeline benefit (free smartphone or bring your own phone data plan) with interactive digital health programs to support and motivate Members. Not only does *MyHealthLine* provide the ability to maximize the number of Medicaid Members who have the necessary tools to engage in telehealth, but exclusive *MyHealthLine* features include free calls to and from member services, targeted text campaigns, and secure, person-to-person text capability to meet Member's communication preference. By providing these free technology solutions to our Members, significant barriers to using telehealth will be eliminated.

ROBUST DATA GOVERNANCE FRAMEWORK

The Partners will establish a robust Data Governance Structure that will include three foundational components: Privacy and Security, Data Quality, and Technical Assistance. Implementation and maintenance of the Data Governance Policy will be led by the HIT Director, with oversight by the Program Officer and Executive Committee. The Data Governance Plan will be submitted to the Department on or before the Operational Start Date for the RAE and updated annually thereafter.

Privacy and Security

RMHP will maintain a thorough data governance policy that details how we meet all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 C.F.R. Part 2, 45 C.F.R. § 160,162 and 164, the Health Insurance Portability and Accountability Act of 1996

(HIPAA) as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/ HITECH Act (P.L. 111-005), and State of Colorado Cyber Security Policies. The privacy and security policies will define the conditions for Member information to be shared with whom, under what circumstances and the specific data elements. Further, these policies will specify the security requirements that partnering organizations must meet in order to receive Member data. This will assure that Member data is always held to the highest standards for privacy and security.

Data Quality

The primary focus of the data quality function within the Data Governance Framework is to confirm that the data going into the system accurately reflects the Member's health status and service utilization. This is a critical function that under girds the entire population health and risk stratification model. The goal of data quality is to mitigate the risk of having inaccurate data populating the system and then misinforming the analytics functions. The functions that reside here will be to clarify and map data elements to match the state definitions and provide continuity throughout Region 1. Like any quality improvement activities, RMHP's Data Quality procedures will focus upon multiple points of failure, in a multi-lateral, feedback driven process that includes providers, technology providers, measurement and other experts, as necessary. The process will focus on the following key elements:

- **What output is expected?** Do the values and outputs present in a specific quality measure or application tie to the technical specifications for that measure?

- **Is it the data?** Are we missing key elements in data interfacing and production necessary to meet the technical specifications for the measure or application at issue? Has the data been received in the proper format as expected? e.g., 834 or 837 or HIPAA standard transaction with a statement on EDI system edits/checks?

- **Is it the technology?** If the data required to fulfill the technical specification for the measure are present in the output, is a technology problem (either in the tools or data source interfacing) producing unexpected or erroneous results?

- **Is it our workflow?** If the data flow is adherent to the technical specs, and the technology is performing as designed, perhaps our existing business process, recordkeeping or data entry procedures are inconsistent with the expected measure or application output. Do we need to undertake workflow re-design or other process improvement efforts to better align our routine practice and process with the results we are seeking?

- **Is it our knowledge base?** If there is no problem with adherence to the measurement or application output specifications at any level, and our workflow is optimized for both efficiency and intended outcomes, are there any fundamental gaps or blind spots in our understanding of the measure or application output? For example, are we misinterpreting predicted outcomes as retrospective or current status?

Technical Assistance

Given the importance of vigorous information sharing and analytics to the success of the Partners' population health strategy, it is critical that as many providers as possible develop the

capacity to access and fully participate in information exchange and analytics. Many providers do not possess the internal resources necessary to utilize data sharing and business intelligence solutions. Increasing these providers' technical capacity to fully participate in the RAE information infrastructure will be a critical component of the practice transformation work. The technical assistance component of RMHP's Practice Transformation program will serve as a resource for those practices seeking to increase this capacity, and will actively encourage and encourage Network Provider use of the BIDM System Web Portal.

RMHP possesses not only the expertise in measurement, quality improvement and technology necessary to achieve this objective, but also an *established, skilled, practice-facing workforce* that has the capacity to meet regularly with PCMPs, other Network and Health Neighborhood providers to build data use and quality improvement competencies within ACC Phase 2. Clinical Informaticists are deployed to practice sites to provide hands-on guidance to practices, helping them stay on task and report data so they can achieve their own goals. Clinical Informaticists also assist practices with optimizing health information technology and the use of electronic medical records and data mapping, data reports, report building, registries and other tasks. They provide face-to-face coaching on the meaning and application of practice data – in well-defined, results oriented engagements.

Finally, RMHP and our community partners are exceptionally well prepared to share data and actionable, ground-level business and human intelligence with the Department and other RAE organizations regarding performance of the ACC in the communities we serve. Our capabilities to aggregate, exchange and analyze data include, and also exceed, our core competencies in administrative data management and outbound, HIPAA X12 format encounter and data production to the interChange. Additionally, we are prepared to collect and transmit electronic clinical quality measurement (eCQM) data, social risk factors data, patient reported data and associated analytic directly to BIDM infrastructure and resources – through electronic interface solutions, traditional secure file transfer processes, and DIRECT messaging through HIE partners.

Offeror's Response 22

Describe the Offeror's data management system, including the structure, claims processing system, export capability, and ability to integrate with other systems such as the Colorado interChange and BIDM System. Include a system architecture diagram.

OUR DATA MANAGEMENT SYSTEM: BUILT ON A ROBUST CORE INFRASTRUCTURE

As a health plan operating in Colorado for over 40 years and the Regional Care Collaborative Organization (RCCO) for Region 1 in Phase 1 of the Accountable Care Collaborative, Rocky Mountain Health Plans (RMHP) has the structure and processes in place to achieve and exceed the data management functions for the Regional Accountable Entity (RAE). The Partners are investing in an approach and system that will bring long-term value to the State and the members of the community we serve. Our care management tool, CommunityCare, meets and exceeds the Department's requirements. Within the CommunityCare platform, we will also offer Healthify, a web-based, mobile-friendly application that connects users to relevant community resources. Through our community partnerships and system infrastructure, we will provide value to the Department, State of Colorado, and serve our Members and providers well.

Our data management system supports and aligns with our approach to integrated clinical care, operations and management structure discussed throughout the proposal. In addition to providing the core functions described in the RFP, the Partners will bring benefit to the State through:

- Use of one common person-centric care management platform, deployed to participating community partners for integrated care management functionality. Through a secure web-based application, the Partners, network providers, and health and community-based organizations within the health neighborhood have access to one HIPAA compliant shared platform. Members also have access to the platform through a secure Member portal, available via phone application or computer, to access their care plan, track appointments and medications and securely email their care coordinator.

- Investment in health information exchange (HIE) and social information exchange (SIE), recognizing that no one entity or place will be the end-all be-all assessment or source of data. This includes investment in SIE to connect community organizations within the structure to better address social determinants of health and connect community-based resources with the health care system.

- Investment in system architecture that allows data to move without application or tool limitations. Providing data directly to users in a meaningful and usable format, through an unencumbered HIPAA-compliant flow, remains the goal. Our architecture enables data to get to the point of care where it can positively affect care for our Members, even as applications and tools change and needs evolve.

- Commitment to promoting secure exchange of Member data, readily accessible by providers at the point of care.

UNDERSTANDING AND LEVERAGING DATA FOR IMPROVED CARE COORDINATION

Through our experience serving Colorado Medicaid Members for over 40 years, we have firsthand knowledge of the Department's data systems and have demonstrated our ability to use them successfully for a range of management, coordination and care activities, including process improvement, population health management, federal compliance, claims processing, outcomes tracking and cost control. We support the Department's efforts to incorporate additional data sources, and look forward to incorporating data from other State systems within this data infrastructure. We will leverage and build upon the Department's data systems and performance analytics to successfully implement an information-based approach to delivering and coordinating care. Through our data system architecture, we can easily provide data to the Department's and State's systems to support Colorado's measurement and population health activities.

INTELLIGENT SYSTEMS: THE HEART OF OUR DATA MANAGEMENT STRATEGY
One Comprehensive Care Coordination Tool

We possess and maintain one comprehensive care coordination platform, CommunityCare, to support communication and coordination with the Partners, the provider network, the health neighborhood and members.

Within CommunityCare, our network of community providers have a comprehensive view of the services used by any given Member population, data about each Member's risk level, gaps in care, health assessments and the Member's care plan.

CommunityCare enables care coordinators to document members of the care team, authorized by the Member, to have access to information beyond the core care team (e.g., nutritionist, pharmacist, physical therapist or behavioral health specialist).

To facilitate communication, the care team can receive alerts whenever another member of the care team updates the Member record in CommunityCare or when alerts are received through health information exchange. Using the information in the alert, the team can use CommunityCare to schedule a team meeting and send a secure email to invite the Member.

CommunityCare integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging. It includes a Member's acute care, preventive care, chronic disease management, medical, behavioral health, social and long-term care services. This dynamic, person-centered electronic record houses the Member's individualized care plan and provides the care team with real-time online access to view, update and communicate about each Member's medical information 24 hours a day, seven days a week. This record is available to the care team whether they are direct users of the tool or connect via secure interfaces such as DIRECT or via health information exchanges. CommunityCare provides transparency to our provider network by facilitating the coordination and integration of care and supports our provider payment programs. This aligns with the RAE goal of accelerating a shift toward value-based payment.

RAE Provider and Community Partner Access to One Care Coordination Platform

The RAE partners will make this one care management platform available for use not just within the walls of one organization, but with primary care practices, behavioral health providers, community care teams, hospitals, and other community partners whose use will improve the care we provide to members of our community.

Access to this care management tool is **at no cost to our RAE provider network**. System security and data architecture will be in place so a provider can **use this care management tool across the provider's entire patient population. Use is not restricted by the patient's payer**. The goal is to provide a streamlined solution to encourage provider and Member engagement with the information and functionality. As a secure web-based application, RAE providers and care team members can access CommunityCare 24 hours a day, seven days a week, except during brief periods of maintenance.

- *RAE Provider Access:* RAE network and connected health neighborhood providers such as hospitals can access CommunityCare using an icon on our *Link* dashboard.

- *Member and Caregiver Access:* Members and caregivers can access the Member's care plan through a secure web-based CommunityCare portal. Through CommunityCare, Members can create a calendar to track doctor appointments and medications. Members and caregivers also can securely email one another directly from the portal.

- *Care Coordinators:* CommunityCare enables care coordinators to document and report clinical progress to the care team from an office or in the field using mobile technology. Care coordinators can use data related to social determinants to assist Members with population health-based programs, such as those targeting employment or housing.

- *Working Together:* Care coordinators can help Members access their record, print a copy, request a copy or request that it be amended or corrected. Using mobile technology carried by the care manager (e.g., tablet), a Member can review the care manager's notes, and electronically sign the care plan. With the RAE network connected through one platform, sharing referrals and changes in status is simpler and supports the integrated functions of physical health and behavioral health providers.

Single, Comprehensive Member Record Functionality

CommunityCare enhances RAE providers' and care teams' ability to develop and share care plans and co-manage high-risk Members requiring multiple specialists and care providers. The platform design supports care team collaboration by sharing the care plan, evidence-based medicine gaps in care, referrals, progress notes and pharmacy data with the care team through secure sign-on access. For example, primary care medical providers may access the Member record during a Member office visit by signing into the cloud application and accessing the Member record through a link in the cloud application. Signing in with his/her unique identifier and password, the PCP may review the Member record to identify gaps in care that need closure or to review current specialist referrals.

To facilitate real-time care management actions, the care team receives alerts when the PCP or any member of the care team updates the Member record, and through this mechanism, care team members are informed of changes to the Member record. The PCP may use the alerts

functionality within CommunityCare or secure email invites to convene care team meetings by working with the Member and the care manager to make sure the time and place allows for the Member participation. In addition to real-time alerts, when a member of the care team signs on to the Member's record, a list of alerts will display for review.

As presented by the diagram at the end of this section, CommunityCare becomes the central hub of communication flow between the PCP, care team and the Member. The platform allows the providers and care team members to maximize opportunities to continually engage and educate Members when they access services. In addition, CommunityCare allows the care team to engage in timely care coordination among providers and make certain the Member is receiving the most relevant education, information and guidance to make choices that improve his/her health outcomes. The ability for the team to quickly access information, more closely coordinate care, and work as a team with the Member at each encounter can influence significant health events such as reducing the frequency of using the emergency department for non-emergent conditions. CommunityCare provides the following functionality, which includes all Department required care-management tool elements:

- **Accessibility**: Centralized Member record accessible via the internet and mobile devices
- **Identifying Information**: Member identifying information including Member name and Medicaid ID and demographic information such as age, gender identity and race/ethnicity
- **Care Planning Tools**: Tools that provide the team with Member priorities, goals and important concerns to make sure the patient-centered approach can be maintained through the care. The tools also provide the team with important medical history information. This includes the name of the authorizing provider and any servicing providers (if different) as well as their contact information.
- **Stratification Level**: Advanced analytics and evidence-based medicine tools that integrate medical data with administrative data to identify risk and stratify Members' needs as well as connect Members to a variety of programs, such as wellness, chronic care or high-risk case management
- **Attachments**: The ability to attach images and files, such as laboratory and radiology reports, disenrollment agreement, advance directives and health care proxy
- **Assessments**: A variety of nationally recognized, e.g., mini-mental state examination (MMSE), CAGE questionnaire, valid and reliable assessment tools (including initial risk screening and ongoing assessment and reassessment) and a notification process that reminds the team to perform assessments at specific time intervals
- **Concise Care Plan**: A shared, dynamic, coordinated care plan integrates medical, behavioral, social and long-term services and supports issues and data, and shares vital Member information across the team. This care plan provides information about the names and entities providing care coordination including the name of the lead care coordinator, if a Member chose one. In addition, this care plan provides care coordination notes, activities and Member needs.

- **Notes**: A notes tab where emergency contact information, prior authorizations, physician orders, documentation of contacts with family members and persons giving informal support can be accessed

- **Alerts**: The right information at the right time (e.g., ADT notifications) to identify opportunities to engage Members and provide them with relevant information and education

- **Community Reports**: Reports about the involvement of community agencies that are not part of the provider network, including any services provided

- **HIPAA- Compliant data sharing and use**: A full range of secure communication and collaboration tools

- **Right and Roles based access**: Rights and roles based access allows providers and care coordinators to gain access to only the information that they require.

We will provide a copy of the Centralized Member Record at the State's request for the purpose of monitoring the quality of care being provided in accordance with federal law (e.g., 42USC 1396a(a)(30)) and for purposes of conducting performance evaluation activities.

CommunityCare has the capacity to capture information that can aid in the creation and monitoring of a care plan for the Member, such as clinical history, medications, social supports, community resources, and Member goals. We will collect and report the information identified in Section 5.13.2.1.3 for our entire network. We will work with the Department to plan for how our systems will exchange data with other Department tools such as the BIDM System and the LTSS Case Management system.

Social Service Resource Directory

To effectively address the social determinants of health, connecting Member need with easy access to community resources is critical, and has historically been a challenge. To solve this problem, a community resource tool is built into our care coordination platform. This tool, called Healthify, is a web-based, mobile-friendly application that connects users to relevant community resources. We will use Healthify in combination with the local 2-1-1 resources that are regularly updated and validated.

Healthify connects users to relevant community resources. Anyone with CommunityCare access – RAE providers, members, and community partners – can use Healthify. This tool provides a robust taxonomy of social services, empowering users to bridge the gap between health care and social needs, for example, by referring Members/families to organizations in the community such as, food banks/pantries, housing, legal resources, transportation, WIC, clothing, etc.

A simple search feature enables users to sort relevant categories by type of service and preferred location. Every resource includes a map, contact information, eligibility requirements, service hours, required items and other applicable information to facilitate a successful referral.

Healthify users can target cultural, linguistic and educational support for prevalent demographics, including rural areas where Medicaid populations struggle with numerous social

barriers and health outcomes. Most care managers and community health workers in the field use smartphones to access the tool's database; however, they can also access it with any internet-capable device, including tablets and laptop/desktop computers.

SHARING DATA WITH SUBCONTRACTORS AND OTHER MANAGED CARE ORGANIZATIONS

Using our clinical electronic data interchange (EDI) framework, we will share data with our community partners and the State as allowed under HIPAA. Connecting our RAE provider network and health neighborhood to our data system architecture and health information exchange is vital to enable enhanced care management, care coordination and other capabilities of an integrated clinical model. Our comprehensive framework and related standards enable us to exchange, integrate, share and retrieve electronic health information to support clinical health services. In addition, our solution offers several capabilities to share relevant information within the RAE network for care coordination and monitoring purposes.

Reporting Portal: RMHP maintains a secure, HIPAA compliant reporting portal that is accessible 24 hours a day, seven days a week. Through this portal, providers have access to custom reports for quality reporting, performance measurement, care coordination, and stratification. For RAE activities this functionality will be expanded and enhanced to serve the needs of the RAE provider and health neighborhood network.

POWERFUL CLAIMS PROCESSING SYSTEM

RMHP operates a highly developed, full-feature claims processing system, called *Facets*. Facets is a managed care information system supporting Member enrollment, provider network maintenance, and claims processing. Business rules such as claims payment of covered services, authorizations, and benefit limits are maintained or facilitated through Facets.

Through RMHP's experience as a capitated Medicaid health plan, its non-Medicaid lines of business, and its participation as a Comprehensive Primary Care Plus plan, RMHP has processes to pay capitation or global monthly payments to providers, and to accept and process corresponding encounter claims from providers. RMHP accepts and processes electronic and paper claims, and standard claim types, including medical, behavioral health, hospital, institutional, dental, and vision. Pharmacy claims are handled through our Pharmacy Benefits Manager.

RMHP has processes for auditing claims accuracy, and reviewing claims for fraud, waste and abuse. RMHP also has processes for processing coordination of benefits claims, including Medicare cross-over claims, both as a Medicare health plan and as a Medicaid health plan.

RMHP's system has the capability to pay behavioral health covered services under the capitated behavioral health benefit using the billing procedure codes specified in the Uniform Service Coding Standards manual on the Department's website. RMHP currently processes claims for behavioral health covered services for its commercial, Medicare, exchange and CHP+ lines of business using the system's ability to pay claims based upon unique billing and coverage criteria defined for each line of business.

RMHP has the ability and expertise to process all RAE behavioral health and MCO claims in-house.

RMHP processes claims timely and accurately. The following measures are tracked closely, with corresponding processes for quickly resolving any issues, which may affect timely and accurately processing claims. The following measures include a total calendar year 2016 period.

- Percent of clean electronic claims finalized in 30 days = 99.75 percent
- Percent of clean paper claims finalized in 45 days = 98.87 percent
- Percent of all claims finalized in 90 days = 99.98 percent

In 2016, RMHP processed and paid more than one million claims. Of these, over 25,000 claims were from behavioral health network providers.

ROBUST ENCOUNTER REPORTING & MANAGEMENT SYSTEM

RMHP operates a robust, closely calibrated Medicaid encounter reporting system. We will build upon our well-established medical, facility, and pharmacy encounter submission and reconciliation process to include Medicaid behavioral health encounters in our reporting to the Department. We have seven years of experience submitting and processing encounter claims with the Department as RMHP began submitting electronic encounter claims in 2010. RMHP submits the following types of encounter claims to the Department: ANSI ASC X12N version 5010 837 HIPAA transaction files for both professional and institutional encounters. RMHP also submits pharmacy encounters via the NCPDP 1.2/D.0 HIPAA transaction files.

In June 2017 RMHP received Department approval for the full spectrum of Medicaid and Child Health Plan Plus (CHP+) encounter submission and reconciliation processes with the Department's interChange. This shows RMHP's ability to submit and reconcile encounter claims with the Department's new interChange. This approval includes submitting and reconciling behavioral health services covered under the CHP+ benefit. RMHP will submit and reconcile all encounter data on all State Plan and 1915(b)(3) Waiver services included within the capitated behavioral health benefit electronically, following Department rules. The encounter data submitted and reconciled will meet the Department's quality and timeliness standards.

THE RIGHT RESOURCES TO PUT DATA TO GOOD USE
Expert Personnel

RMHP employs highly experienced personnel with extensive Colorado-specific experience working with the Department and Medicaid Management Information System (MMIS) configuration and edits to adjudicate, submit and reconcile payments, enrollment records, and encounter claims, including exchange with the new interchange and BIDM.

Customized Provider Feedback Tools

RMHP has highly developed architecture and data flows necessary to support a wide variety of customized provider feedback tools, with direct ties to Alternative Payment Methodology (APM) detail and the ability to drill down into:

- Client Health
- Attribution
- Pattern of Care and Resource Utilization
- Total and Categorical Costs of Care
- Diagnosis
- Prescriptions
- Risk Relativity
- Demographic Detail

COMMITMENT TO INTEGRATION

Services Oriented Architecture

Our services oriented architecture is structured to promote the flow of data, *not* to rely on the latest touted applications or tools. Relying too much on applications and tools to process data and information often results in limiting integration and innovation. Getting data where it needs to be, as close to the point of care as possible, is where opportunity exists to affect a person's care, and this is our focus and forte.

The Partners, including RMHP, behavioral health and primary care providers will be connected with Community Health Information Exchange by the time of RAE award. This permits **real-time** (within 4 minutes) transfer of alerts and notifications statewide, including admission, discharge and transfer (ADT) exchange for emergency department, inpatient, and other health, social and behavioral transitions for all of our RAE Members. Colorado's health information exchange organizations, CORHIO and QHN, have established connectivity and bidirectional exchange. Through QHN's connectivity with RMHP, QHN's subscription service, and the CORHIO and QHN connectivity, there are existing processes in place to provide alerts and notifications from CORHIO-connected entities and facilities to QHN for RMHP members.

RMHP is a strong partner in the State's efforts to advance an interoperability strategy and plan, and our strategies and system architecture are built upon where we are heading, not where we are now.

Getting Data to Those Who Can Help the Most

Through interoperability and system architecture, we can get information in the hands of people who are closest to our Members. One example of this is when an RMHP Member is discharged from a hospital in Denver, and her Care Manager in Durango receives an alert notifying of this event, and has a Member outreach workflow to follow. This occurs due to RMHP's subscription service with QHN, QHN and CORHIO's connectivity with each other, and with the providers in Colorado, and RMHP's care management platform that can accept and process alerts into workflow for care managers and other care team members.

CONNECTIVITY TO COMMUNITY BASED ORGANIZATIONS THROUGH SOCIAL INFORMATION EXCHANGE

Social Information Exchange

Since 2004, Quality Health Network has been the health information exchange for Western Colorado, providing secure exchange of electronic health information between authorized medical providers. Health information exchange in Colorado is expanding to include social information exchange. Social information exchange allows both medical and community service providers (housing, home visitation, behavioral health, etc.) to have access to a robust, practical data compilation of the many factors that influence the health of an individual.

Key goals of social information exchange are:

- Facilitate a whole person approach to care and support

- Diminished redundancy in collection of demographic, assessment and other information

- Streamlined and secure communication and information sharing between medical and non-medical care team members that meets both HIPAA (health) and FERPA (education) confidentiality standards

- Referral tracking and closure

- Timely, consistent dissemination of alerts, such as Admission, Discharge and Transfer (ADT) messages

As shown by the Region 1 Operating System Architecture diagram at the end of this Response 22, the connectivity of social information exchange and health information exchange facilitates meaningful ability for health care providers and social service providers to effectively address the social determinants that are affecting Members' health.

> *"The goal of health IT is not about making records electronic or making sure every doctor has an EHR, but having interoperability – so patients are comfortable that when they get care, their providers have the current data."*
>
> *~November 2016 RMHP Issue Brief: A Home for Patient Data*

IDENTIFICATION AND REFERRAL CONNECTIVITY BETWEEN HOSPITALS, PROVIDERS AND COMMUNITY BASED ORGANIZATIONS

Building on the work to connect social information exchange and health information exchange, many of the RAE Partners, network providers, and community-based organizations are included in the recent award funding for the CMS Center for Medicare & Medicaid Innovation (CMMI) Accountable Health Communities Model (AHCM) cooperative opportunity. The AHCM initiative is focused on maximizing community systems integration and referral processes and measuring the impact of those services on health care utilization and costs. We are building measurable identification and referral processes for evidence based programs like Women, Infants and Children (WIC) and Nurse Home Visitor, and screening, like Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Essentially, this initiative engages medical and behavioral

health providers in asking patients a few questions to assess their need for social services, and then making appropriate referrals for services to community-based organizations.

OPEN DEPLOYMENT OF POINT OF CARE SOLUTIONS

The RAE's system architecture and the deployment of a wide array of telehealth, social information exchange, and care management solutions on an "open" / multi-tenant basis enables workflow across multiple populations at the point of care.

RMHP's telehealth leadership is demonstrated through multiple use cases, involving behavioral health, Long Term Services and Supports (LTSS) and physical health engagement. Because telehealth offers tremendous potential to expand capacity, we are committed to removing obstacles to adoption experienced by providers and Members. Through the system architecture, notifications and alerts from interactions during these use cases can be routed to the participating provider's electronic health record through health information exchange.

OPERATING SYSTEM ARCHITECTURE

The Region 1 RAE Operating System Architecture visual on the following page illustrates the applications, tools and flow of data within the RAE. This diagram includes the following.

State of Colorado

The Department's data systems, including: interChange, the State's Medical Management Information System, and BIDM, the Department's data analytics system.

Rocky Mountain Health Plans

The State's interChange provides Member enrollment information to Facets, RMHP's claims processing system, which also includes Member enrollment and provider network information.

Other data from the Department, such as health needs survey data and claims processed by the State will be loaded into RMHP's Data Hub. The Data Hub includes data, business intelligence and analytics. Through the system's architecture to exchange data through the Data Hub, data can easily flow to the appropriate application, tool, partner, or vendor. All data exchanges are conducted following HIPAA security requirements.

Within RMHP, data from the Data Hub is exchanged with Facets, its claims processing engine, a Member Services Platform, which includes documentation of communications with Members, grievances and appeals, and CommunityCare, which includes a rights and roles based integrated care coordination tool and the Healthify service resource directory. Also attached to the Data Hub is Impact Pro, a multidimensional predictive modeling and care management analytics solution, and portals for Members and providers.

RAE Partners

RMHP, as well as all community mental health centers and community health center partners, will use the shared care management application to provide efficient, team-based coordination of all assessment, recordkeeping, care planning and service delivery functions within the RAE. RMHP will also compile all grievances received by the Partners for tracking and reporting. Our partner providers will submit reports and data through RMHP's secure provider portal.

Network Providers

Our network providers, including participating behavioral health providers, primary care providers, and hospitals may choose to have direct access to Community Care, which includes its social services resource directory. Reporting, such as CCAR and quality measures, is submitted via the provider portal. Alerts and messaging can be provided to network providers via health information exchange.

Community Based Organizations

CommunityCare will be made available to all health system community care teams, community health workers, local public health agencies, single entry points, community centered boards, family resource centers and other community partners. This connectivity allows for the efficient inclusion of these community-based organizations in supporting members' needs.

Data Exchange and Data Aggregators

Colorado is fortunate to have strong leaders and organizations that are developing, deploying and advancing data systems to support the Department's vision for ACC Phase 2. Colorado has two strong Health Information Exchange organizations that provide connectivity and the exchange of clinical data. The Colorado Community Managed Care Network is deploying and advancing a robust data aggregation application, Azara, that uses data from community health center and behavioral health provider electronic health records and aggregates the information for clinical data reporting, claims analysis, care coordination and reporting. These organizations are also working with the Department to align with the Department's plans for the interChange and BIDM. To address the social determinants of health, connectivity is being established between these systems and social services systems. The Partners and this network of leaders and data systems will bring the strengths of each of our systems together to build a stronger more unified whole. This approach builds on the existing systems and platforms, and establishes the framework for Colorado to be a leader in supporting whole person health through an integrated data network.

Members and Caregivers

Whole person care is not possible without the participation and voice of the Member. Members and Member-approved caregivers can use the Member Portal to request care coordination support and engage in self-directed supports and services. Through the portal, Members can view their care plan, set goals and monitor progress. Members and caregivers will also have access to MyHealthLine, which combines the national Lifeline benefit (free smartphone or bring your own phone) with interactive digital health programs designed to support and motivate Members. Members can make free calls and securely text their care coordinator. In addition, progress notes and alerts from the Member's use of the RAE's telehealth solution are routed via health information exchange to the participating behavioral health provider, care coordinator, or primary care provider for continuity of care.

REGION 1 REGIONAL ACCOUNTABLE ENTITY ROCKY MOUNTAIN HEALTH PLANS
OPERATING SYSTEM ARCHITECTURE
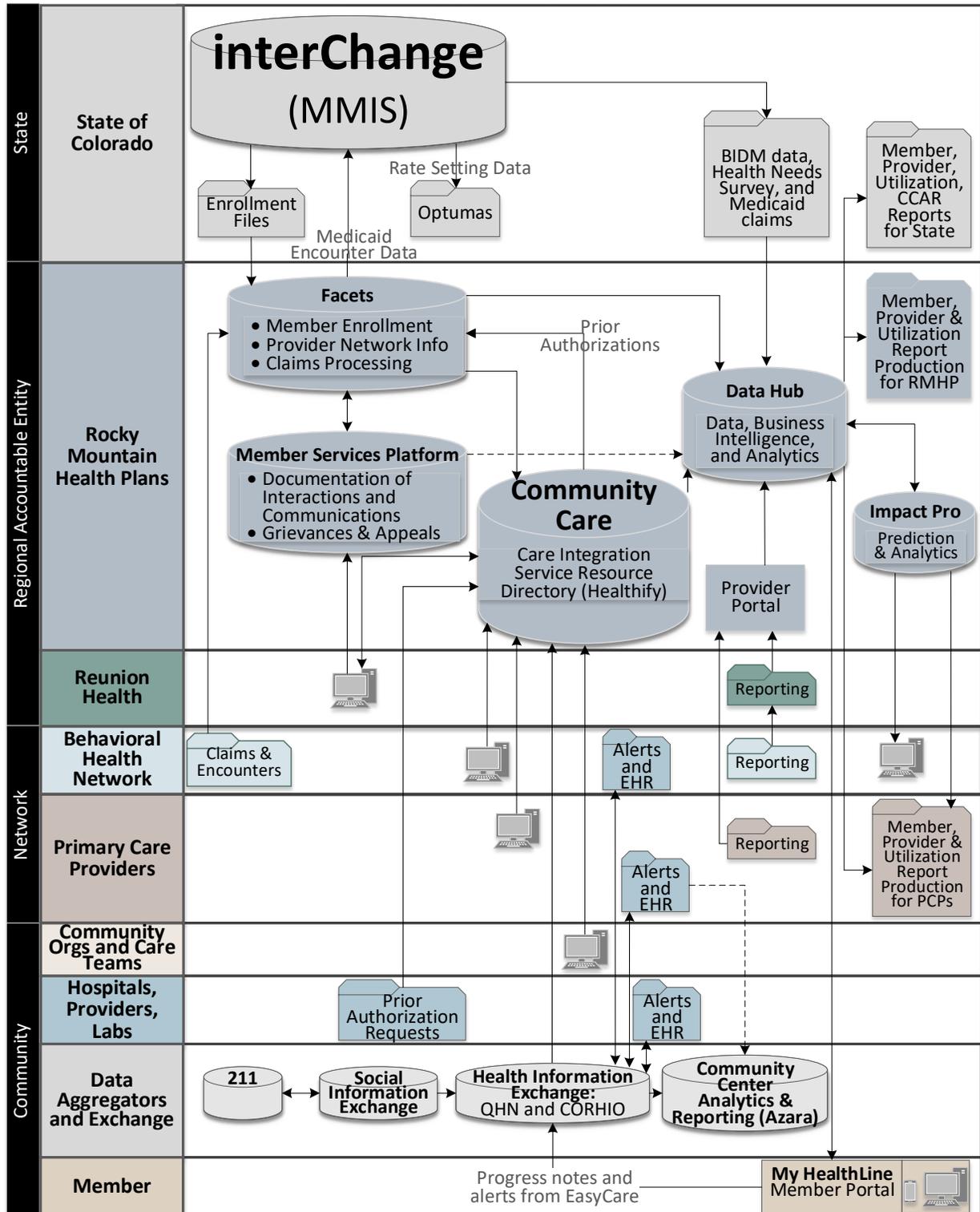
Describe how the Offeror will implement and maintain an ongoing Quality Improvement Program, in accordance with the requirements of Section 5.14, and how the Offeror will address quality throughout the administration of the program.

EXPERIENCE

RMHP, a longstanding health maintenance organization with full Medicaid accreditation from the National Committee on Quality Assurance (NCQA), will partner with Reunion Health and other providers in the Health Neighborhood to provide the experience, infrastructure and skill set necessary to meet the requirements of section 5.14 (Quality Improvement Program) of this Request for Proposal (RFP). RMHP and Reunion Health will create one integrated behavioral health and physical health operating platform, with comprehensive quality assessment, performance measurement and continuous quality improvement (CQI) with integrated data and feedback solutions that comply with 42 C.F.R. § 438.310-370.

We are committed to quality assessment and performance improvement in every aspect of our enterprise. NCQA accreditation of RMHP's Medicaid program, which is effective until renewal in 2020, is an indication of the rigor of the quality processes we will implement as a RAE in Phase 2 of the Accountable Care Collaborative. RMHP has the most extensive experience among the Partners with state and federal Medicaid Managed Care quality improvement activities and reporting, so all quality assessment, monitoring and reporting activities will be performed by RMHP. RMHP's quality assessment processes will also ensure an appropriate separation of duties in performance of RAE measurement functions. However, all quality improvement activities will be reported within the transparent community governance model, and will enable the Partners and community stakeholders to collaboratively identify best practices and rapid-cycle interventions to improve performance. The RAE structure developed by the Department promotes shared accountability for performance, which we are confident will have a positive impact on the health outcomes of our Members.

QUALITY IMPROVEMENT PROGRAM

RMHP has substantial experience designing and implementing quality improvement (QI) programs and we will execute each of the activities listed in Section 5.14.2.1 of the RFP. We will submit a QI Plan to the Department 30 days after the effective date of the contract. On an annual basis, we will submit a QI Plan Update as part of our Annual Quality Report to the Department, detailing the progress and effectiveness of each component of our QI Program. Our reports will include all required information. In the remainder of this response, we provide detailed descriptions of each component of the QI program listed below:

Component of the QI Program	Current Activity	Current Performance
Performance Improvement Projects (PIP)	Transitions of Care For Criminal Justice Involved (CJI) Individuals Released to Parole in La Plata and Mesa Counties, respectively. We followed the CMS-structured 10-step process and the Department's External Quality Review Organization (EQRO) validated and scored the PIP; we are now in re-measurement year 2.	Goal is to support the individuals to establish care with a PMCP visit within 90 days of RMHP RCCO enrollment. Our target, based on a literature review was that 35% would meet the goal. • RCCO results--**48%** met the goal • RMHP Prime results-- **53%** met the goal
Collection and submission of performance measurement data, including Member satisfaction data	For RMHP Prime and CHP+, RMHP submits HEDIS and CAHPS data annually. All submissions are timely, complete and validated by the EQRO.	2016 HEDIS results show improvements in Comprehensive Diabetes Care, follow-up care for children prescribed ADHD medicine and management of Chronic Pulmonary Obstructive Disease (COPD). RMHP has opportunities to improve in Adult BMI assessment, Breast Cancer Screening and Use of imaging studies for Low Back Pain.
Mechanisms to detect overutilization and underutilization	RMHP uses a number of data sources to detect overutilization and underutilization, as detailed in Response 16. For example, RMHP's Monthly Readmission Review Committee reviews all readmissions to determine if the readmission was avoidable, and how best to prevent readmission in the future. RMHP monitors underutilization related to preventive care and has numerous interventions to support Members to get the care they need, including outbound calls to families of children with special health care needs.	RMHP's readmission review committee routinely reviews case notes to improve performance. Many readmissions are due to transfer to a higher level of care, like a newborn who needs care at Children's Hospital in Denver. Others are often readmitted for unrelated conditions or stepped procedures. When avoidable readmissions occur, RMHP assigns a member of the care coordination team to work with the Member.

Component of the QI Program	Current Activity	Current Performance
Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs	RMHP strives to increase screening rates for postpartum depression in multiple community sites since we know there is a link between postpartum depression and delayed childhood development. Additionally, RMHP has developed and piloted an algorithm for proactively identifying people with special health care needs (PSHCN) using claims, diagnosis, procedure and pharmacy data.	Postpartum depression screening and proactive identification and outreach to potential people with special healthcare needs are new programs and we do not yet have more than anecdotal data. The anecdotal data reveal that families of children with special health care needs identified by the rubric did need care coordination help to navigate services and providers.
Quality of care reviews	RMHP's Medical Practice Review Committee reviews all potential Quality of Care concerns and any noted trends.	In 2016, there were two potential quality of care concerns that were thoroughly investigated and peer-reviewed. Both cases were resolved satisfactorily.
External quality review (EQR)	RMHP participates in and collaborates with all external quality review activities, including validation of performance measurement submissions, PIP validation and annual site audits.	The 2015-2016 External Quality Review Technical Report for Health First Colorado reported an overall compliance score for RMHP Prime of 99%, i.e., 99% of all elements reviewed during the site audit were met. The report, which is a review of all mandated EQR activities, revealed that RMHP met all validation requirements for performance measure reporting. (RCCO is not formally scored in this review).

Component of the QI Program	Current Activity	Current Performance
Advisory committees and Learning collaboratives	RMHP hosts a number of Advisory Committees and Learning collaboratives, most notably the Western Slope Member Advisory Committee, the Deaf Learning Group in Larimer County and the RMHP Prime Executive Committee. Learning collaboratives are presented on a quarterly basis by the Practice Transformation team for their Practice Transformations programs, including the State Innovation Model (SIM) and the CMS Comprehensive Primary Care Plus Initiative (CPC+).	RMHP documents recommendations from its Advisory Committees, reporting back to the Committee with progress on action taken. Learning collaboratives are well attended by PCMPs and their office staff. They consistently rate well among attendees.
Ad hoc reporting	RMHP complies with all ad hoc reporting requests and in a timely and collaborative manner. Additionally, RMHP convenes and has invited the Department and other statewide stakeholders to advisory groups. RMHP routinely informs the Department's proposed initiatives with experience and data.	RMHP has provided or contributed to numerous reports for the Department, including Legislative Requests for Information (LRFI), quality data collection, and performance improvement efforts.

To best achieve improvement in each component of the Quality Improvement Program, the Partners have developed a committee structure that is designed to bring the subject matter experts together to evaluate, monitor, and assure coordination of RAE-wide efforts designed to improve the value of health care delivered to Members. Clinical excellence, Member experience, behavioral health services and total cost are all prioritized focus areas.

Region 1 RAE Quality Improvement Program Committee Structure

Name of Committee	Function	Key Committee Members
RAE Quality Improvement Committee (RAE QIC)	Provides oversight over all aspects of RAE performance, including Key Performance Indicators for physical and behavioral health, other reportable indicators, member satisfaction, process improvement. The Committee also identifies best practices.	Each of the Partner FQHCs and CMHCs will have at least one Quality representative, as well as representatives from each of the following Departments/Committees: • PIAC member(s) • Population Health • Care Management • Health IT and Data • Utilization Management
Region 1 Performance Improvement Advisory Committee (PIAC)	The regional PIAC's purpose is to engage key stakeholders to provide guidance on how the RAE can best improve health, access, cost, and Member and Provider satisfaction. PIAC members will review and make recommendations based on data. The Partners will be fully transparent with this committee to encourage relevant feedback.	• Members • Members' families and/or caregivers • Network PCMPs • Network Behavioral health providers • Health Neighborhood Community Partners, including specialists, hospitals, LTSS, oral health, nursing facilities • Advocates and Community organizations • Local public health agencies and child welfare interests
Quality Improvement Committee (QIC)	Provides oversight over all aspects of the RMHP Quality Program as it relates to External Quality Review Activities, including: • Medical Record review • Performance Improvement Projects • Surveys • Network Adequacy • Calculation and audit of quality and utilization indicators • Collection and submission of performance measurement data, including Member experience of care • Mechanisms to detect both	Reports to RMHP's CMO and the COO. The following Departments and Key Personnel attend the quarterly QIC meetings: • Representative(s) from the RAE QIC • Program Director • Chief Clinical Officer • Chief Population Health Officer • Quality Improvement Director • Pharmacy Director • Care Management Director • Customer Service Director (inclusive of the OneCall Support Center) • Clinical Program Development and Evaluation • Chief Network Officer

Name of Committee	Function	Key Committee Members
	underutilization and overutilization of services • Administrative data analysis • Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department • Care coordination record review • Quality of care concerns • Encounter data validation • Provider and RAE site visits and audits The QIC evaluates performance and establishes quality improvement priorities.	• Benefits Administration • Member Enrollment and Billing • Health IT and Data Director • Utilization Management Director
Member Experience Advisory Council (MEAC)	The Member Experience Advisory Council reports to the QIC on a quarterly basis. The MEAC's primary focus is on the Member experience with a cross-functional, integrated approach to operational/service quality that reflects the RMHP and RAE goal for consumer driven excellence.	Members of the MEAC include representatives from: • RAE PIAC • Partner FQHCs and CMHCs • RAE Program Director • Customer Service (inclusive of the OneCall Support Center) • Care Management • Population Health
Access and Availability Committee	The Access and Availability Committee reviews the RMHP network for sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs of Members, and to confirm that RMHP has mechanisms in place for Members to access primary care, behavioral health care and specialty care.	Members of the Access and Availability Committee include representatives from: • Provider Network Management • Network PCMPs and Specialists • Care Management • Performance Improvement Advisory Committee • Quality Improvement • Customer Service (inclusive of the OneCall Support Center)

Performance Improvement Projects

The Partners have extensive experience in initiating, maintaining and completing performance improvement projects (PIPs) in collaboration with each other, the Department and the Department's External Quality Review Organization (EQRO). We will meet the requirements in section 5.14.3 of this RFP. When presented with the Department's priorities during the Annual

Quality Meeting in 2015, RMHP identified two Department priorities that resonated well with the needs of RMHP Medicaid Members: improving care for Criminal Justice Involved (CJI) individuals and improving transitions of care. Our literature review (completed as one of the steps of the PIP) found a study that applied one of two interventions to individuals recently released from a corrections facility to encourage initiating care with a primary care provider. The intervention was to either enroll the individual in a Primary Care Transitions clinic or use a community health worker for outreach. The study showed that both interventions were able to engage these individuals at a rate of between 37.7 percent and 47.1 percent, respectively[127]. This study influenced our goals for this PIP since RMHP uses a transdisciplinary community-based care coordination team model with CHWs, which is analogous to the community health worker approach in the study. Ultimately, we agree with the Department that connecting CJI individuals with medical and behavioral health care soon after they are released may positively impact incarceration recidivism.

Following the prescribed process for PIPs, we defined the study question, "Do targeted interventions to improve transitions of care for individuals released from prison into parole increase the percentage of paroled members that have a visit with a primary care provider within 90 days of Medicaid Prime and RCCO enrollment?" We also defined the study population, the numerators and denominators for calculating the measure, any exclusions to the defined population, and the interventions. Our results are depicted in the following table:

RMHP Prime and RCCO Corrections PIP Results to Date
RMHP Prime results (released to parole in Mesa County)

Timeframe	Indicator Measurement	Numerator	Denominator	Rate
FY 2014-2015	Baseline	15	74	20.3%
FY 2015-2016	Re-measurement 1	39	73	53.4%

RMHP RCCO Results (released to parole in La Plata County)

Timeframe	Indicator Measurement	Numerator	Denominator	Rate
FY 2014-2015	Baseline	2	8	25%
FY 2015-2016	Re-measurement 1	15	31	48%

Our intervention results in a substantial improvement in connecting CJI individuals with a PCMP after their release to parole. The data reported above include CJI individuals who were released and supported with RMHP care coordination services, sometimes prior to their enrollment into either RMHP Prime or RCCO. This would technically exclude them in the numerator, but our care coordinators took action to address the more immediate needs of the individual. As a result of this process, RMHP CCTs have earned the trust of the local Department of Corrections parole offices and community corrections agencies, thereby increasing collaboration across systems. RMHP care coordinators have developed a reputation as a trusted resource for individuals with known medical, behavioral health or social determinants of health (SDoH) concerns. To support this work, RMHP developed a **health literacy presentation for CJI individuals** to help them navigate the health care system. RMHP care coordinators present the

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[127] American Journal of Public Health, Am J Public Health. 2012 September; authored by Wang et al. and retrieved via this link: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482056/,

health literacy training at monthly parole orientations in Mesa and La Plata Counties. They also provide a **wallet card** with care coordination resource information to recently released CJI individuals so that they have the information they need to reach out for help.

"Jim" in La Plata County
Jim's mother called the parole office in La Plata County when she found out her son was being released. Jim has a history of a psychiatric disorder that prompts his violence, his mom explained to the parole office; she wanted to make sure that there was a plan in place before Jim's release to make sure he had the best chance of succeeding. The parole office called Eve, a member of the RMHP Four Corners CCT, and a trusted resource for complex cases such as this. Before Jim's release, Eve convened and facilitated a multidisciplinary care team meeting with the District Attorney, Public Defender, Parole Officer, Department of Corrections Mental Health Advocate, and Behavioral Health Inc. (for housing support), to make sure he had housing and psychiatric care in place when he was released. Most importantly, Jim and his mother/legal guardian were part of the meeting (Jim was allowed to call in and contribute via speakerphone from the County jail). Once there was a plan in place, Jim was released to subsidized housing and received mental health and medical care within a week of his release.

RMHP is interested in extending beyond the CMS-prescribed methodology of the PIP to maximize our potential to create and test well-informed interventions in a structured manner. The current PIP methodology is a basic scientific approach to assessing and determining whether specific interventions are successful. We believe that the process can be scaled to accommodate multivariate interventions and outcomes-related studies. We look forward to the opportunity to utilize resources for evaluation, including the data and analyses provided by the Business Intelligence Data Management (BIDM) System, to assess the efficacy of care coordination and population health management interventions and processes, using a Continuous Quality Improvement (CQI) approach. In ACC Phase 2, RMHP anticipates contributing to more rigorous approaches to evaluating interventions, and a stronger framework for coordinated rapid cycle learning and evidence gathering. To that end, RMHP has been part of a number of peer reviewed and other published studies, including the following:

American Psychologist, January 2017: *Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care*[128]

Journal of the American Board of Family Medicine, October 2013: *The Journey of Practices to Meaningful Use: A Colorado Beacon Study*[129]

The Commonwealth Fund, April 2013: *The Colorado Beacon Consortium: Strengthening the Capacity for Health Care Delivery Transformation in Rural Communities*[130]

Annals of Family Medicine, January/February 2007: *Use of Chronic Care Model Elements Is Associated With Higher-Quality Care for Diabete*s[131]

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[128] Link: https://www.apa.org/pubs/journals/releases/amp-a0040448.pdf
[129] http://www.jabfm.org/content/26/5/603.abstract
[130] Link: http://www.commonwealthfund.org/publications/case-studies/2013/apr/colorado-beacon-consortium
[131] Link: https://www.ncbi.nlm.nih.gov/pubmed/17261860

Performance Measurement

The Partners support the Department's efforts toward transparency by publically reporting RAE performance measures to consumers and stakeholders. We look forward to participating in the measurement and reporting of the measures required by the Department, with the expectation that our performance will be placed and evaluated in the public domain. RMHP voluntarily reported its outcomes related to RMHP Prime's performance in its first year[132], and will soon release results for the second year. In addition, RMHP posts on its own website its performance on the Department's Key Performance Indicators (KPIs) and RCCO Annual Site Review Reports so that our stakeholders can review and evaluate our performance for themselves.[133]

Additionally, we will collaborate with the Department to develop measure criteria, reporting frequency and other components of the Department's performance measurement program. We will report data as requested by the Department and by CMS. RMHP's Quality Improvement, Community Integration and Practice Transformation teams have been statewide leaders in supporting development of measurement criteria for SIM, the ACC Payment Reform Initiative (HB 12-1281) and CPC+. In addition, RMHP's Quality Improvement Department sits on the HCPF Medical Quality Improvement Committee (MQuIC). The Partner FQHCs are working with the Colorado Community Health Network and the State of Colorado to develop value based payment models and the performance measure criteria to support new payment models. Finally, our CMHCs report on a wide range of performance measures and have been an important source of input on performance measures developed by the state. The Partners look forward to supporting the state's initiatives related to performance measurement and the subsequent value-based payment models these initiatives will support.

Further, we will assist our network providers collect and report data for performance measures. We fully support network providers in using the BIDM to track their performance. Additionally, through RMHP's Practice Transformation programs, PCMPs participating in SIM have access to *Clinical Informaticists*, who help PCMPs track and extract data from their electronic health records (EHRs). The Practice Transformation team also has Clinical Informaticists who work collaboratively to support practices with health information technology needs including compiling and analyzing data. As the Region 1 RCCO, RMHP has used data from the Statewide Data Analytics Contractor (SDAC) to create interactive analyses for providers and Community Care Teams (CCTs) to enable them to better manage their population and target Members for care coordination based on utilization patterns and the acuity of their condition. This empowers providers and their patients to use data to drive improved outcomes. We understand that the goal for BIDM is to include behavioral health encounter data, which, combined with medical claims data and social risk factor data will provide a more complete picture of our Members and their risk for disease.

The Partners will participate in all six components of the proposed pay for performance model, including:

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[132] Prime practice performance outcomes can be found here: https://www.rmhpcommunity.org/content/prime-year-1-practice-outcomes

[133] Publically reported data on the RMHP website is found here: https://www.rmhpcommunity.org/topic/data-measurement

1. Improving the nine key performance indicators
2. Participating in the initiatives associated with the Department's flexible funding pool
3. Publically reporting the following: data for clinical and utilization measures, r HEDIS data and measures that align with SIM, CPC+, and other state and federal initiatives, public health and system level measures, and Member experience data
4. Use of behavioral health base standards, which contribute to the behavioral health capitation rate
5. Use of the behavioral health enhanced standards, which may also contribute to the behavioral health capitation rate
6. Participating in the behavioral health incentive program by meeting the Department's requirements for participation and reporting on measures determined by the Department

In its 40 plus year history, RMHP has focused on key performance indicators not only as a mechanism to indicate effectiveness, but to drive value-based payment methodologies. **RMHP is consistently ranked first or second** among all of the RCCO regions for risk-normalized, comparative performance on **postpartum care rates, ER utilization, 30-day readmissions** and **total cost of care**. This high performance is due to a constant effort to design and build a functional system for delivering care that supports the Member in getting the right care at the right time and in the right place. The RAE structure offers even greater opportunity to continue these efforts especially as they relate to the KPIs for both physical and behavioral health care.

In addition, the RMHP Prime medical loss ratio (MLR) calculation allows RMHP and its provider partners, including the participating Reunion Health partners[134] to earn additional reimbursement based on performance on the following HEDIS measures:

- Adult Body Mass Index Assessment
- Hemoglobin A1c Poor Control
- Antidepressant Medication Management, Effective Acute Phase Treatment & Continuation Phase Treatment
- Deployment of the Patient Activation Measure (PAM) in PCMP practices

RMHP, its Prime providers and community agencies met total cost and quality targets established by the State of Colorado for the first year of RMHP Prime implementation. As a result:

- More than $5 million in performance-based payments were distributed by RMHP to participating PCMP and CMHC providers, who were also accountable for aligned quality performance targets in the same domains.
- Sixty percent of these payments distributed to PCMPs.
- Thirty percent of these payments distributed to community mental health centers.

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[134] Reunion Health partners who are currently participating in Prime include: Mind Springs Health, the Center for Mental Health, Mountain Family Community Health Center, Marillac Community Health Center and River Valley Family Health Center

- Ten percent of the payment was retained by RMHP.
- A total of 48 percent of the physician groups participating in the program achieved quality targets necessary to qualify for payments in the first measurement year, which were distributed on the basis of attributed patient volume and risk scores.

Capitated Behavioral Health Base Standards; Behavioral Health Enhanced Standards; Behavioral Health Incentive Program

Our CMHC Partners in Reunion Health have a comprehensive performance improvement program that will successfully meet the Department's proposed Behavioral Health Base Standards and the Behavioral Health Enhanced Standards. We look forward to the opportunity to participate in the Behavioral Health Incentive Program, pending available funds and meeting the outlined compliance standards for participation.

Region 1 CMHCs have participated in regional monthly Quality Committee meetings for many years. They work closely together to review performance data and identify best practices to improve rates across the region. Each CMHC has its own quality program and uses well-tested and proven methods to improve performance including, Lean Rapid Improvement Events (RIEs), Plan-Do-Study-Act (PDSA) tests of change and Performance Improvement Projects (PIPs). An example of this is Mind Springs Health's Intervention Plan for improving performance on the FY 2018 performance measures, shown below:

Indicator 1: Mental Health Engagement Non-Foster Care
(**Interim Goal:** 42.34% of individuals who complete an intake continue to engage in treatment)

Intervention: Mind Springs Health (MSH) will create a Depression Treatment Model (DTM) of care that prioritizes services during the acute treatment phase. Approximately 25 percent of MSH clients are diagnosed with a depressive disorder. A Lean RIE was completed on 4/28/2017 in Grand Junction wherein the team developed a DTM that front loads therapy and psychiatry during the acute treatment phase. A multi-disciplinary team plans treatment during an initial meeting with the client. PHQ-9 assessments are completed at every meeting with a DTM member, with the Team staffing further treatment needs at 4-week intervals during the acute treatment phase.

Action Plan:
- Pilot DTM implemented with one team in Grand Junction by 7/1/2017. Completed.
- All teams in Grand Junction trained in DTM model by 8/30/2017.
- DTM fully implemented with one team in Grand Junction on 10/7/2017.
- All MSH Outpatient teams trained in DTM model by 11/30/2017.
- DTM fully implemented with all MSH outpatient teams by 12/30/2017.

Indicator 2: Engagement of SUD Treatment
(**Interim Goal:** 28.2% of individuals who start SUD treatment continue to engage in treatment)

Intervention: MSH will add case management time in Mesa and Summit County Detox Facilities to engage high utilizers and other clients diagnosed with severe SUD into services. Case Managers and Peers will identify recidivating clients through reporting, outreaching and engaging these clients with peer and case management support. Peers and CMs will initiate and

refer to psychoeducational and therapeutic SUD groups that incentivize attendance through access to resources and peer support. Additionally the internal reports will identify and report new SUD clients to outpatient treatment teams who will work to actively contact each outpatient client.

Action Plan:
- Case management time added to Summit and Mesa County Detox Facilities in first quarter of 2017--Complete
- Detox high-utilizer reports developed by MSH Informatics Department 6/15/2017--Complete
- Mesa and Summit Detox teams as well as OP clinics trained in use of reports and plan for outreach by 7/7/2017--Complete
- Structured outreach and engagement by detox and OP teams begins 7/7/2017

Indicator 3: Follow-up appointment within 30 days after a hospital discharge for a mental health condition
(**Interim Goal:** 63.6% of discharged individuals have a follow up appointment within 30 days)

Intervention: Each clinic will block at least two hours of psychiatric and/or therapist (mental health practitioner) time for open access clinics (OAC). These will be available daily, twice weekly, or weekly, depending on the size of the clinic. Each patient discharging from West Springs Hospital into MSH outpatient services will be scheduled to meet with a designated Peer or Case Manager at the receiving outpatient clinic within 30 days of discharge. At the first outpatient appointment, the Peer or Case Manager will engage the client using Motivational Interviewing skills, assess immediate service and resource needs, complete needed intake/referral paperwork, and accompany the client to the clinic's open access time to complete either a medication bridge prescription appointment, therapy appointment, diagnostic evaluation, or a behavioral health screening.

Action Plan:
- All West Springs Hospital patients scheduled with a Peer or Case Manager at the receiving MSH outpatient clinic within 30 days by 5/31/2017--Complete
- Grand Junction outpatient teams trained in OAC model by 6/30/2017--In process
- OAC times are in staff schedules for Grand Junction outpatient teams by 8/1/2017
- All MSH outpatient teams trained in OAC model by 9/30/2017
- OAC times are in staff schedules for all MSH outpatient teams by 10/1/2017

Indicator 4: Emergency Department Utilization for mental health condition
(**Interim Goal:** 15.59/1000)

Intervention:
- MSH's Mesa Crisis Team will hire additional crisis evaluators; allowing Mind Springs to conduct all crisis evaluations for Medicaid covered individuals at the St Mary's Hospital ED. This is the highest volume ED on the Western Slope, and therefore will help make the greatest gain on this measure. The evaluation is focused on how to keep someone safe as opposed to being focused on hospital admission or diversion. St Mary's can call a

Mind Springs mobile evaluator who will respond within one hour to the ED to do the evaluation for any Medicaid Member who presents to St Mary's.

- Create bed-based respite in addition to the existing home-based respite. Mind Springs plans to build a Peer run Respite House in the future and hopes to build capacity in the first quarter of the FY. Adding respite options will allow the crisis teams to divert individuals from the ED.

Action Plan:

- Advertised for additional crisis staff in May 2017--Complete.
- MSH crisis mobile evaluators begins providing services St. Mary's Hospital ED by 7/1/2017
- Plan for bed-based Peer respite finalized with St. Mary's by 8/1/2017
- Bed-based Peer respite implemented by 9/15/2017

This comprehensive, proactive plan demonstrates that the Partner CMHCs have a thorough process for identifying key indicators, measureable goals, specific interventions and expected outcomes, which will support successful participation in the Behavioral Health Base and Enhanced Standards and Behavioral Health Incentive program. Additionally, the CMHCs will have support from RMHP's data analytics infrastructure, as well as RMHP's quality improvement department to support the performance improvement process.

Member Experience of Care

The Partners use a number of mechanisms to monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Partners and network providers. These mechanisms include Member surveys, anecdotal information, call center data, and grievance and appeal data.

RMHP has established processes to qualitatively and quantitatively evaluate Member experience, including:

- Inbound calls to our Customer Service department
- Outbound calls from our Customer Service department
- Direct communication/interaction with our community care teams or internal care management team
- Public forums
- Member Advisory Councils
- Community meetings
- Email via the RMHP Community website
- Filing a formal complaint or grievance
- CAHPS surveys
- HealthStream consumer surveys of inpatient and outpatient behavioral health care
- Primary care patient advisory councils in select practices

Client Satisfaction Surveys

RMHP will work with the Department and its designated vendor to customize the CG-CAHPS survey, develop a sampling methodology, support and assist the PCMPs in the region chosen to be part of each year's CG-CAHPS survey and assist the PCMPs with sample frame creation and updating of Member contact information. We will also develop strategies with the Department to increase Member participation in the CG-CAHPS survey.

Most importantly, the Partners will support the Department in interpreting CG-CAHPS results and creating interventions at the Member, provider, RAE and Statewide levels to improve Member experience with their providers and the Health First Colorado program. Many of the Partner FQHCs and CMHCs collect patient satisfaction data using validated surveys, patient and family participation on the Board of Directors, patient advisory committees and feedback from patient comment cards. RMHP conducts yearly CAHPS surveys for Adults and Children, holds Member Advisory Committees and has Members on its Western Colorado Executive Committee, in addition to regional PIACs and other community committees. While collecting information from Members is a great start, there should be a systematic way to analyze and interpret the information received, and a commitment to act on that information in order to improve the member experience in navigating the system to better engage Members in their care. The Partners are committed to this goal.

RMHP has a Member Experience Advisory Committee (MEAC), which is a director-level committee designed to use a cross-functional, integrated approach to operational/service quality that reflects RMHP's goal for Member-driven excellence and to systematically improve RMHP's focus and accountability for quality of service. The Committee reviews several data sources including trending data derived from customer service calls, and complaints and grievances as well as CAHPS, and then acts on that data to improve care. In the Quality Improvement Plan Annual Report (2015), some of the Member related actionable opportunities for improvement identified were:

- CAHPS Member Satisfaction Survey - The Committee discussed an overall plan to improve member satisfaction based on recent CAHPS results. Top priorities for improvement included:
  - Simplify/limit Member involvement in the process of submitting claims
  - Improve the quality of physicians in network (personal doctors)
  - Make information on cost of specific medicines easily available
  - Improve Member access to care (ease of getting needed care, tests, or treatment)
- Voice of the Consumer results - Members indicate the health plan is doing well, including being easy to contact and that the plan has earned the Members' trust. Members indicated the plan takes care of their needs. Items that need to continue to be improved include reducing confusion during plan sign up, what it means to become a "Member," and understanding coverage. Items that need improvement include disenrollment/termination process, patient navigation between RHMP and providers, and drug coverage clarity.

*In 2015, the MEAC Committee launched the **Voice of the Consumer** initiative when RMHP determined that more consumer input was needed to understand the barriers to care our Members experience. RMHP's Senior Customer Experience Analyst interviewed many RCCO Members in their homes and other comfortable settings and used pictures and dialogue to show Members' experience when navigating the system for a better understanding of what works for members and what does not work.*

"I went in for an annual checkup and the doctor said, 'you haven't had one since 2013, you're going to have a mammogram.' Before I get home it was this message telling me the date and time on my voicemail. And I'm like okay, I'll go. Had that not happened I would never had treatment. And so once it was diagnosed they did their magic, I get a call back from the doctor's here saying okay, we've submitted everything, it's going to be covered under Medicaid, and then I get my nurse navigator who takes care of everything else."

– RCCO Member Frisco, CO

The Partners will support the Department in administering the Experience of Care & Health Outcomes (ECHO) Survey for Behavioral Health to Members accessing behavioral health services. In addition, RMHP will work with CMHCs and other contracted behavioral health providers to support this important work. Currently, one of the key CMHC Partners in Region 1, Mind Springs Health, administers a version of the ECHO survey via a third party vendor, HealthStream, to assess client satisfaction with their inpatient mental health hospital services as well as their outpatient services. Mind Springs Health hired a staff member who is trained in Lean/Six Sigma to review the survey data and develop interventions to address trends found in the data.

The Partners will integrate their Quality Committee structure to include representation from the FQHCs, CMHCs, RMHP and Members to review the results and data from CG-CAHPS, ECHO, and all other surveys conducted, as well as other data sources, including grievance and appeal trends, information from customer service calls and other formal and informal mechanisms for feedback, to inform the QI Plan. The integrated MEAC will identify, develop, and implement interventions with network providers, as well as with the Partners, to address trends identified for improvement, monitor interventions and report them at least annually at the Department's Operational Learning Collaborative. We will also incorporate interventions for improvement and results into the RAE QI Plan. If the Partners determine that there is a consistent pattern of complaints or negative feedback from Members regarding a network provider, the Partners will work with that provider to develop a strategy for correcting the pattern.

Mechanisms to Detect both Over and Underutilization of Services

The Partners, with RMHP as an experienced payer, have thorough capabilities for monitoring overutilization and underutilization of services, and for assessing the quality and appropriateness of care furnished to its Members. The Partners' QI Plan establishes a framework to assess, monitor and improve our efforts to validate that Members are getting the right care at the right time in the right place.

We have a number of methods to quantify over and underutilization of services. To detect overutilization of services, we use claims data to identify utilization patterns that indicate possible inappropriate overutilization; for example, use of the emergency department (ED) more than four times in a 12-month period. We are able to monitor inpatient admissions and ED use and, in addition to supporting transitions of care for these visits, care coordinators will provide additional care coordination and support to help mitigate future avoidable ED visits and admissions. As another example, RMHP has a comprehensive Medication Safety Program and uses the population management function in its technology platform to identify Members who are potentially overusing opiates. We also have a polypharmacy program for Members who have more than eight drugs prescribed concurrently for 90 days, or more than $10,000 in drug costs in less than 90 days. In these cases, RMHP's pharmacists will perform full medication reconciliation and work closely with PCMPs and other care team members to engage the Member and prescribing provider(s) to adjust medications as appropriate.

The monitoring of underutilization of services focuses on underuse of preventive care and behavioral health. This includes well visits for adults and children, immunizations for children and other preventive care for adults, such as age-appropriate cancer screenings, SUD screenings and depression screenings. One example of our approach is a campaign RMHP designed in our shared care coordination tool to identify and reach out to families with children who have gaps in EPSDT screenings. Care coordinators did the outreach, and several of the families who were reached asked for help getting pediatric specialty care. RMHP sends gaps in care reports to PCMPs so that they can outreach to their patients needing preventive care, which is an effective way for PCMPs to engage their patients and reinforce the medical home relationship. We will continue to work with providers, care coordinators, and Members to notify Members of the importance of preventive care and how to obtain needed care.

Underutilization of behavioral health services is prevalent, and can lead to a decline in physical health, lower productivity and in extreme cases, self-harm or harm to others. RMHP is working with behavioral health and physical health providers to increase the number of Members who are receiving regular depression screenings and who are referred to treatment when the results of the screening are positive. Advanced PCMP practices and Partner CMHCs in Region 1 currently conduct routine evidence-based depression screenings to identify a need for behavioral health support. A special effort is being made to screen for postpartum depression, and several Region 1 pediatric providers and community partners have started to screen for postpartum depression during well-baby visits or assessment for eligibility in other programs, e.g., WIC or adult parenting classes.

The Piñon Project

The Piñon Project in Cortez, Colorado, is a designated Family Resource Center that provides supportive services and programming to families, youth and community members. RMHP has an agreement with Piñon to extend their services to pregnant women and women with children under two. Piñon will help find prenatal care, assist in making appointments and also use the Edinburgh Postpartum Depression Scale (EPDS) to assess for postpartum depression for up to a year after delivery. If the screen is positive for depression, Piñon will make referrals for community mental health services as appropriate. Piñon representatives will have access to

RMHP's care management software to document EPDST results, referrals, and other activities in order to better coordinate care across the community of service providers. This program started in June, 2017 and we are eager to receive preliminary results.

We will continue to collaborate with the Department in administering the Client Overutilization Program (COUP) for Members who meet the criteria for inappropriate overutilization of health care services. The Partners' data analytics strategy will create better understanding of each Member from a medical, behavioral health and social needs perspective. When the Department identifies a Member who appears to be a candidate for COUP, we will use the data to attempt to determine the root cause(s) of the overutilization issue. With that knowledge in hand, we will reach out to the Member and offer care coordination services with the goal of reducing inappropriate utilization by linking the Member to suitable medical, behavioral health, social and community services, as driven by the Member's choices.

Care coordinators undertake thoughtful reviews to understand why services are being overutilized. In some circumstances, high levels of utilization are appropriate. If the overutilization pattern is inappropriate and persists, the Partners will evaluate the Member for the clinical appropriateness of restricting the Member to either one provider and/or one pharmacy until it is determined that the Member has the support needed to exit the COUP program. The Partners will support recruitment of providers and provide technical assistance to providers that choose to participate as lock-in providers.

RMHP has also adopted Impact Pro, an advanced analytics tool developed by UnitedHealthcare, to gain a more sophisticated, precise understanding of over and underutilization, and will disseminate that information to our Partners. Impact Pro synchronizes claims data with evidence-based medicine guidelines to identify opportunities for proactive engagement with Members. Additionally, Impact Pro identifies potentially underutilizing Members who are not obtaining appropriate preventive care and screening, and who are at risk for developing costly and debilitating health conditions. This provides data-driven opportunities for our CMHCs, FQHCs and PCMPs to intervene and coordinate services, and for these partners to reach out to the care coordination team and Community Care Team resources to support intervention if needed.

Mechanisms to Assess the Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs
RMHP has developed a rubric for proactively identifying people with special health care needs (PSHCN) using claims, diagnosis, procedure and pharmacy data. The Partners' population management and predictive modeling platform, Impact Pro, will further facilitate the ability to identify Members who potentially have special health care needs (SHCN) using algorithms that identify predictive utilization patterns, as well as health risk assessment and other data sources. Once identified, the list is compared to Members actively receiving care coordination and those affiliated with Community Centered Boards (CCBs). If it is determined that the Member may not be receiving supportive services, care coordinators will perform outreach calls to determine if the Member would like added support. RMHP has piloted this program with children with SHCN and discovered that the algorithm accurately identified these children. Subsequent outreach

calls made to the family revealed that many of these children needed support and the families were glad to have the help the RMHP care coordinators provide.

Quality of Care Concerns

RMHP's QI department has existing systems for investigating, analyzing, tracking, trending and resolving any alleged quality of care (QOC) concern. Our QOC structure supports the following activities:

- Send an acknowledgement letter to the originator of the QOC concern.
- Investigate the QOC issue(s).
- Follow-up with the Member to determine if the Member's immediate health or behavioral care needs are being met.
- Send a QOC resolution letter to the originator of the QOC concern which includes
  - Details of the case to foster an understanding of the QOC resolution
  - A description of how the Member's health care needs have been met
  - A contact name and telephone number to call for assistance or to express any unresolved concerns

RMHP acts upon reported QOC concerns, and it also will investigate concerns that were not explicitly reported as a QOC concern but come from other sources, like grievances. In the last reported year, RMHP investigated two QOC concerns using its Medical Practice Review Committee, the clinical staff in the Quality Improvement Department and the Peer Review Committee. We refer QOC issues to the Peer Review Committee (PRC), when appropriate, and refer or report the QOC issue to the appropriate regulatory agency and Child or Adult Protective Services for further research, review or action, if appropriate. We will notify the appropriate regulatory, licensing board or agency when the affiliation of a network provider is suspended or terminated due to QOC concerns and document the incident in a QOC file. We also review the National Quality Forum (NQF) list of Serious Reportable Events annually to determine if additional adverse event review categories need to be developed and monitored.

Additionally, upon request, we will submit a letter to the Department with all of the information required, and will omit the names of the persons conducting the investigation or participating in a peer review process.

External Quality Review

RMHP has willingly and cooperatively participated in external independent annual Site Reviews and performance measure validation in compliance with Department standards, Contract requirements and CMS mandatory activity protocols. We believe the external quality review process is a critical element of an ongoing quality improvement program and appreciate the fresh perspective the external quality reviewers bring to the process.

RMHP consistently performs well on all external quality review activities. RMHP earned a composite score of 99 percent for the 2016 RMHP Prime site audit, which is in alignment with previous years' site audits. In 2016, RMHP met or exceeded all performance goals for all reported HEDIS quality of care and use of services measures, including measures related to the treatment of behavioral health concerns. While the RCCO Site Reviews are not formally scored,

RMHP has received very positive feedback for each of the RCCO Site Reviews that has occurred, as well as high scores on care coordination documentation reviews.

Advisory Committees & Learning Collaborative

The Partners have extensive experience in participating in the Department's multidisciplinary advisory committees and learning collaborative with both statewide and regional PIACs. These PIACs work to engage stakeholders and provide guidance on how to improve health, access, cost and satisfaction of Members and providers in the program.

The Partners strive to have Member representatives on our decision-making and advisory committees and host several Members-only advisory committees. These are described in greater detail in Offeror's Response 9. We have summarized some of our stakeholder engagement activities to improve quality, Member experience and cost of care below:

- *Member Advisory Committees and Focus Groups*: Conducted throughout the region with different areas of focus as driven by stakeholder interest and request, including:
  - Focus group in Loveland to talk to Members about their experience of care and ER utilization
  - Larimer County Bridging Communications Advisory Committee – focused on improving access to and experience of care for individuals who are hard of hearing or Deaf
  - Western Slope Member Advisory Council for people living with disabilities
- *Voice of the Consumer, Latino Initiative*: Focused on experience of care with monolingual Spanish speaking Members
- *Regional Leadership Development:* Engaging formal and informal community leaders and influencers throughout the state to develop functional leadership groups that drive improvements in care and address SDoH
- *Western Colorado Executive Committee:* Comprised of providers, Member advocates and subject matter experts to drive health care reform and value based payment models
- *Community Care Team (CCT) Oversight Committees*: Community based committees that provide direction and leadership for care coordination activities in each community that has a community care team
- *Intellectual/Developmental Disabilities (I/DD) Steering Committee:* Comprised of leadership from the four CCBs and three CMHCs participating in the Cross-System Crisis Response Pilot Program (I/DD Pilot) to better coordinate care and services for individuals with an I/DD and a co-occurring behavioral health condition.
- *Practice Transformation Learning Collaborative*: Scheduled quarterly for practice teams participating in RMHP Prime, CPC+ and RMHP Practice Transformation programs. RMHP is contracted with CMS to provide learning collaborative on the Western Slope for any practice participating in CPC+.

In addition to continuing the stakeholder engagement activities we have described as the RAE, RMHP will implement its learning collaborative model in Region 1 for Members, too. These

have been extremely successful and well received by providers. Learning collaboratives can provide Members with the opportunity to participate in day-long face-to-face learning and sharing of best practices. Experienced experts deliver educational content and Members have the opportunity for peer-to-peer learning with other Members. RMHP is happy to host other region's Members in learning collaboratives as well. We believe this approach provides a valuable ongoing process to obtain and respond to feedback with the ultimate goal of improving Member experience and quality of care.

We will participate in and contribute to the Department's QIC and Operational Learning Collaborative, as well as ad hoc committees. We are supportive of the opportunity to monitor, report and share best practices for activities that potentially address and improve the components of the quadruple aim.

Learning collaboratives – A testimonial from Mid-Valley Family Practice in Basalt, CO

"RMHP has organized several CPC learning collaboratives, which have consistently been a value to our clinics. The main thing is RMHP listens to clinic feedback and incorporates suggestions for improvement. Thank you! The learning collaboratives build on each other and provide instrumental collaboration between clinics. This collaboration is the infrastructure that is needed as clinics involve themselves with innovative ideas. Learning from each other is vital for successful and sustainable innovation. In addition, RMHP put on learning collaboratives for care coordinators for specific training around care management."

Ad Hoc Quality Reports

RMHP is an experienced Medicaid managed care organization with extensive familiarity in providing to the Department and its agents any information or data relative to the Contract. We will fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested as required in section 5.14.10 of the RFP.

RMHP is committed to transparency at all levels of stakeholder engagement and quality reporting. RMHP has provided or contributed to numerous reports, including Legislative Requests for Information (LRFI), quality data collection and performance improvement efforts. Additionally, RMHP convenes and has invited the Department and other statewide stakeholders to advisory groups. RMHP routinely informs the Department's proposed initiatives with experience and data.

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.

INTRODUCTION

The values of the Partners reflect our concern for our communities and our commitment to legal and appropriate business practices. These values serve as the foundation for our business decisions and relationships, and the guiding tenets for our approach to Compliance. We will comply with all requirements set forth in Section 5.15 of the Department's Request for Proposal (RFP) and we will take prompt steps to correct any violation of Accountable Care Collaborative (ACC) program rules, contract requirements, state and federal regulations, and confidentiality regulations, including 42 C.F.R Part 2. In this section we describe our approach to conducting compliance and monitoring activities in accordance with all applicable law that are focused on providing high-quality medically necessary services in accordance with the contract requirements.

COMPLIANCE PROGRAM STANDARDS AND PROCEDURES

Our compliance program is outlined in our Compliance Plan. The Compliance Plan includes our code of conduct, policies and procedures governing confidentiality and integrity of records, conflicts of interests, and detecting/monitoring/reporting fraud, waste and abuse. Together these documents set the parameters for employee behavior by establishing acceptable and expected conduct compliant with ACC program rules and contract requirements. The compliance program also establishes disciplinary and punitive measures for non-compliant behavior and the failure to detect noncompliance. The goal of our compliance program is to provide guidance and oversight so that all work is done in an ethical and legal manner, in accordance with ACC program rules, the contract, applicable regulations and to make all employees are aware of their obligation to help detect and prevent fraud and abuse.

We are committed to educating providers about regulatory updates and maintaining channels of communication for both providers and Members to report potentially non-compliant activities (anonymously, if they prefer). We will investigate any such reports, from whatever source, thoroughly and completely.

We will review our Compliance Plan annually and update it as necessary, delivering it to the Department on or before July 31st each year.

Compliance Leadership and Organizational Structure

The Regional Accountable Entity (RAE) Executive Committee will conduct oversight of compliance. The RAE Executive Committee will establish a Compliance Committee, chaired by the Compliance Director, that will have responsibility for oversight of our regulatory and contractual compliance performance, including risk assessment, compliance policy development, education and dissemination of information, conducting investigations of alleged regulatory or policy violations and requesting monitoring initiatives and audits be conducted.

The Rocky Mountain Health Plans (RMHP) Compliance Director will direct the RAE compliance program, coordinating with the Compliance Officers from the Partner organizations. The RAE Compliance Director reports directly to the Executive Director and to the RAE Executive Committee.

Managing Contract Compliance

RMHP will use Compliance 360 software to manage compliance with the Department's contractual requirements. This innovative software stores Contract requirements and documents including Contract attachments, amendments, and all relevant policies and procedures. Compliance 360 is comprised of several modules including a Policies and Procedures Module. Our Compliance staff will be responsible for loading and managing the policies and procedures. All RMHP employees can access the approved policies and procedures, work processes, and any corresponding forms, templates and other attachments.

The Department's independent auditor, Health Services Advisory Group (HSAG), has confirmed RMHP's high rate of compliance with federal health care regulations and managed care contract requirements through its desk reviews and on-site audits. For the most recent audit, conducted in early 2017, RMHP achieved a summary score of 95 percent in meeting all the standards reviewed for the Prime program and 98 percent for CHP+. We will bring the same proven and successful approach to compliance to the RAE that allowed us to achieve these scores when we are selected for contract award.

Confidentiality and Integrity of Records

The Partners understand the importance of safeguarding the sensitive information the Department will entrust to us when we are selected for contract award. Every partner maintains rigorous administrative, technical and physical safeguards for the protection of Member health information as well as policies and procedures that govern its use and disclosure in accordance with all applicable laws. This includes policies regarding the release of substance abuse information only in compliance with policies set forth in 42 C.F.R. Part 2. In the event of a breach, RMHP will notify the Department within five business days of the suspected loss or compromise of sensitive information and will work with the Department regarding recovery and remediation.

Training and Education

Officers and board members of the Partner organizations undergo compliance, confidentiality and fraud, waste and abuse training upon election and annually thereafter. All of the Partners' employees receive compliance and confidentiality training as well as fraud, waste and abuse awareness training as part of their new employee orientation within 90 days of hire and annually thereafter. Our training also includes the procedures and mechanisms for reporting potential compliance violations. Information concerning fraud, waste and abuse, as well as whistle blower protection for reporting, is included in our employee handbook. In addition, procedures for reporting will be posted on the Partners' websites and included periodically in Member and provider newsletters.

Specific departmental training occurs on an on-going basis. This training focuses on how different departments should conduct their day-to-day processes to identify potential fraud or

abuse activities. This specialized training is focused on those departments that can become a valuable resource in fraud, waste, and abuse detection, prevention, and investigation.

As part of RMHP's annual Compliance Week, all employees are required to complete online courses for fraud, waste, and abuse; sexual harassment; cultural competency and diversity. Management is provided with a training document developed by Human Resources that reinforces requirements such as Compliance Plan management responsibilities, facility Access and security, and RMHP's drug policy. Throughout the year employees are provided with periodic trainings for HIPAA Privacy and Security. There are additional department specific training requirements. For example, the Home Health department has required courses such as Disaster Preparedness and Safety & Infection Control.

We will develop training specific to federal and state standards and requirements applicable to the RAE contract. RMHP's Compliance Director, Key Personnel and all employees (including employees from the Partner organizations) will undergo this training.

Training records will be available for review by the Department upon request.

Enforcement and Disciplinary Mechanisms

Our training also includes information about disciplinary standards and sanctions for violation of the Compliance Plan and related operational policies and procedures. We publicize our standards and disciplinary guidelines in our employee handbook and on our intranet.

Employees are made aware that failure to report violations due to negligence or reckless conduct may result in disciplinary action. Disciplinary actions range from oral warnings to immediate termination of employment, or other actions as appropriate. Business Associates will be held to the same standards as required within Business Associate Agreements as well as state and federal regulations.

The Partners enforce disciplinary standards in a timely, consistent and effective manner when non-compliance or unethical behavior is determined. We periodically review records of discipline to evaluate whether disciplinary actions are appropriate to the seriousness of the violation and are fairly and consistently administered and imposed within a reasonable timeframe. Our compliance program requires that the promotion of and adherence to all elements of the compliance program will be factors in evaluating the performance of all appropriate employees.

Communication About Compliance and Reporting Concerns

An open line of communication exists between employees and the Compliance Officer at each of the Partner organizations. In addition, a readily available and well-publicized hotline number has been established for confidential and anonymous reporting within each organization. Anonymous reports can be made by anyone through our website.

The RAE Compliance Director coordinates oversight of the RAE Compliance Plan and general compliance, and provides regular reports to the RAE Executive Committee. The RAE Executive Committee will provide direction concerning compliance to the Compliance Director and the Chief Program Officer. Each Partner will continue to meet their contractual and regulatory

requirements and quarterly and ad hoc meetings will be held for the Partner Compliance Officers within the Region to educate and provide consistent oversight and reporting.

Articles will appear periodically in Member and provider newsletters about compliance, including how to report suspected non-compliance or fraud, waste or abuse to the Compliance Director or through the confidential and anonymous mechanisms already described.

Duties of Directors and Department Heads

Each RMHP department appoints a designated Compliance Staffer for compliance activities. The designated Compliance Staffers will coordinate departmental compliance activities with the RAE Compliance Director and Legal and Regulatory Affairs Department. The designated Staffer is familiar with all applicable laws and regulations relating to the department, the operating procedures relevant to the Compliance Plan, and any applicable risk areas that exist in the department. Each department works with the Compliance Director and Legal and Regulatory Affairs Department to establish compliance policies. These policies typically include the following features:

- Written policies and procedures for risk area activities undertaken by departmental personnel
- Educational and training programs to address compliance issues of particular importance to the department
- A program for all new department personnel to receive training with regard to compliance and standards of conduct
- A program for routine "spot checks" of departmental processes and work to review compliance, with the results of such reviews being reported to the department's Compliance Staffer and to the Legal and Regulatory Affairs Department
- A system that tracks risk areas and compliance issues that have been raised within the department and the resolution of those issues

Any director, department head, or manager receiving a disclosure from an Individual relating to alleged misconduct or non-compliance immediately notifies the Legal and Regulatory Affairs Department who, together with the Compliance Director and the Compliance Committee, will conduct such investigations and take such remedial or other action as is appropriate under the circumstances. If the alleged conduct constitutes a violation of any law, rule or regulation, then the Chief Program Officer and the Compliance Committee of the RAE Executive Committee shall be notified at their next regularly scheduled meeting, unless, the circumstances warrant calling a special meeting.

INSPECTION AND AUDITS

The RAE will comply with all Department inspection and audit requests, including unannounced, on-site inspections by the Department and its federal partners or designees. Auditors will be granted access to our claims system and data. If requested, we will submit policies and procedures to the Department within five business days. In addition, we will:

- Make staff available to assist in any audit or inspection under the Contract.

- Provide adequate space on the premises to accommodate Department, state or federal personnel conducting all audits, site reviews or inspections.

- Allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

- Fully cooperate with any annual, external, independent review performed by an External Quality Review Organization (EQRO) or other entity designated by the Department.

- Preview the monitoring instrument to be used as part of the assessment for a routine site review.

- Submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's audit.

- Make available to the Department and its agents for site review all records and documents related to the Contract, either on a scheduled basis or immediately on an emergency or unannounced basis.

FRAUD, WASTE AND ABUSE

Health care fraud and abuse is expensive and growing more costly each year for the health care industry. While the vast majority of individuals working in and interacting with the health care system are honest, we understand the importance of operating a robust program to prevent, detect and investigate fraud, waste and abuse.

Potential fraud or abuse activities that relate to employees are reported to the Human Resources for each Partner. All non-employee potential fraud, waste or abuse activities are reported to the RMHP Internal Audit (IA) Manager or to Legal and Regulatory Affairs.

The IA Manager in the IA Department is responsible for implementing a comprehensive plan to detect, correct, and prevent fraud, waste and abuse. Our IA Department not only includes fraud detection steps in its audit programs, but also investigates allegations of fraud or abuse. Preliminary review and documentation of suspected fraud is handled within each individual department. If, after this preliminary review, a conclusion is reached that fraud, waste or abuse is possible, the department reports the instance to the IA Manager for investigation. The IA Manager is responsible for leading investigations where fraud or abuse is considered likely. Individuals within each operational department continue to be available as resources during the investigation process.

The IA Manager receives cases to investigate from not only internal sources but from external sources including providers and Members. Members, providers and others may contact the IA Manager with information regarding fraud, waste, abuse or systemic errors by calling the Customer Service Department or by directly contacting the IA Manager using any of the reporting mechanisms already discussed. Our staff is trained using specific procedures to gather all necessary information on the first contact since the caller may choose to remain anonymous.

We use CGI's Customized Audit System (CAS 5.0), which provides an industry-leading solution to the detection of fraud, waste or abuse in medical claims. Claims data is gathered and uploaded by the IA staff and sent to the vendor monthly. Provider data is updated on an on-going basis. When the vendor receives claims data, it is loaded into their server and numerous edits are run on the data. All suspect claims are tagged for review and the IA staff reviews the claim. The IA Manager or staff consults with trained medical professionals employed by RMHP when necessary. If errors are identified, in addition to recoupment of payments, outreach and education are provided. To test whether education and corrective actions result in improvement, providers may be re-audited. If the same errors are present, this may indicate fraudulent intent and appropriate processes for reporting or disciplinary action are initiated.

IA is responsible for ongoing auditing and monitoring that includes the following:

- Audits of compliance with procedures in various departments including, Customer Service, Care Management, Appeals and Grievances, Member Enrollment, Billing and Provider Network Management. These audits may include evaluating the timeliness of decisions made in Care Management or Grievances and Appeals; and inter-rater reliability for consistency of application of utilization management guidelines.

- Validation and testing of new and modified provider contracts.

- Sampling and testing of paid and encounter claims.

- Accurate and timely enrollment of Members.

- Internal referrals through compliance, clinical and quality department staff from chart audits, clinical outlier reports, and utilization reviews on providers.

- Identification of suspicious provider practices that Members may reveal to customer service staff when asking questions (e.g., why claims for services they did not receive, or for providers they did not see, are paid).

- Double billing, false claims or encounters, service verification, data validity, accuracy and effectiveness.

- Improper billing and other abhorrent practice patterns such as high volume sessions, high volume of payments, high quantity of patients, etc.

In addition, our system will include:

- Processes for monitoring Members for improper prescription for controlled substances, inappropriate emergency care or card sharing.

- Processes to screen all provider claims, collectively and individually, for potential fraud, waste or abuse.

- Processes to identify overpayments to providers including identifying instances of improper payment (e.g., up-coding, unbundling).

- Processes to recover overpayments to providers.

- Processes to identify and report to the Department suspected instances of Medicaid fraud.

- Processes to provide individual notices to all or a sample of Members who received services to verify and report whether services billed by providers were actually received by Members.
- Network provider audits to evaluate compliance with documentation and other applicable requirements.

When a monitoring or auditing activity is undertaken, a full report is issued that includes any issues that have been identified as well as corrective actions that have been, or will be, taken. Reports of findings are made to management and the Compliance Committee, as appropriate.

Findings of monitoring reviews and routine and/or special audits are also used to aid in fraud detection.

We will notify the Department if we identify or suspect possible provider or Member fraud as the result of any of our monitoring or auditing activities in accordance with the requirements and timeframes set forth in the RFP.

The RAE will immediately report known confirmed intentional incidents of fraud and abuse to the Department and to the appropriate law enforcement agency, including, the Colorado Medicaid Fraud Control Unit (MFCU) and the Program Integrity Unit through the Department. In addition, we will participate in any identified regulatory meetings with the Department. We will assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation. Further, we will provide assistance to the Department, its Recovery Audit Contractor, and the MFCU, as requested by the Department related to the review of overpayments, abuse, suspension of payments, or termination of a network provider or the investigation of possible fraud by a network provider.

QUALITY IMPROVEMENT INSPECTION, MONITORING AND SITE REVIEWS

As well as supporting and complying with all of the Department's requirements set forth in Section 5.15.6 of the RFP concerning quality improvement inspection, monitoring and site review, the RAE will conduct its own oversight activities to validate that our Partners and providers meet expectations and accountabilities set forth in our agreements. Below we provide an example of our approach to oversight.

Under Phase 1 of the ACC, RMHP is responsible for ensuring that appropriate care coordination is provided for all Medicaid members. To that end, RMHP has a comprehensive and collaborative program of oversight for its community based integrated care teams. We maintain Community Integration Agreements that guide activities of these community care teams (CCTs), which act as extenders to RMHP Care Management to support care coordination activities for RMHP Medicaid members.

We hold regularly scheduled Oversight Committee meetings with designated CCT Leadership and the RMHP Community Integration and Care Management teams to define and guide the community's organization around care coordination activities, policies and procedures and strategy for improving care for members within the community. Regularly scheduled Cross-Community Care Team Collaborative meetings with all CCTs across the RMHP region are held to

discover best practices among CCTs, refine policies and procedures, provide training and provide information about RMHP, ACC or broader issues. Ad hoc meetings are also held with each community to problem-solve specific cases and address operational questions and concerns.

Regularly scheduled reporting from RMHP to CCTs includes:

- The Case Management Analysis Tool (CMAT), which includes the patients affiliated with the CCT, their utilization activity, their affiliation with a PCMP and a risk score based on the member's clinical history as derived from claims.

- Member Population Report, which contains aggregated data showing performance of the CCT on identified Key Performance Indicators.

- High risk and low risk MMP Member report, which contains MMP members considered to be high risk and therefore will be prioritized for assessment.

- Other supportive reports as requested.

Regularly scheduled reporting from CCTs to RMHP includes:

- Report on care coordination and outreach activities for Medicare-Medicaid Program (MMP) members affiliated with the CCT, which includes: number of unique MMP members contacted within the reporting period, contact attempts, completed assessments and timeliness of assessments.

- Report on care coordination activities for RCCO Members affiliated with the CCT, which includes: the number of open cases, number of cases closed due to member goals being met, number and type of care coordination interventions and number of full time equivalent (FTE) dedicated to care coordination.

- Periodic in-depth updates on CCT activity, which includes qualitative stories on Members who benefitted from CCT support, relationships with community providers and strategic planning activities.

- Other ad hoc reports as requested by RMHP or the Department.

Additional oversight activities include:

- Care coordination chart reviews – For accountability purposes, RMHP care management staff or HCPF will review CCT care coordination documentation for thoroughness, accuracy and clinical appropriateness. RMHP reviews charts for randomly selected members and planned with advance notice to the CCT or unannounced at the discretion of RMHP or HCPF.

- Feedback from participating practices and community partners – RMHP maintains open and frequent communication channels with PCMPs and community partners and periodically solicits feedback regarding the CCT's effectiveness in serving members with complex care coordination needs and the CCT's level of collaboration with PCMPs to support the member in meeting their identified goals for care.

We monitor CCT performance against standards set forth in the Community Integration Agreements and if we determine that a CCT is not performing at the level defined by RMHP the following progressive action will be taken:

- RMHP will engage the CCT leadership in collaborative conversation regarding expectations and concerns. RMHP will work collaboratively with the CCT to develop an informal plan of action to address the concern(s).

- RMHP will engage its internal Medical Management Committee and the broader RAE Executive Committee, as necessary, to review and monitor concerns related to CCT performance.

- If positive action is not taken to resolve the concern, RMHP will convene a meeting with the CCT's Oversight Committee for collaborative conversation regarding expectations and concerns. RMHP will work closely over time with CCT Leadership and the Oversight Committee to discover and agree upon solutions to address unmet expectations and concerns.

- If positive action is not taken to resolve the concern after convening with the Oversight Committee, RMHP will issue a formal written corrective action to CCT Leadership as guided by the RMHP Medical Management Committee and provide a copy to the CCT Oversight Committee. The CCT will be given a defined timeframe to develop an action plan that directly addresses the unmet expectation. The action plan requires a defined timeframe for correcting the concern and defined action steps to address the concern. RMHP must approve the Corrective Action Plan and the CCT must implement the plan upon approval by RMHP.

- If the Corrective Action Plan is not implemented in its entirely as approved by RMHP, RMHP will provide the CCT Leadership with a letter of intent to terminate the Community Integration Agreement within a specified period of time unless the corrective action plan is implemented.

If the corrective action plan is still not implemented in its entirety, the Community Integration Agreement will be terminated according to the terms of the contract.

We will leverage our experience in monitoring and oversight to drive quality outcomes for our Members enrolled with the RAE.

PROHIBITIONS

The RAE will comply with all requirements in Section 5.15.7 of the RFP concerning prohibitions against payment for provider-preventable conditions (PPCs) identified in the State plan, payment to network providers not enrolled as Medicaid providers and relationships with individuals or entities excluded from participation with any federal health care program. RMHP has experience in the RMHP Prime program with reporting serious events and we will use claims data, quality of care complaints, provider/facility self-report, and concurrent review upon hospital discharge information to identify PPCs. RMHP's provider credentialing staff will monitor for network providers not enrolled with Medicaid and individuals/entities excluded from participation. Our approach to screening is discussed in the next section.

SCREENING PROCESS

The first line of defense against Medicaid fraud, waste and abuse is to screen persons or entities. This includes upon hire, as part of our contracting process, and to continue screening on a routine basis. Conducting proper database searches can prevent inappropriate Medicaid payments to excluded providers and reduce time-consuming and expensive activities if an improper payment is made.

The Partners recognize that they are subject to various laws, regulations and contract requirements that restrict them from maintaining relationships with particular persons or entities that have been sanctioned, penalized or convicted of a crime or have failed to meet applicable licensing or credentialing requirements for participation in state and federal health care programs. We will not knowingly enter into or maintain relationships with such persons or entities and we have processes and procedures in place to support continuous compliance with screening and credentialing standards.

Each Partner's Compliance Officer provides oversight of the screening process that includes verifying that prospective employees, employees, as well as entities and individuals with whom they do business are not included in the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) . RMHP's provider credentialing staff handles network provider applications and these providers undergo a credentialing process that includes screening against the LEIE, the U.S. General Services Administration's System for Award Management (SAM) Suspension and Debarment List, the Treasury Department's Office of Foreign Assets Control (OFAC) databases, as well as the National Practitioner Data Bank (NPDB). We rescreen monthly to verify that employees, network providers, individuals and entities with which we do business continue to meet applicable requirements and are not excluded from participation in federal health care programs. We will terminate relationships with parties who appear in these databases and report the discovery to the Department within five business days.

REPORTING

The Partners understand the importance of providing timely and accurate reporting to the Department. We will leverage the organizational structure, expertise, technology and lessons we have learned from our own experience to support the integrity, completeness, and accuracy of all data and reports submitted to the Department. For example, we are already partnering with three Community Mental Health Centers and five Community-Centered Boards on the Western Slope and in Larimer County in the Cross-System Response for Behavioral Health Crisis Pilot Project. This innovative pilot integrates behavioral health and intellectual/developmental disabilities (I/DD) systems to serve people in crisis who too often lack access to necessary mental health services. The pilot also requires us to collaborate on reporting and we have the necessary policies and procedures in place to consolidate information from our partners and submit reports to the Department about our activities. RMHP maintains stringent processes for internal review and validation of data prior to submission and our staff has the qualifications and experience to produce and deliver useful and accurate performance data.

As part of our commitment and responsibility to comply with ACC rules and contract requirements, RMHP will file with the Department all required reports, notices and disclosures

set forth in Section 5.15 in the RFP in compliance with all applicable guidelines and requirements. These include:

- Fraud, waste and abuse compliance reporting
- Administrative reporting
- Financial reporting
- Health insurance providers fee reporting
- Disproportionate share and graduate medical education hospital report
- Notices and disclosures
  - Policies and procedures
  - Security breaches and HIPAA violations
  - Ownership or control disclosures
  - Disclosures of information on persons convicted of crimes
  - Business transaction disclosures
- Conflict of interest disclosure
- Solvency notification
- Subcontracts and provider contracts
- Warranties and certification notification
- Notification of actions involving licenses, certifications, approvals and permits

We will also provide any ad hoc reports the Department might request. We will leverage our experience with projects such as the I/DD pilot to provide complete and accurate reporting that includes data from our Partners to the Department should we be selected as a RAE.

MAINTENANCE OF RECORDS

RMHP will maintain policies and procedures, including records retention schedules, addressing the maintenance of records pertaining to the Contract. Subcontracts and provider agreements will contain clauses requiring maintenance of records applicable to their duties as well as granting access to RMHP to monitor compliance. We are committed to creating and maintaining complete and accurate records of all our business activities and will comply with all maintenance of records requirements as outlined in Section 5.15.15 of the RFP, including retaining the following records for a period of no less than ten years:

- Grievance and Appeal records in accordance with 42 C.F.R. § 438.616
- Base data in accordance with 42 C.F.R. § 438.5(c)
- MLR reports in accordance with 42 C.F.R. § 438.8(k)
- Data, information and documentation specified in 42 C.F.R. §§ 438.604, 438.608 and 438.610

COMPLIANCE WITH 42 CFR PART 2

As noted within the Preamble to the updated 42 CFR Part 2 regulations, the goal is "to ensure that a patient receiving treatment for substance use disorder is *not made more vulnerable* by reason of the availability of their patient record than by an individual with a substance use disorder who does not seek treatment." As the RAE, we will maintain and update policies and procedures for compliance with 42 CFR Part 2 regarding the confidentiality of substance use disorder (SUD) information, and with more restrictive state and/or local laws and requirements. When conducting these activities, the RAE will coordinate with its Partners and providers to confirm that any necessary Member Part 2 compliant consents permitting the use and disclosure of this information is obtained. Alternatively, to the extent applicable, the RAE will verify compliance with 42 CFR §2.53 in the event of RAE program related audit or evaluation. Information sharing will include:

- Providing the required re-disclosure notice with any permitted disclosure of Part 2 SUD information.

- Identifying if there is a treatment/provider relationship.

- Separating Part 2 records from, or clearly identifying Part 2 records if comingled with, other information so that such Part 2 records are not inadvertently disclosed.

- If the RAE is the named entity in the patient/Member Part 2 consent, then the RAE:

  - Will follow rules regarding what may be disclosed and to who, including identification of a specific individual if the treating relationship criterion is not met.

  - Will provide upon request a list of specific recipients who receive information or data under general designation of consent.

CONCLUSION

As a health plan in operation for more than 40 years in Colorado, RMHP has the experience, systems and processes in place to comply at every level with the Department's requirements for the Accountable Care Collaborative Phase 2. We are always committed to doing the right thing and will work collaboratively with our RAE Partners to not only meet, but also exceed, the Department's expectations in our operation of an effective Compliance Program.

Section 6.0 Additional Statement of Work Activities
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.

The Partners positively affirm their willingness and ability to perform the work described in the proposed Accountable Care Collaborative (ACC) Medicare-Medicaid Program (MMP) scope of work. We understand that this program will be transitioning to the ACC in January 2018. We commit to working with the Department on this or other similar programs in the future to serve full-benefit Medicare-Medicaid Members.

Rocky Mountain Health Plans (RMHP), as the Regional Care Collaborative Organization (RCCO) in Region 1, implemented the MMP program for its qualified Members starting in September 2014. Building on the infrastructure and resources of Phase 1 of the ACC, we have been providing greater integration between Medicaid and Medicare as well as improving transitions of care into and out of long term services and supports for dual-eligible Members.

One of the key strategies of the MMP is the Service Coordination Plan. By documenting medical, social and behavioral health needs along with Member short-term and long-term goals, we take a person-centered approach to helping coordinate care across providers. RMHP and its community care team partners have successfully completed 6,941 assessments (representing a contact attempt and completion rate of greater than 95%) and 43,464 interventions for the Members in the MMP since its inception in 2014. The assessment number is inclusive of initial assessments and follow-up assessments.

When RMHP receives a new MMP Member, we assign a care coordinator located in the geographic area closest to the Member. The designated care coordinator collects data from multiple sources, to determine if the Member is connected with long term care supports and services or other care coordination sources. We will contact the Member and if reached, conduct a full care coordination assessment as described above to determine if the Member has any gaps in services or needs support to navigate the complex system of Medicare and Medicaid benefits. Finally, we connect them to the needed services and supports – MMP Members can have highly complex needs ranging from chronic and debilitating medical conditions and behavioral health conditions to lack of social supports, such as housing and transportation. Reassessment is performed every six months or when the Member has a change in condition, such as a hospitalization. RMHP's goal for MMP Members is to provide them the support they need to navigate the system in a way that is seamless and that meets their individual medical, behavioral health and social needs.

In addition to the work directly supporting the Department's MMP, RMHP also operates a Medicare health plan with approximately 25,000 members, many of whom also qualify for Medicaid. As a plan that operates a Medicare plan and a Medicaid plan, RMHP understands the challenges that Members face as they try to navigate the different rules from each program, which are often conflicting. RMHP's customer service staff and care coordinators are very

knowledgeable about both programs and help Members bridge the differences, as well as connect individuals who are dually eligible with community services like transportation, housing, and food support.

As an entity responsible for Medicare outpatient behavioral health services for its Medicare members, RMHP is encouraging integration of physical and behavioral health care for this population by working with a number of advanced primary care practices in its network to support integrated behavioral health activities. Many advanced practices will assess their patients for depression and anxiety, which is often under-treated in this population. We would continue to promote these activities in an extended version of the MMP, should they align with the Department's goals.

Our experience with the existing MMP as well as our past and current work with dual-eligible Members prepares us to be an effective and knowledgeable partner with the Department as the MMP evolves into its next stage, should funding be available.

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.

The Partners are willing and able to perform the work described in the proposed Wraparound Program scope of work, and will share responsibility for overseeing the implementation and success of the program.

COACT AND LOCAL COLLABORATIVE MANAGEMENT PROGRAMS: COLORADO'S WRAPAROUND FRAMEWORK

We have extensive experience with the Collaborative Management Program, which brings together agencies and services for at-risk, high systems-use children, youth and families. Also known as House Bill 04-1451, the Collaborative Management Program defined a county-level framework for collaboration whereby mandated providers must partner through a Memorandum of Understanding and create a Joint Interagency Oversight Group.

A number of counties in our region are considered Communities of Excellence through Colorado's Trauma Informed System of Care, or COACT Colorado[135]. Each Community of Excellence receives funding to support wraparound facilitators, family advocates, infrastructure development, and flexible funding services for families. Communities of Excellence also receive technical assistance in family engagement, youth engagement, cultural competency, and lesbian, gay, bisexual, transgender, and questioning responsiveness. We will leverage the expertise of these providers in all Wraparound Program efforts.

Rural Area Approach: Keeping Care within the Community

Sustainability of the Wraparound model requires different approaches in rural and urban settings. Challenges exist in rural areas when executing this type of evidence based program, due to lack of resources (e.g. number of qualified, licensed providers), and geographical barriers. We are committed to finding creative solutions to these complex challenges to make the program viable throughout our region.

We propose to implement a modified Wraparound Program in rural communities. A modified version of the program will allow children and families to receive strong care within their communities. Families will be able to participate in a therapeutic regimen that will fit their needs, while remaining in their communities. We will also use telehealth when appropriate. This will allow a high-fidelity team based in an urban area to provide support to children and families in rural and frontier communities. The high-fidelity team will also act as consultant to staff members in rural and frontier communities, to help the local team solve problems as they arise.

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[135] Source: http://coactcolorado.org/about/

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.

The Partners are willing and able to perform the work described in the proposed Colorado Pre-Admission Screen and Resident Review (PASRR) scope of work.

The current Omnibus Budget Reconciliation Act (OBRA) coordinators for Region One are employed by each of the community mental health centers, who are partners in this submission. The OBRA Coordinators have a deep understanding of the PASRR rules and requirements and have successfully managed all aspects of PASRR. In addition, the OBRA Coordinators have provided consultation to other OBRA Coordinators and PASRR training providers. The OBRA Coordinators have long-established relationships with the Single Entry Points (SEPs), nursing homes, hospitals, assisted living facilities, group homes, hospitals, and Case Management Agencies in Region One. The OBRA coordinators have also developed a strong cadre of trained Level II assessors.

The Partners will integrate our combined experience and strengths, as well as our long-established partnerships with other community agencies, to effectively manage PASRR. We will encourage and incentivize better coordination between assisted living facilities, hospitals, skilled nursing facilities and community mental health centers as part of our overall strategy for integrated, whole person care. Our existing relationships will allow for a smooth transition from the current PASRR management process to the new model managed by the Partners as the RAE in Region One.

Offeror's Response 28

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Brokering of Case Management Agencies scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

The Partners positively affirm their willingness and ability to perform the work described in the proposed "Brokering of Case Management Agencies" scope of work and will negotiate with the Department in good faith, provided existence of appropriate funding.

The Partners fully support the principles of conflict-free case management inherent in the role of Case Management Agency (CMA) Broker. We understand that this is an impactful change in the current Community Centered Board (CCB) business model, and will support a sustainable process for separating service provision and case management for both Members receiving services, and for the agencies that currently provide case management and accompanying services to eligible Members. We believe the timeline established by legislation is appropriate, and will engage with the CCBs in Region 1 in discussions regarding strategies for navigating the transition. We will support the goal for case management and supportive services to be provided seamlessly, while maximizing choice for the Member. The Partners support the principles of No Wrong Door and will work to maximize access to long term care supports and services (LTSS) regardless of how the RAE encounters the Member.

RMHP has demonstrated a strong commitment to services for intellectually or developmentally disabled individuals as the contractor overseeing the Cross-System Crisis Response Pilot Program (I/DD Pilot). Most of the CCBs in Region 1 are participating in the Pilot and RMHP has developed strong trust-based relationships with each of the CCBs. We are uniquely positioned to successfully serve as the CMA Broker due to our awareness of- and experience with- the different community strategies needed for frontier, rural and urban areas as they relate to conflict-free case management. We have a person-centered and proactive approach to supporting the intellectual or developmental disability (I/DD) population with alternative models of care. This innovation will contribute to our ability to build a strong network of CMAs that meet the needs of the individuals served, and plan appropriately for individuals with I/DD to optimize Members' ability to live in the community and achieve their goals.

To comply with the principles of conflict-free case management, we will develop processes and protocols for the following activities, including:

- Performing a brief initial screening with the Member to determine whether they may be appropriate for CCB services. We will integrate this screening into our care coordination assessment for individuals who may qualify for LTSS rendered by a CCB. If there is a good possibility that the member could be eligible for LTSS due to I/DD, we will refer the Member for eligibility determination at the CCB.
  - The Partners will *not* use the screening process as a barrier to care. Any Member who wants to be considered for LTSS may go to a CCB for eligibility determination, and our care coordinators will support the Member in obtaining an appointment if requested. The screening is a way to inform the Member and/or their representative if they are likely to qualify for LTSS, in order to maximize efficiency for the Member.

- Receiving the eligibility information from the CCB

- Meeting with the Member and/or their family/designated representative

- Initiating a brief person-centered intake/assessment process to determine which services best align with the Member's needs and preferences; to include other home and community based (HCBS) waiver services, aging services, etc.

- Offering a tool that clearly summarizes the qualifications and expertise of each CMA in the Partners' region, as well as the services each CMA provides that may conflict with unbiased care management for a Member

- Assisting the Member or designated representative in choosing a CMA, or assist the Member or the Member's designated representative in setting up interviews with CMAs to aid in their decision

- Referring the Member to the CMA of their choice using a referral protocol developed by the Partners in collaboration with the CMAs in the region

- Providing the Member or Member's representative with the CMA information in written form, and that the Member/representative understands that the Member is free to change their CMA at any time if desired.

- If the CMA determines that the services they offer do not align with the Member's needs, the CMA may contact the RAE to support the Member in selecting a CMA that is appropriate to the needs of the Member

Throughout the process, the Partners will align the above activities with the Department's implementation of No Wrong Door, and will collaborate with the Department, CCBs, and stakeholders to adjust activities to support the transition during each phase of implementation.

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 perform the work described in the proposed Health Information Exchange Connectivity Assessment scope of work, in partnership with Health Information Exchanges (HIEs), our provider network and the Department. We will conduct the assessment across our Network Providers and report our findings to the Department annually.

We believe that the information collected through the assessment will improve the readiness of systems in Colorado for the Quality Payment Program (QPP) and Advanced Payment Models (APM) operated by the Centers for Medicare and Medicaid Services (CMS).

Rocky Mountain Health Plans (RMHP) participated in the first-year assessment of provider network Electronic Health Record (EHR) interoperability and utilization of Health Information Exchange (HIE) services. For this effort, we focused on practices we have supported in our Practice Transformation programs during the past three years. Many of these practices are also participating in the State Innovation Model (SIM). To maximize efficiency, we collected data using the SIM specific survey tool for SIM practices, and used the tool provided by the Department to collect data from the non-SIM practices. RMHP and Quality Health Network (QHN) populated information from our respective systems. We then sent the pre-populated surveys to the practices for review and completion. RMHP gathered the completed surveys from the practices and provided the data to the Department in their requested file format. We also entered the survey information into the SIM provided tool for the SIM practices.

Offeror's Response 30

Provide a description of a capitated payment reform initiative the Offeror seeks to implement in Region 1 or Region 5 that describes:

a. Payment methodology, including:
   i. The rate structure and logic model.
   ii. Performance and/or quality measures that are incorporated into the proposed value payment model and how they affect payments.
b. Policy innovation goals or targets that may enhance the Medicaid program and support the Accountable Care Collaborative's goals to improve Member health and life outcomes and to use state resources wisely.
c. Mechanisms for cost neutrality or cost savings, and the estimated amount of projected cost savings, if applicable.
d. Population and geography, including:
   i. Regions or counties in which the capitated payment reform initiative will operate.
   ii. ii. Approximate number of Members included in the capitated payment reform initiative.
   iii. Eligibility categories included in the capitated payment reform initiative.
      a) Any limitations on who may participate.
e. Provider network, structure, and value-based payment arrangements.
f. How the proposed capitated payment reform initiative structure will foster communication, cooperation, and alignment with the Contractor's Accountable Care Collaborative structure.
The Offeror's response shall include a Letter(s) of Support from the local system of care (Denver Health Medicaid Choice or Rocky Mountain Health Plans Prime).

Rocky Mountain Health Plans (RMHP) is currently sponsoring the Prime capitated payment reform under an agreement with the Department in six counties in Region 1. We are very pleased to submit a proposal to build up reforms in ACC Phase 2 to improve health outcomes and Member satisfaction and support the financial sustainability of the Medicaid program in accordance with C.R.S. 25.5-5-415. Responses to the points set forth in Offeror's Response 30 are set forth below.

PROVIDE A DESCRIPTION OF A CAPITATED PAYMENT REFORM INITIATIVE THE OFFEROR SEEKS TO IMPLEMENT IN REGION 1 OR REGION 5 THAT DESCRIBES:

a. Payment methodology, including:

The rate structure and logic model

RMHP has found the rate structure and risk cohorts developed by the Department's actuary for Prime to be sound. The Department's partnership with RMHP and communication with RMHP's actuary has been very transparent and productive. RMHP will continue to use the 4 Quadrant stratification framework originally established our 2013 Prime proposal, and will expand it as discussed in this RFP response to include social risk factors as a third dimension.

Performance and/or quality measures that are incorporated into the proposed value payment model and how they affect payments.

The existing, quality-adjusted Medical Loss Ratio floor method is clear, appropriate and fully aligned with Prime goals. We believe that CMS-approved quality contingency measures in comprehensive domains of performance – chronic conditions, behavioral health (e.g.,

depression), health-behavior (obesity) and patient activation should continue as the basis for the adjusted Medical Loss Ratio.

b. Policy innovation goals or targets that may enhance the Medicaid program and support the Accountable Care Collaborative's goals to improve Member health and life outcomes and to use state resources wisely. Mechanisms for cost neutrality or cost savings, and the estimated amount of projected cost savings, if applicable.

The overall structure and alignment of the Prime program is extremely sound and productive. We believe that the implementation of the interChange and BIDM process creates an opportunity for further alignment, through the submission of provider EHR clinical quality measures (eCQMs) for Prime directly to the Department for benchmarking and evaluation.

c. Mechanisms for cost neutrality of cost savings, and the estimated amount of project cost savings, if applicable.

RMHP and its partners have developed structural supports, at every level, to develop clinical, operational, leadership and data integration for behavioral health services; efficient team based care and patient activation to produce measurably higher value; budget neutrality compliance and lower total cost trends over time. Prime has also approach has produced substantially higher behavioral health access. In the April 15, 2017 Legislative Request for Information regarding Prime, the behavioral health penetration rate reported for Prime members was 20%, in 2015-16, compared to less than 15% of all Medicaid enrollees, statewide. RMHP's analysis shows that total cost trends for Members to advanced PCMPs grew at a 2-4% slower rate from 2014-16.

d. Population and geography, including:

Regions or counties in which the capitated payment reform initiative will operate

RMHP will continue to operate the program in Mesa, Montrose, Garfield, Pitkin, Rio Blanco and Gunnison counties.

Approximate number of Members included in the capitated payment reform initiative

There are currently 38,000 enrollees in Prime. We do not anticipate that the number of enrollees will increase or decrease at a rate that is substantial different from overall Medicaid trends.

Eligibility categories included in the capitated payment reform initiative

The existing categories for Prime will be maintained, and grouped into risk cohorts as determined by the Department's actuary.

Any limitations on who may participate

RMHP does not request limitations upon the categories that are currently enrolled.

e. Provider network, structure, and value-based payment arrangements.

RMHP utilizes attribution based, risk-adjusted payments and incentives to support the Prime network. All providers in RMHP's network participate and receive payments based upon objective criteria. Primary care payment is significantly reformed, and incentives are utilized to align and focus Community Mental Health Center (CMHC) support for the program.

f. How the proposed capitated payment reform initiative structure will foster communication, cooperation, and alignment with the Contractor's Accountable Care Collaborative structure.

The existing RMHP Prime model is incredibly conducive to the RAE structure and goals established by the Department for ACC Phase 2. Within Prime, CMHCs participate actively in program governance functions, alongside PCMPs and other providers in the Health Neighborhood through the Prime Executive Committee process. CMHCs also receive incentives and shared savings when overall cost and quality targets are achieved. Integration of the Capitated Behavioral Health contract in the RAE structure will be both a natural and highly productive opportunity to create efficiencies and deeper degrees of integration than are possible in the current model, in which administration of the Capitated Behavioral Health Benefit is carved out to a separate PIHP contractor.

The Offeror's response shall include a Letter(s) of Support from the local system of care (Denver Health Medicaid Choice or Rocky Mountain Health Plans Prime).

Please see the enclosed Letter(s) of support from Reunion Health in Response 8, which includes all FQHCs and CMHCs currently participating in Prime. Also attached here is a letter from WestPAC, the independent primary and specialty care physician group established to advise RMHP, pursuant to the conversion of our organization from a 501c4 entity to UnitedHealthcare enterprise.

June 21, 2017

To Whom it may concern:

We are the physicians who serve on the Western Slope Provider Advisory Committee ("WestPAC"), which was established at the request of the Colorado Medical Society and approved by the Division of Insurance during the alignment of Rocky Mountain Health Plans (RMHP) and United Health Care (UHC). We provide an advisory capacity to RMHP in order to continue the forty year history of unique collaboration between Rocky and physicians. We are a diverse group of physicians throughout rural Colorado, including Grand Junction, Montrose, Durango, Snowmass and Delta, and represent a range of practice sizes from very small practices to one of the largest primary care practices in the state. We also are primary care and specialist physicians

We write this letter to reflect our unanimous support for Rocky in their current work with the RCCO and the future Regional Accountable Entity (RAE). We unanimously and strongly endorse RMHP as the administrator of the future RAE. We also support continuation of the Medicaid PRIME product and RMHP as the administrator of the program in its current form. We all believe that RMHP's continue role in this regard is essential for health delivery.

RMHP has been a critical presence on the western slope for over forty years. Their collaborative approach with providers and communities has resulted in innovative and effective care for underserved populations. More important, they work continuously to help physicians *create the future* -- with supports that meet the demands of modern practice. These include smarter payment models, data sharing and analytic support, integrated behavioral health and the community "backbone" resources required to address the social determinants of health. RMHP's attention to local Colorado communities is well-aligned with the Department's vision for Colorado Medicaid, but their ongoing, bold commitment to innovation and improvement in partnership with primary care and specialists is what sets them apart from other competitors for the RAE regions. We firmly believe that having RMHP continued and expanded representation of RAE regions will greatly benefit our communities.

Many of our communities have benefited from RMHP's continued leadership and collaboration within the states PRIME program. Our patients have also benefited from this innovative program. We not only support this program as it is, but also suggest future consideration of expansion of it into other geographic areas and into the pediatric low acuity population.

We have partnered closely with RMHP for many years and feel confident in expressing full support for the continuation of their representation of the PRIME product and are pleased to be in support of RMHP. We look forward to collaborating further in these efforts.

Regards,

WestPAC Committee Members

Dr. William Kelley

Dr. Gina Martin

Dr. Michael Pramenko

Dr. Greg Suchon

Dr. Cecile Fraley

Dr. Gary Knaus

Dr. Waqqar Farooqi

Dr. Patrick Pevoto

Dr. Greg Reicks

Offeror's Response 31

Provide a statement that the Offeror agrees to:

a. Operate the Accountable Care Collaborative, as described in Section 5, irrespective of whether or not the Department exercises its option for implementing the Offeror's proposed capitated payment reform initiative.

b. Accept the actuarially certified Capitated Rate developed after the award based on the Contractor's proposed capitated payment reform initiative if the Department chooses to exercise its option to implement the Offeror's proposed capitated payment reform initiative.

OPERATE THE ACCOUNTABLE CARE COLLABORATIVE, AS DESCRIBED IN SECTION 5, IRRESPECTIVE OF WHETHER OR NOT THE DEPARTMENT EXERCISES ITS OPTION FOR IMPLEMENTING THE OFFEROR'S PROPOSED CAPITATED PAYMENT REFORM INITIATIVE.

RMHP acknowledges and agrees to this provision of the RFP.

ACCEPT THE ACTUARIALLY CERTIFIED CAPITATED RATE DEVELOPED AFTER THE AWARD BASED ON THE CONTRACTOR'S PROPOSED CAPITATED PAYMENT REFORM INITIATIVE IF THE DEPARTMENT CHOOSES TO EXERCISE ITS OPTION TO IMPLEMENT THE OFFEROR'S PROPOSED CAPITATED PAYMENT REFORM INITIATIVE.

RMHP acknowledges and agrees to this provision of the RFP.

APPENDICES

Appendix A - Covered Behavioral Health State Plan and 1915(b)(3) Waiver Services

BRIEF SUMMARY OF SOME STATE PLAN SERVICES AND HOW THEY ARE PROVIDED

Individual Psychotherapy

Individual therapies employ a range of evidence-based practices including Cognitive Behavioral Therapy (CBT), Motivational Interviewing, and self-management techniques that are provided to Members with a covered mental health or substance use disorder. Highly trained and skilled licensed clinicians offer these therapies, alone or in combination with group interventions, family therapy, recovery/peer services, case management, and Medication Assisted Treatment (MAT) or in conjunction with any one of the other waiver Services for individuals with primary mental health diagnoses.

Individual brief psychotherapy

There are many evidence-based brief approaches to psychotherapy that can be delivered in 30-minute sessions to effectively treat acute stressors, depression, substance use disorders (SUD), and anxiety. Approaches include Behavioral Activation, Solution-focused Brief Therapy, Motivational Interviewing and Problem Solving. Brief therapy is a particularly critical component of behavioral health treatment in FQHCs and other physical health settings.

Group psychotherapy

Group psychotherapy is provided to a small group of individuals with a common symptomatology or goal and is intended to provide skills-building to cope with symptoms, improve functioning and develop interpersonal skills. Modalities of group therapy include CBT, Dialectical Behavioral Therapy (DBT), and Modified Dynamic Group Therapy. Group therapy can provide interpersonal support, encouragement and challenge from peers in a therapeutic manner within the group setting.

A Sample of Group Interventions:

- DBT for adults, adolescents or families
- CBT for residual psychotic symptoms, mood disorders or trauma
- Diagnosis-specific such as those for bi-polar or psychotic disorders
- Chronic Disease Self-Management
- Integrated dual diagnosis treatment
- Parenting groups such as Incredible Years
- Skills-building groups for adolescents such as refusal skills, anger management and problem-solving
- Gender-specific SUD counseling
- Peer-led groups
- Evidence-based women's trauma treatment including Seeking Safety and Trauma Recovery Empowerment Model

Family psychotherapy

Interventions for family members and other informal support systems are available for Members with a covered mental health or SUD and their families. These services employ a range of practices demonstrated to be effective, including Functional Family Therapy, Multi-Systemic Therapy, Nurturing Parents, and Family Psycho-education. Consistent with the philosophy and goals of resilience,[136] parenting groups, psycho-educational sessions, wellness groups, peer-led family groups, and family therapy build the capacity of the family or informal support systems to support the client and to promote mental health and wellness within the support system itself.

Behavioral health assessment

The cornerstone of treatment of mental health and SUD is the clinical assessment of a Member's behavioral health status, including the Member's strengths, abilities, and resources. The assessment sets the stage for collaborative service planning with the Member, family, and other providers. This assessment covers a variety of issues including trauma history, co-existing behavioral or physical health issues, treatment access barriers and client and family member preferences. The assessment results in recommendations about the level of care, setting of care, and adjunct services. This service is the precursor to receiving most State Plan and waiver services.

Medication management

The Partners have a network of highly competent psychiatrists, advanced practice psychiatric nurses, and physician assistants with prescriptive authority. These personnel are skilled in the delivery of medication management services, including diagnostic clarification, requisite lab work and prescribing to Members with a covered mental health diagnosis. Nurses and qualified medication administration professionals work with the care team so that Members get the medications they need when they need them. Medication management is a critical part of identifying underlying medical issues. We know that people with serious persistent mental illness die 20-30 years earlier than the rest of the population, and lab testing for cardiovascular disease and endocrine disorders as part of the medication management protocol are key to early diagnosis and treatment of co-morbidities.

Outpatient day treatment

Our Partner CMHCs have outpatient day treatment programs for children, adolescents, and adults. For children, outpatient day treatment is typically provided in partnership with a school. Day treatment programs in schools provide intensive family therapy, school assistance, and consultation with school staff to treat at-risk youths and their families. Services are typically provided at the school and in the home. At school, the class size is smaller, with a teacher and a full-time therapist working with the students to support both academics and emotional behaviors. Treatment at home consists of family therapy to support the child in the home environment. This intensive program is meant for children and adolescents who are at risk for placement in a more restrictive setting, like a regional treatment center, or transitioning from a regional treatment center back into their communities.

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[136] Goals of resilience: the ability of a person, family, organization, or community to cope with and adapt to challenges or setbacks

CMHCs also offer day treatment for adults. For example, Mind Springs Health (Mind Springs) offers outpatient day treatment for members in their West Springs facility, where members can attend individual and group therapy during the day. Mind Springs plans to expand this service once their new facility is complete in 2019.

School-based services

School-based clinicians within the Region 1 provider network are embedded within more than 10 school districts, mostly in rural areas. They provide a range of services from prevention and early intervention, brief counseling, crisis intervention, Day Treatment Alternatives to out-of-home placement, and other school-based programming. School-based services are intended to identify mental health and substance use concerns early in a child's development with the goal of reducing extended or chronic behavioral health concerns.

Targeted case management

All of our Network CMHCs provide Targeted Case Management (TCM), which is a defined benefit often used for Members with serious mental illness. Services include facilitating enrollment, coordinating home- and community-based waiver services, and coordinating with non-waiver resources. TCM also ensures non-duplication of waiver services and the monitoring of waiver services across multiple funding sources. Services are targeted for specific populations, such as adolescents experiencing severe emotional disturbance. TCM services are highly individualized and flexible and designed to assist Members in accessing a range of services.

Rehabilitative services

The CMHCs have an enhanced capacity to meet the needs of adults and children with behavioral health disorders. Modalities and remedial services offered include: crisis intervention, social skills development, substance use disorder services and psychosocial rehabilitation. Many of the network providers are credentialed to treat individuals with co-occurring mental health and SUDs.

Substance use disorder assessment

Upon intake, all Network CMHCs use evidence-based screening tools, such as the AUDIT, DAST and tobacco use screen. If the screening is positive for a concern with SUD, then further assessment or referral is undertaken. The assessment relies on the American Society of Addiction Medicine's level of care criteria as well as developmentally appropriate, standardized assessment tools for adults and youth. The assessment is the basis for recommendations for treatment priorities, aiming for the least intensive, but safe, efficient and effective setting for treatment. This service is designed for all adult and adolescent Members and is combined with follow-up therapy services, case management, and drug screening and monitoring. The CMHC Partners all use an integrated assessment tool for every intake, thus evaluating for both mental health and substance abuse issues.

Alcohol/drug screen counseling

Alcohol and drug screen counseling is available throughout the network of behavioral health and PCMP providers, including CMHCs and FQHCs. In addition, some CMHCs offer tobacco cessation groups.

Medication-assisted treatment

Medication-assisted treatment (MAT) is the administration of controlled substances like methadone, Suboxone or Vivitrol, which are designed to reduce or eliminate the negative consequences of drug dependence. Typically, opiate replacement therapy--the form of medication-assisted treatment currently covered by the Department-- is completed with a daily administration of methadone and conducted by federally certified opiate treatment programs. Suboxone and Vivitrol are also used in qualified clinics with qualified providers.

CMHCs offer medication-assisted treatment. For example, Mind Springs has a robust Suboxone clinic in its Glenwood Springs office and works closely with the Department of Corrections probation office to coordinate services. Additionally, in northwest Colorado, there are robust community efforts to address opioid addiction. Mind Springs has a psychiatric provider who is certified to provide Vivitrol and Suboxone to individuals in Steamboat and Craig. We also work through telemedicine to assist patients in remote areas with MAT. SummitStone Health Partners (SummitStone) offers Vivitrol clinics in both Fort Collins and Loveland and has an integrated Suboxone clinic operated jointly with Sunrise. Other forms of MAT provided through our network include naltrexone and acamprosate for alcohol use and varenicline and bupropion for nicotine dependence.

Social ambulatory withdrawal management (detoxification)

Each of the CMHCs provide detoxification services. Upon presentation, the individual receives a physical assessment to determine if they will be safe to detoxify without clinical monitoring. CMHCs will also assess the individual from a safety perspective, to discern whether there is any potential for self-harm or harm to others. Once it is established that they are safe for social withdrawal management, they meet with a therapist who assesses their level of motivation for change. The therapist also checks that they have their daily living needs met, including a place to shower, sleep and eat. The services supporting withdrawal management include: supervision, observation and therapy provided in an outpatient SUD or co-occurring disorders facility.

On the West Slope, social withdrawal management is operated by Mind Springs Health, which allows for increased alignment with crisis services and linkage to outpatient care upon discharge from the detoxification program. Additionally, The Center for Mental Health is starting a social withdrawal management program in Montrose in 2018. SummitStone works with North Range Behavioral Health for withdrawal management services, maintaining a close connection and record sharing for continuity of care if the individual moves to outpatient services offered by SummitStone. One of the challenges of SUD treatment is engaging a Member who is recovering from SUD to continue supportive services when they finish the acute withdrawal management phase. Mind Springs Health successfully engages about 30 percent of people who have been in withdrawal management services into outpatient treatment. This is commendable engagement as typically only five percent are engaged into ongoing treatment. Much of Mind Springs' success is due to the use of peer mentors, who follow the Member from the withdrawal process to ongoing outpatient therapy, which increases the chance that the Member will continue on a path towards recovery.

Outpatient hospital services

The Partners' network of behavioral health providers offers an extensive array of outpatient behavioral health hospital services that address a range of covered diagnoses, co-occurring problems, and population characteristics. In addition to providing multiple intervention approaches, outpatient services occur in a variety of settings, including physical health sites, in order to maximize access. The Partners will not require an initial authorization for Members to receive outpatient hospital services (either mental health or covered SUD services).

We acknowledge financial responsibility for all Medicaid services associated with a Member's outpatient hospital treatment, including all psychiatric and associated medical and facility services, labs, x-rays, supplies, and other ancillary services, when billed on a UB-04 and ANSI 837-I X 12 claim form, and the principal diagnosis is a covered psychiatric diagnosis. The same financial responsibility applies to procedures billed on a CMS-1500 and ANSI 837-P X 12 claim form, and the principal diagnosis is a covered behavioral health diagnosis.

Emergency and Post-Stabilization Care Services

Crisis and emergency services are critical to a continuum of care for adults, adolescents, and children with mental health diagnoses and SUDs. Two of the CMHCs, Mind Springs Health, and SummitStone manage Colorado Crisis Services walk-in centers and mobile response. We recognize that emergency and crisis services are some of the most important components of a high-quality behavioral health program. Crisis Centers serve anyone regardless of their insurance status. We design our crisis and emergency response system to perform the following activities:

- Response to unscheduled concerns or crises is always available from a compassionate, professionally-trained and qualified emergency clinician.

- Immediate steps are taken to ensure the safety of the client and support system, including performing a thorough evaluation and safety risk assessment.

- A Crisis team is immediately available for calls or walk-in to crisis locations 24/7 (some after hours and weekend coverage may be provided in the emergency room for safety reasons).   Mobile response is also available 24/7 and response times are dependent upon whether the Member is in a Rural or Urban setting

- Arrangements for care are made for the least restrictive setting while fully considering client and family preferences. Both Mind Springs and SummitStone have crisis stabilization units, which provide onsite therapy for up to five days.

- Crisis follow-up is available to ensure connection to services if inpatient care is found to be unnecessary.

- The staff at Crisis Centers have a thorough understanding of the proper procedure for Colorado involuntary holds through CRS 27-62-102.

List of Crisis Triage Activities
- Conduct a risk assessment to screen for imminent danger to self or other or for acute or chronic symptoms requiring immediate intervention.

- Initiate a welfare check if contacted by someone concerned about the safety of another person.

- Schedule a face-to-face evaluation through a CMHC Crisis Response Center provider (available at Mind Springs and SummitStone).

- Mobilize the client's support system as requested.

- Provide mental health and SUD information on how to access treatment.

- Link to a network provider or a provider of the client's choice for follow-up.

- Facilitate contact with the nurse or psychiatric provider for emergency medication issues.

- Perform evaluation by a psychiatric prescriber if available.

- Assist Member in attaining medical clearance for inpatient admission if needed.

Services Available through Colorado Crisis Services

TALK Helpline: When an individual contacts Colorado Crisis Services' help line (844-493-TALK), a licensed clinician answers the call within 15 seconds (or three rings). These calls take precedence over all other calls. These emergency clinicians are highly trained in telephonic crisis triage, having the capability to keep a caller on the line while dispatching emergency responders, if necessary. In every case, staff keeps the caller on the line until a safe intervention can be assured. An automated call tracking system records all calls and captures key strokes on the call documentation system. The functions of the system enable the training and supervision of crisis clinicians, who can contact 911 if the crisis warrants.

Mobile Crisis Response: This is for Members in distress who cannot travel due to lack of transportation, symptom interference or safety concerns. Mobile Crisis Response provides 24/7 response, de-escalation, and assessment by trained clinical staff, generally within one hour in Urban areas and two hours in Rural areas, to ensure crisis intervention for individuals who are unable to travel to office or emergency room based care.

24/7 Walk-In Crisis Centers and Crisis Stabilization Units: Individuals can walk in 24/7 to the Mind Springs or SummitStone crisis centers and they will receive crisis care and stabilization, with follow-up outreach and referral to ongoing or intensive treatment services as needed. Individuals can stay up to five days in the crisis stabilization unit.

Emergency Crisis Services include a face-to-face crisis response that is delivered in a safe location. Our goal is to keep Members out of emergency rooms, which can aggravate symptoms and which are less equipped to offer mental health assessment and stabilization. Licensed and trained clinicians conduct an emergency assessment to evaluate the situation and make recommendations for follow-up care. Interpreter services are arranged for clients who are not fluent in English. In order to accomplish the goal of providing for safety in the least restrictive setting, the crisis services provider reviews the Member's Self Care Plan, when available, and consults with other providers and agencies involved with the Member. These discussions include a review of the preferences of the client, family, and other informal support systems prior to making recommendations for services. As with other services, principles of client

independence, choice, and empowerment are primary, along with client, family and community safety.

CMHCs maintain close working relationships with local law enforcement agencies, emergency rooms, detoxification centers, homeless shelters, and jails to enable coordination of crisis and emergency services. CMHCs provide crisis intervention training (CIT) and Mental Health First Aid (MHFA) training to law enforcement agencies throughout the region, facilitating enhancement of law enforcement knowledge and skills in de-escalating behavioral health crises.

Payment for Emergency and Post-Stabilization Care Services

The Partners will administer payments for post-stabilization care services as specified in 42 C.F.R. § 438.114(b) and 42 C.F.R. § 422.113(c). We will streamline approval processes and be available 24/7 to support timely pre-approval and ensure post-stabilization care providers understand how to obtain approvals for services.

We will limit charges to members for post-stabilization care services to no greater than the amount the Partners would charge the Member if they had obtained services through our contracted network. RMHP is familiar with administering the post-stabilization care benefit in a capitated environment and will manage the benefit to align with all regulations, while being fiscally responsible. Our financial responsibility for unapproved post-stabilization care services end when one of the following conditions is met:

- A plan provider with privileges at the treating hospital assumes responsibility for the Member's care.
- A plan provider assumes responsibility for the Member's care through transfer.
- RMHP and the treating provider reach an agreement concerning the Member's care.
- The Member is discharged.

RMHP's Utilization Management Department will conduct retrospective reviews to assess approval processes and delivery of emergency and post-stabilization care services in compliance with Department and state regulations.

Inpatient Psychiatric Hospital Services

A strength of the partnership between RMHP and Reunion Health in Region 1 is that Mind Springs Health owns and operates West Springs Hospital, the inpatient mental health hospital that serves the Western Slope. SummitStone has a long-established collaborative relationship with hospitals in the northeastern part of the state, as well as with Denver-area hospitals. We will work with the hospitals inside and outside Region 1 to provide inpatient care for Members of all ages with covered primary psychiatric diagnoses. In addition to hospitals, the Partners' statewide provider network includes a range of other community supports such as state plan-covered intensive case management programs like Assertive Community Treatment and hospital alternatives like Acute Treatment Units and crisis residential placements for youth. These alternatives provide an opportunity to avoid hospitalizations and to quickly reestablish safety in settings that are in closer proximity to the community.

When Members of any age require hospitalization, CMHC care transition staff work in partnership with the Member, hospital staff, family members and community treatment providers to develop a transition plan for discharge. The transition plan includes coping strategies for the Member and their support system, comprehensive and holistic outpatient follow-up services, and scheduling of needed outpatient behavioral health services. The plan also includes assistance with other services such as transportation, coordination with other service agencies, housing, medications, and physical health care appointments. To facilitate smooth transitions and timely outpatient service access, the Reunion Health CMHCs have systems in place that will arrange clinician and prescriber access within seven days of discharge from the hospital.

Twenty-four hour psychiatric services for Members under the age of 21 with a covered mental health diagnosis are provided by licensed and specialty psychiatric units. Inpatient hospital services are available to all members under the age of 21 when medically necessary. We understand that Members who are inpatients on their 21st birthday are entitled to receive inpatient benefits until discharged from the facility or until their 22nd birthday, as outlined in 42 C.F.R. § 441.151.

The Partners will be responsible for all inpatient hospital services with a primary covered psychiatric diagnosis that requires an inpatient level of care and is being managed within the treatment plan of the Member. We are financially responsible for the hospital stay when the Member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures, such as labs and ancillary services. We are not financially responsible for inpatient hospital services when the primary diagnosis is physical in nature or is a substance use disorder that is evident at the time of admission.

RMHP, in its capacity as the licensed, risk-bearing entity that manages the behavioral health capitation benefit, may contract with an Institution of Mental Disease (IMD) to provide inpatient and SUD treatment. West Springs, owned by Mind Springs, is a state-approved IMD. SummitStone has close relationships with IMDs in the northeast part of the state and the Denver metro area. These existing relationships will allow for continuity of care when the Member is discharged to a step-down unit or outpatient services. In all cases, we strive to manage inpatient facility stays to allow for stabilization while arranging for services and treatment in a less-restrictive setting that is as close as possible to the Member's natural environment in order to facilitate and sustain progress.

The Partners understand that they are financially responsible for a Member's admission to any free-standing inpatient psychiatric facility, provided the Member presents with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment. In the case of a SUD as the primary diagnosis, the Partners will not be responsible for continued acute stabilization, safety and assessment services associated with that admission. If a mental health disorder is the primary diagnosis, the Partners understand that they are financially responsible for the remainder of the hospital stay as medically necessary in accordance with 10 CCR 2505 10 8.076.1.8. The assessment phase to determine the exact nature of the problem shall generally not exceed 72 hours.

NON-STATE PLAN 1915(B)(3) WAIVER SERVICES

The CMHCs and partners will provide or arrange for all the covered services in 5.12.5.8. A complete description of each service and highlights of how our CMHCs provide or arrange for these services is found below.

The Partners will provide or arrange for the following 1915(b)(3) waiver services to Members in at least the scope, amount and duration proposed in the Uniform Service Coding Standards (USCS) Manual. These services will be provided exclusively through the CMHC network providers in the Region.

Vocational Services

For Members with severe and persistent behavioral health concerns, employment is key to establishing and maintaining hope for the future and realizing long-term recovery. Although all working-age Members with covered primary mental health diagnoses may require assistance with employment, state Division of Vocational Rehabilitation (DVR) and workforce services are likely to meet the employment needs of many of these Members. However, Members with mental-health related disabilities often require specialized support that DVR is not able to provide. Many Members with mental health disabilities also have co-occurring SUDs, and some are transitioning from criminal justice facilities, creating additional challenges in helping them prepare for employment.

SummitStone offers vocational services through its Clubhouse, Spirit Crossing. There are a variety of employment support services available to Clubhouse members and adult SummitStone's consumers, including: Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE). Supported Employment services are offered to SummitStone's consumers receiving outpatient services. Enrollment in Supported Employment services is administered through the Clubhouse with an Employment Specialist, however Clubhouse membership is not required. All individuals complete a vocational profile to set personal goals with outcomes that meet personal interests and describe work experience and desire to work. Referral to DVR may be considered when Supported Employment needs are expressed.

Vocational programming includes Supported Education. Spirit Crossing supports members with their educational goals. Services include assistance with completing enrollment and financial aid applications, study groups and tutoring, adult education on-line learning and GED preparation. Adult enrichment programs are also supported, which include English as Second Language, conversational Spanish, and basic Microsoft Office programs.

Mind Springs Health offers vocational services at the Oasis Clubhouse. Services include:

- Job Counseling
- Resume Development
- Work-Related and Social Skills Building
- Sheltered Employment
- Supported Employment

- Job Search Support

Mind Springs has established a Supported Employment Service and has partnered with businesses to offer employment for a pre-screened, motivated employee with ongoing mentorship and support, at no cost to the member or the business.

Intensive Case Management

All of the network CMHCs in Region 1 offer intensive case management (ICM) to Members who have a complex set of problems or those who require a high intensity of services related to a primary mental health diagnosis. Access to an array of services within the natural community environment can be provided through ICM. This is especially important for adults whose mental illness is disabling, making it impossible for them to function without extensive support. Many of the adults requiring this service will also have a co-occurring SUD. Individuals with complex service needs within other groups, such as older adults and adults without dependent children (a Medicaid eligibility category), also benefit from ICM services.

ICM includes a range of very flexible but intensive supports and services that are frequently delivered in conjunction with other State Plan and Waiver services to enhance engagement and increase the effectiveness of the other services. These include behavioral health therapies, psychiatric services, medication management, vocational services, residential care, peer specialists, and clubhouse and drop-in center services. ICM provides the "glue" that enables members to successfully participate in other services. Case management staff coordinate across multiple service sites and providers, arranging for transportation, helping to sustain motivation to participate in both behavioral and physical health care, educating Members about the interaction of their illnesses and medications, and helping to engage natural support systems.

The principles of resilience and recovery are woven throughout ICM. Peer mentors are part of that dialogue, demonstrating that recovery can happen and supporting members on their path.

Prevention/Early Intervention Activities

Several of the Partnership's population management interventions address prevention and early intervention, including Zero Suicide, Mental Health First Aid training for community partners and the University of Pennsylvania's Positive Psychology initiatives, which will be piloted in two Western Slope middle schools. Because of our ability to aggregate data from different sources, including Health Needs Survey, eligibility and enrollment data, claims, and risk stratification, the Partners and our providers will be able to respond quickly to changing community priorities in project-based prevention initiatives. The Partners are also committed to integrating a prevention and early intervention philosophy in all service delivery. Locating services in a variety of community settings and hosting partnerships with a range of community efforts is key to our commitment to prevent and intervene early in mental health concerns.

Clubhouse and Drop-In Centers

Clubhouse programs and drop-in centers offer a range of socialization and support services to adults with serious mental illness. Maintaining the foundational values of clubhouse standards, yet expanding the practices to reach a broad population base, clubhouse programs are independently governed communities offering social support, independent living skills, and employment opportunities to adults across the service area. The concept of the "work-ordered

day" is a central focus. Services available include pre-vocational skills development, opportunity for social skills enhancement through meal preparation, and social and recreational activities. In response to the health risks associated with serious mental illness, the clubhouse programs have begun increasing their emphasis on health and wellness, conducting wellness screening and education onsite and connecting residents with health and wellness activities. Mind Springs and SummitStone both host clubhouses with a comprehensive array of services.

Residential

Residential services for children are provided in a Residential Treatment Center (RTC), which provides 24-hour psychiatric care and supervision in a therapeutic environment. While the typical stay for a child/youth is 30, 60 or 90 days, the Partners prefer a strategy of a shorter stay, for instance 15 days, in order to move the child/youth Member into a less restrictive setting. Recent research indicates that longer RTC stays can result in persistent negative behaviors. A shorter stay accompanied with careful discharge planning and arranging the right services for both the youth and family can yield more sustainable positive outcomes. Mind Springs has an RTC affiliated with its West Springs hospital.

SummitStone hosts a residential facility for adults, Choice House, which provides room, board and 24-hour supervision in a safe, structured environment. Intensive staff oversight provides structure and support for transition to semi-independent or independent living and offers a viable alternative to hospitalization. Stays are limited to 30, 60, or 90 days with planning for outpatient support and care coordination upon discharge.

Assertive Community Treatment

The Assertive Community Treatment (ACT) model is an evidence-based approach for adults with serious mental illness. ACT is distinct from many other service delivery approaches in its use of a multidisciplinary team with small caseloads that shares responsibility for the care of one client across the entire team. The ACT team is persistent in engaging clients in services. The program makes available peer support services, individual and group therapy, psycho-education and skills-building groups, medication follow-up, and coaching and mentoring to deal with day-to-day challenges. Crisis and emergency services are also available 24/7. A key component of ACT is a focus on special populations such as the Criminal Justice Involved and the homeless. All of the CMHCs in Region 1 offer ACT.

Recovery Services

All Region 1 network CMHCs provide Peer-based recovery Services. Over the past decade a growing number of recovery-focused organizations have pioneered the development and delivery of peer recovery support services for people seeking to achieve or sustain long-term recovery from mental health and SUDs. These services contribute to enhanced recovery for individuals and families by linking professional treatment with organized communities of support. Peer-based recovery support is the process of giving and receiving nonprofessional, non-clinical assistance to achieve long-term recovery. This support is provided by people who have experienced and recovered from behavioral health issues and now assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

Peer recovery support services can be delivered across the full continuum of recovery, regardless of whether or not a person uses clinical treatment services. They can be offered before individuals enter treatment, when they are waiting for a service opening, or while they are in treatment, and therefore providing a connection to community. Following treatment, peer recovery support services help people manage their own recovery by developing skills and resources, as well as helping Members find volunteer work or other work to further enrich their recovery. Peer support programs are an important mechanism for increasing individuals' self-efficacy belief and decision-making capabilities. Evidence shows that seeing or visualizing those similar to oneself successfully performing activities typically increases a person's belief in his or her own ability to perform those activities successfully.

Respite Services

Respite care is provided as part of the Crisis Services program and is offered by all Region 1 CMHCs for adults or children/youth who need temporary care at any given time to allow their caregivers time away to replenish the resources needed to care for their family members with an emotional disorder or mental illness. Respite is provided in a variety of settings including caregiver homes and outpatient program locations, as well as residential facilities. Activities include supervised recreation, therapeutic activities, and behavior management. Respite providers include a range of credentialed staff specially trained to work with individuals who have mental health needs and their caregivers. As with other services, CMHCs provide respite services in the context of a comprehensive service plan. Respite services may be identified within an initial service plan, a discharge or step-down plan from inpatient or residential care, a crisis plan, or a wrap-around plan.

Respite care allows adults to stay for up to 14 days and children for two consecutive nights to receive counseling, medication management and support for families and caregivers. Child-specific respite services specialize in supporting the family in its efforts to care for the child and in developing a multi-generational, in-home treatment plan

In compliance with Department requirements, the Partners will regularly evaluate the effectiveness of the 1915(b)(3) Waiver services throughout the term of the contract. Suggested changes will be proposed to the Department for approval prior to implementation. The Partners will submit the 1915(b)(3) Waiver services Report quarterly and will follow all Department regulations for the report.

Appendix B – Letters of Support

LETTERS OF SUPPORT FOR ROCKY MOUNTAIN HEALTH PLANS AND REUNION HEALTH

Name of Entity Expressing Support
A Kidz Clinic
Castle Valley Children's Clinic
Center for Independence (CFI)
Colorado Cross-Disability Coalition (CCDC)
Community Connections
Delta County DHS
Denver Health and Hospital Authority
Disabled Resource Services
Disabled Resource Services – Deaf Services Department (Deaf Community WorkGroup)
Foresight Family Physicians
The Fort Collins Youth Clinic
Gunnison Valley Family Physicians
Health District of Northern Larimer County
Karis, Inc.
Lake Fork Health Services District dba Lake City Area Medical Center
Mesa County Physicians IPA
Mesa County Public Health
Member Advisory Committee
MidValley Family Practice
Mountain Medical Center
North Colorado Health Alliance
Northwest Colorado Center for Independence (NWCCI)
Pediatric Associates of Northern Colorado
Pediatric Associates Prof., LLC
Pediatric Partners of the Southwest
Pediatric Partners Valley View
Pinon Project – Family Resource Center
Quality Health Network
Rangely Family Medicine
Roaring Fork SBHC
Rocky Mountain Family Physicians, P.C.
San Juan Basin Public Health
Signal Behavioral Health Network
Silverton School Telehealth Clinic
Southwest Area Higher Education Council
Southwest Center for Independence (SWCI)
Southwest Health System, Inc. (Southwest Medical Group)
Summit Community Care Clinic SBHC
Telluride Regional Medical Center

Name of Entity Expressing Support
UC Health - Ft Collins Family Medicine Residency Program
UC Health – Ft Collins Family Medicine Center
UC Health-Community Health Improvement Department
Ute Mountain Ute Health Center
Western Valley Family Practice, P.C.
Yampa Valley Medical Associates

A Kidz Clinic
360 E 8th Street
Delta, CO 81416
(970) 874-2753
akidzclinic.org

July 7, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of A Kidz Clinic, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

As an integrated school-based health center, partnerships with regional organizations are important to the success and well-being of the children and youth we serve. We work with RMHP in a variety of capacities in which they always deliver top quality care and support. The work provided by RMHP in this capacity is important and we fully support this partnership.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Joey Montoya Boese
Executive Director
joey.boese@deltaschools.com
970.874.2753

Castle Valley Children's Clinic

820 Castle Valley Blvd. Ste.204 New Castle CO, 81647
2615 Dolores Way Unit 103 Carbondale, CO 81623
970-984-3333 fax 970-984-0293

7/24/2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Castle Valley Children's Clinic, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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We work hard to improve the lives of our patients and to decrease health disparities in our community, and RMHP has been a long time partner in helping us achieve these goals.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Jo Ellyn Bradley

Castle Valley Children's Clinic

820 Castle Valley Blvd STE 204 N.C., CO 81647

970-984-3333

Center for
Independence

July 7, 2017

To Whom It May Concern:

I am writing to support the proposal of Rocky Mountain Health Plans for the bid to serve as the Regional Accountable Entity in Region 1 for the Accountable Care Collaborative 2.0.   I am the Executive Director of the Center for Independence, one of nine independent living centers in Colorado.   We are the Certified Independent Living Center that covers twelve counties on the western slope. Mesa County is our home office location with satellite offices in Montrose and Glenwood Springs. As a certified Center for Independent Living, we provide the five core services of

- Independent Living Skills Training
- Advocacy (systems and individual)
- Peer Counseling
- Information and Referral
- Youth and Nursing Facility Transition Services

We have had an excellent working relationship with Rocky Mountain Health Plans (RMHP) over the past few years during the phase one of the Accountable Care Collaborative.   We have seen RMHP support the needs of the disability community. For example, they have worked hard to establish increased access to care for the Deaf and Hard of Hearing communities in several ways.   They are supporting a local group of Deaf individuals who have created educational materials and held community events. They are working with us to help increase access to interpreters in Mesa County.   We are also aware that they are involved in a much-needed pilot program to provide behavioral healthcare to people with intellectual and developmental disabilities.

We have seen that RMHP care coordinators work closely with the medical providers in our community trying to provide better, more coordinated services to those most in need.   We are able to refer to RMHP care coordinators when the people we serve have problems.   We share consumers in the effort to assist with disability benefits, which require medical documentation, findings of disability status, treatment options, and long-term supports.

740 Gunnison Avenue ■ Grand Junction, CO 81501
970-241-0315 Voice & TTY ■ 970-245-3341 Fax ■ 1-800-613-2271

Assisting People with Disabilities Since 1982

We see RMHP as active members of the community we serve and are grateful for their presence. RMHP shares our value for real and meaningful client involvement and person centered care.

We have worked cooperatively with RMHP and will be delighted to continue and strengthen this relationship throughout ACC 2.0. If you have any additional questions, please feel free to contact me at 970-241-0315.

Sincerely,

Linda Taylor

Executive Director
Center for Independence
ltaylor@cfigj.org

740 Gunnison Avenue ■ Grand Junction, CO 81501
970-241-0315 Voice & TTY ■ 970-245-3341 Fax ■ 1-800-613-2271

Assisting People with Disabilities Since 1982

COLORADO
CROSS-DISABILITY
COALITION

1385 S. Colorado Blvd.
Bldg. A, Ste. 610
Denver, Colorado 80222
303.839.1775

July 10, 2017

To Whom It May Concern:

I am writing on behalf of the Colorado Cross-Disability Coalition (CCDC). We are the only statewide disability rights organization that is run by for people with all types of disabilities, to unequivocally support the bid of Rocky Mountain Health Plans (RMHP) for any region. It is my understanding that they are bidding for regions, 1, 4, and 6. CCDC has had an active partnership with RMHP since the inception of the Accountable Care Collaborative project.

RMHP has been focused on client outcomes and excellent customer service throughout the process. They have brought innovative client focused practices to the Medicaid population (such as my digital MD) and have been enthusiastic participants helping to solve unique Medicaid specific problems (such as the crisis program to assure people with Developmental Disabilities access to mental health care). Their care coordinators are the best in the state, particularly for those with high needs. They focus on doing what it takes to help their member. When they get involved with a case we do not hear "that is not my job" or "this is not in the contract." If the proper place to call is another entity, they will assist the client with making that connection rather than just sending a sick or confused person out to fend for themselves.

RMHP is a community partner in all senses of the word. Throughout their region, just the mention of their name brings credibility. They have earned a very high degree of respect throughout the Western Slope, including Southwest Colorado and in Larimer County. They have this respect because they are an excellent community partner and they listen to others, rather than dictating. They are members of their communities, not interlopers or temporary guests. Their deep roots give them an investment in their communities that are unparalleled.

RMHP has put real effort to assure that clients have a meaningful role on a micro and macro level. They promote person centered care, even when others object they focus on the client's best interest. They also have invested in building a strong member council. They are one of two RCCO's that actually supports a client to be a PIAC representative. The PIAC member reports to an active client council that has representatives from throughout the region. The client council is actively involved in RMHP initiatives, such as the Accountable Communities – and provides input on all projects and customer service in general. RMHP turns facilitation over to us as an advocacy organization, and has never suggested any filtering of the message. They invest in this council with a goal of continual development of client leaders to be involved in policy, communications and peer support throughout the region. They do not seek people that will sing their praises and do not spend time at the meetings talking at the council. They seek people that want to be leaders, they spend time listening and then act on feedback. They have supported subsets of clients to address pressing issues in their community. An example of this is their support of a group called *Bridging Communications*. This is a group of Deaf members (now in both Grand Junction and Fort Collins). The group has developed toolkits for providers, hosted trainings, and provided education for peers.

RMHP does the best job of any organization I have seen in balancing the need to support providers without losing the ability to hold them accountable. They have invested a lot in provider training, provider support, and more. During the latest issues with the HPE transition they spent hours coaching and supporting providers through the system. They worked with us to develop a quality disability cultural competence training, certified it for CEU for the providers, and then used evaluation to determine what additional training would be helpful. They also provided tools to providers such as model policies on interpreters, to help them comply with the law without giving "legal advice." They are not afraid to work with providers that are not performing and to speak honestly about shortcomings. They will do everything humanly possible to help errant providers improve their performance. However, if given the authority when push comes to shove, they will focus on the best interest of the client and the tax-payer. If a provider refuses to make necessary changes to get to reasonable outcomes, I do not see this organization as one that will continue to financially reward mediocrity or worse. Just as we want providers to meet patients where they are and work with a-strength based approach, we want RAE's to work with providers using a strength based approach and RMHP does this naturally. We must however, assure that the "accountable" part of the regional accountable entity is not lost. RMHP has always been an insurance company; they have not been a provider and are not going to over-sympathize. A great example has been their role in the mental health crisis pilot. They have helped show providers that it is not impossible to provide mental health care to clients with developmental disabilities that are in crisis. This has eluded our state for years.

We also need to make sure that we do not forget the "regional" focus. As a home town company, RMHP has always been respected on the Western Slope. When they were assigned Larimer County, they did not appear in the community in a heavy handed way, but instead got to know the local community, worked with leaders, supported local organizations, spoke with clients and advocates and became a part of the community. Coloradans do not respond well to large companies that bulldoze their way into a community without the cultural respect for that community. I have no doubt that they could be as effective in any community in Colorado.

RMHP excels at bringing people together and they have been able to do this in effective ways with decades of experience. They know how to get the right people to the right tables and are always eager to be a leader or participant (whichever is appropriate) in an effort to solve problems. As our health care system braces for uncertainty and as we as a state stand ready to reject austerity and embrace a strength based, inclusive approach, this organization has the capacity to play an essential role in ACC 2.0.

In closing CCDC would strongly endorse RMHP as our first choice in any region in Colorado.

If you have any questions feel free to contact me at 303-667-4216 or jreiskin@ccdconline.org.

Sincerely,

Julie Reiskin
Executive Director

www.CommunityConnectionsCO.org
281 Sawyer Dr., Ste. 200, Durango, CO 81303
Main office phone: 970.259.2464
Main office fax: 970.259.2618
cci@cci-colorado.org

July 6, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Community Connections, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

As the Community Centered Board for people with intellectual and developmental disabilities in Southwest Colorado, we serve a population of children and adults who frequently have complex medical and social needs. Our partnership with RMHP has helped our clients and other residents with disabilities coordinate care in a way that has resulted in better health outcomes. RMHP has been an engaged and respectful partner, and we would appreciate the opportunity to continue this relationship in the future through the ACC project.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me at tara@cci-colorado.org or 970-385-3443 if you have any questions regarding our support for this proposal.

Sincerely,

Tara Kiene

President/CEO

DELTA COUNTY, COLORADO

DEPARTMENT OF HUMAN SERVICES

William C. Lemoine
Director

July 10, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Delta County Department of Human Services, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

We have enjoyed a long and beneficial relationship with Rocky Mountain Health Plans. We appreciate the continuity such a relationship has provided for our clients and look forward to it continuing!

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Very truly yours,

William C. Lemoine
Director

cc

Susan Blaine	Debbie Melgoza	Leone Anderson
Child Welfare Administrator	Self-Sufficiency Administrator	Deputy Director, Adult Programs
560 Dodge Street	560 Dodge Street	North Fork Annex, 196 W. Hotchkiss Ave.
Delta, Colorado 81416	Delta, Colorado 81416	Hotchkiss, Colorado 81419
(970) 874-2030	(970) 874-2030	(970) 872-1000
(970) 874-2068 Fax	(970) 874-2068 Fax	(970) 872-1250 Fax

DENVER HEALTH

July 18th, 2017

Colorado Department of Healthcare Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear RAE Proposal Reviewers from the Colorado Department of Healthcare Policy and Financing,

Denver Health and Hospital Authority is pleased to offer our support to Rocky Mountain Health Plans in their bid to serve as a Regional Accountable Entity in Region 1 for the next iteration of the Accountable Care Collaborative (ACC), in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. It is our understanding that RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

As the largest provider of care to Medicaid patients in Colorado, Denver Health encourages collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of care to treat the whole person. Patrick Gordon has reached out to Denver Health regarding working together toward this end, and we believe the organization has the capacity and interest in accomplishing the goals of ACC 2.0.

We support a commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. Our understanding of the Partners' proposal is that it aims to achieve these goals. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative, and we are enthusiastic about the State's vision for the future of this program. We look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Peg Burnette, CPA, FHFMA
Chief Financial Officer
Denver Health and Hospital Authority

DISABLED RESOURCE Services
A CENTER PROMOTING INDEPENDENT LIVING

FORT COLLINS MAIN OFFICE
1017 Robertson Street
Fort Collins, CO 80524
(970) 482-2700 VOICE
(970) 449-6972 FAX

WWW.DISABLEDRESOURCESERVICES.ORG

LOVELAND BRANCH OFFICE
118 E. 29th Street, Suite C
Loveland, CO 80538
(970) 667-0816 VOICE
(970) 593-6582 FAX

July 7, 2017

To Whom It May Concern:

As the Executive Director of Disabled Resource Services (DRS), I support Rocky Mountain Health Plans' bid as the Regional Accountable Entity in Region 1 for the Accountable Care Collaborative 2.0. Disabled Resource Services is a state-certified Center for Independent Living that serves people with disabilities living in Larimer and Jackson counties. To that end, we provide five Federally mandated core services:

- Independent Living Skills Training
- Advocacy (systems and individual)
- Peer Support
- Information and Referral
- Transitions (nursing facilities to community living, youth to adulthood and nursing home diversion)

Other services include a durable medical equipment loan closet, Deaf and Hard of Hearing services, a Vision Matters After 55 program, housing voucher services, benefits counseling/application assistance and support to meet basic needs such as food, prescriptions, rent deposits, ramps and more.

DRS has enjoyed a strong, collaborative working relationship with Rocky Mountain Health Plans (RMHP) during phase one of the Accountable Care Collaborative. RMHP has advocated with us for people with disabilities resulting in improved medical care access for Deaf and Hard of Hearing individuals needing interpreters during medical appointments, exams and procedures. They have also supported a local group of Deaf individuals who created educational materials and held local forums to enlighten the medical community on ways to improve their services. DRS' Deaf Services Coordinator has worked closely with RMHP staff and credit is given to them for these gains made in our community.

RMHP care coordinators work closely with the medical providers in our community to improve coordination of services to those who are most in need. We refer people to RMHP care coordinators when our consumers have problems and know that they will help.

RMHP is an active member of our community and DRS is grateful for their presence because they share our values for real and meaningful consumer involvement in their own care. It is my hope to continue this already strong working relationship with RMHP throughout ACC 2.0. Please endorse them. If you have any questions, please contact me at 970.482.2700.

Sincerely,

Nancy Jackson
Nancy Jackson
Executive Director

United Way
United Way
of Larimer County

City of Loveland

City of Fort Collins

DISABLED RESOURCE Services
A CENTER PROMOTING INDEPENDENT LIVING

FORT COLLINS MAIN OFFICE
1017 Robertson Street
Fort Collins, CO 80524
(970) 482-2700 VOICE
(970) 449-6972 FAX

WWW.DISABLEDRESOURCESERVICES.ORG

LOVELAND BRANCH OFFICE
118 E. 29th Street, Suite C
Loveland, CO 80538
(970) 667-0816 VOICE
(970) 593-6582 FAX

July 6, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Disabled Resource Services Deaf Services Department, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. They have evolved a unique ability to let the organizations that they are partnering with shine and adopt the goals of partners as their own.

RMHP has helped with developing a peer support of our Deaf and Hard of Hearing community members in Larimer County by partnering with Disabled Resource Services. Having RMHP be a foundation, a strong group has resulted that is able to successfully advocate for accessible medical appointments, as well as other communication access needs. In turn, we are now helping the Deaf and Hard of Hearing community in the Western Slope develop their own strategy to advocate for accessible communication at medical appointments.

We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Jenny Miller, Deaf Services Specialist
Disabled Resource Services
1017 Robertson Street, Fort Collins, CO 80524
Phone: 970-581-2066 Email: jmiller8@frii.com

United Way
United Way
of Larimer County

City of Loveland

City of
Fort Collins

J. Dale Utt, D.O.

Gregory C. Reicks, D.O.

Heather Farmer, P.A.C.

Glenda Cain, F.N.P., B.C.

Kathleen Wilson, D.N.P., B.C.

BOARD CERTIFIED IN FAMILY PRACTICE

2503 FORESIGHT CIRCLE, GRAND JUNCTION, COLORADO 81505
(970) 242-2660 FAX (970) 242-0080

7/24/17

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Foresight Family Physicians,** I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Greg Reicks DO

Foresight Family Physicians

2503 Foresight Circle

Grand Junction CO 81505

7/24/2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of The Fort Collins Youth Clinic, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Larry Mortensen, MHA
Executive Director
Fort Collins Youth Clinic
lmortensen@youthclinic.com
970-267-6701

GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS
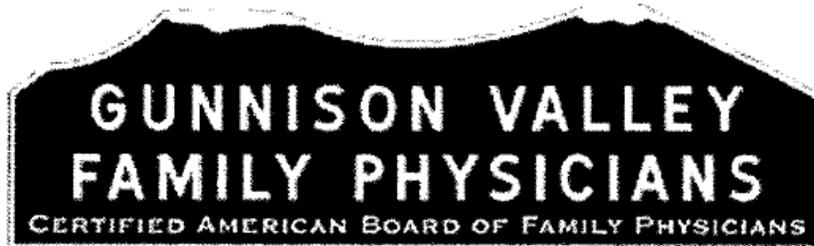
130 East Virginia Avenue, Gunnison, Colorado 81230
(970) 641-0211 [Phone] (970) 641-1268 [Fax]

Jay W. McMurren, M.D.
Board Certified in Family Practice

Lauretta F. Garren, M.D.
Board Certified in Family Practice

Laura A. Villanueva, M.D.
Board Certified in Family Practice

John E. Holder, PA-C
Physician Assistant

Nicol C. Talbert, PA-C
Physician Assistant

Bonnie Strickland, FNP
Nurse Practitioner

07/05/2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Gunnison Valley Family Physicians, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Thank you,

Barbara Rider
Practice Manager

July 11, 2017

Health District
OF NORTHERN LARIMER COUNTY

120 Bristlecone Drive, Fort Collins, CO 80524
970•224•5209   fax 970•221•7165
info@healthdistrict.org   www.healthdistrict.org

Dear RAE Proposal Reviewers from the Colorado Department of Health Care Policy and Financing,

Please accept this letter of strong support for Rocky Mountain Health Plan's proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health.

The Health District has helped to convene and facilitate the local MACC (Medicaid Accountable Care Collaborative) of Northern Larimer County's Oversight Committee for the past six years, since the beginning of the RCCOs. As a result, we have extensive experience working with Rocky Mountain Health Plans (RMHP), Salud Family Health Centers, and SummitStone Health Partners, all of whom we anticipate to be highly committed to the ultimate success of the new, more integrated, RAE approach.

Since 2011, the key players in the local Medicaid Accountable Care Collaborative have worked exceptionally hard to build a unique collaborative care coordination system that includes both physical and behavioral health professionals. Participants have included RMHP, Salud, SummitStone, UCHealth, and the other two major Medicaid primary care provider entities in our community, Family Medicine Center (the residency program connected to Poudre Valley Hospital) and Associates in Family Medicine (the largest local private group of primary care providers). Participants have pooled funding to create an innovative trans-disciplinary care coordination approach to better address the significant needs of those who need moderately intensive to intensive care coordination, and to achieve better health outcomes.

All participants have indicated their strong commitment to continue to develop the best possible integrated innovations to improve the system's ability to effectively address the health care needs of members. Their experience together has allowed them to focus in on those areas where change is most needed, and though they are aware that there is still much to be done, they are already well into tackling the challenges.

Our community has felt lucky to have had the opportunity to work with Rocky Mountain Health Plans as our RCCO. RMHP brings an extraordinary mix of characteristics: strong commitment to the health of the population of its members, support and encouragement of flexibility locally so that approaches are responsive to realities that differ from community to community, a robust and highly useful data component that helps us focus in on our population's particular needs, detailed understanding of impending changes and best practices, attention to approaches useful to providers, and a laser focus on how best practices can innovatively be developed for true continual improvements.

The members of the Oversight Committee regularly comment that they appreciate RMHP's continuous involvement and commitment to our community; they attend meetings regularly, provide important information, are problem-solving partners, and make sure the respective approaches of the parties involved fit together well. Working together, all the partner organizations are a creative force that has made significant improvements to care, and anticipate much more progress in the future.

From what we have observed and heard, it would be hard to find a better RAE than RMHP. In fact, local partners have expressed strong concern if our momentum were to be stopped at this point. We hope you will give them your most serious consideration; please don't hesitate to contact me if you wish.

Sincerely,

Carol Plock
Executive Director

July 10, 2017

Colorado Department of Healthcare Policy and Financing
1570 Grant Street
Denver, CO 80203

To the Colorado Department of Healthcare Policy and Financing:

On behalf of Karis, Inc. (a Mesa County non-profit serving runaway and homeless youth), I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky has historically been a major support for Karis, Inc. and the over 200 unduplicated runaway and homeless that in Mesa County. Laurel Walters (Rocky's Chief Operating Officer) serves on our board of directors, our data and program evaluation are done by a current Rocky analyst, and each year Rocky staff members buy holiday gifts for our youth. Karis Inc. is excited about our new partnership with the Partners as we work to develop supportive housing in Mesa County. Rocky and Mind Springs Health have committed to funding a .75 FTE community mental health worker to support our Project Based Voucher application to the Department of Local Affairs. Karis, Inc. looks forward to working with RMHP in the future to better serve the homeless population in Mesa County.

Karis, Inc. has also worked closely with Mind Spring Health to design and develop our "Widely Integrated Mental Health Program" that provides mental health serves to youth in the community and works to break down traditional barriers to services. The outcomes of this program are profound with youth showing statistically significant decreases in depression and anxiety. We look forward to partnering with Mind Springs Health and Rocky to develop integrated services for Members living in supported housing.

PO Box 2837 • Grand Junction, CO 81502 • (970) 234.1810 • www.karisinc.org

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

John Mok-Lammé
Executive Director - Karis, Inc.
(970) 234 -1810
jmoklamme@karisinc.org

LAKE FORK HEALTH SERVICE DISTRICT dba
Lake City Area Medical Center
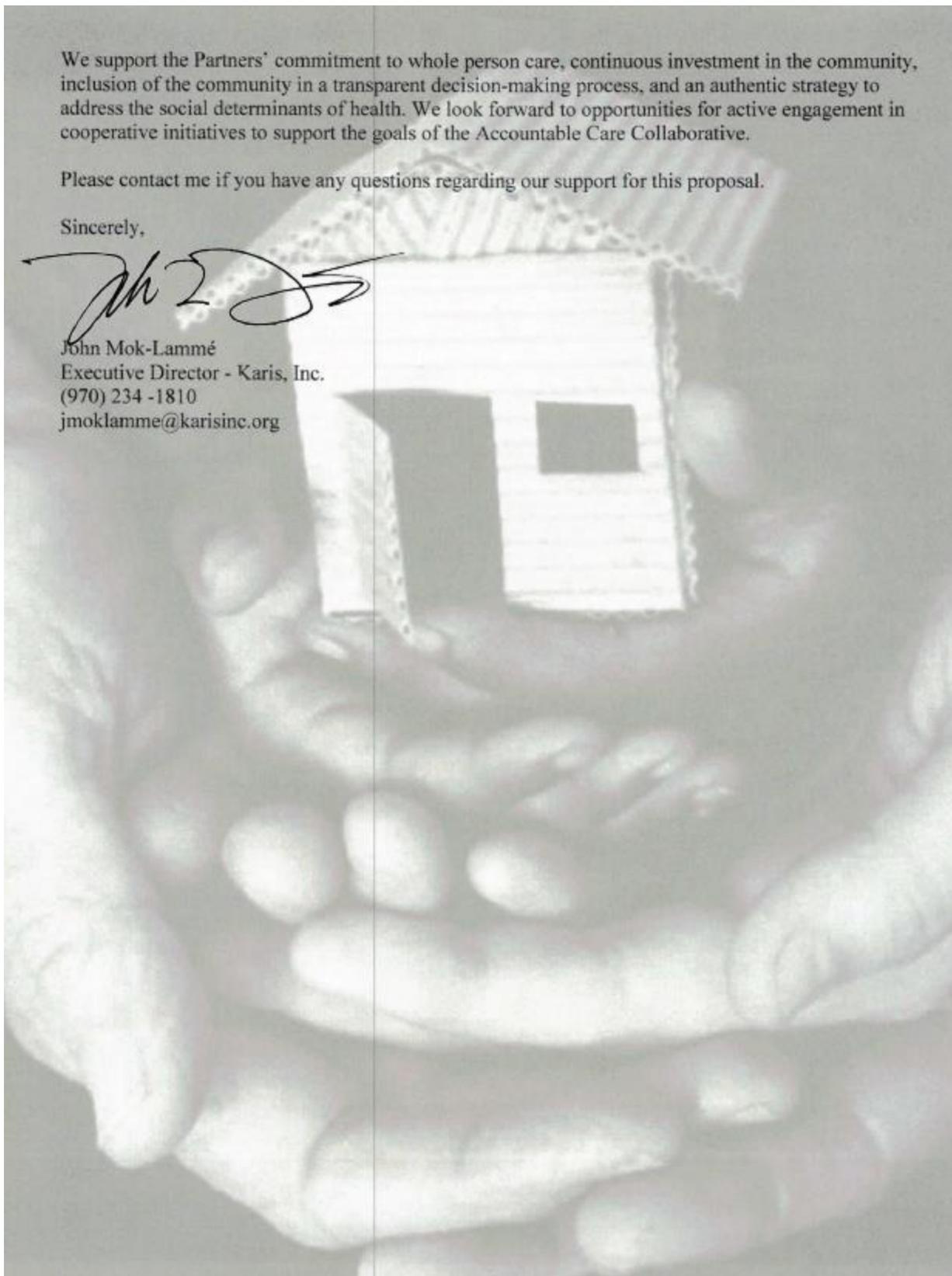
July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Lake Fork Health Service District dba Lake City Area Medical Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Jessica Whiddon
Business Manager

700 North Henson Street - PO Box 999, Lake City, CO 81235 - Phone: 970-944-2331 - Fax:
970-944-2320
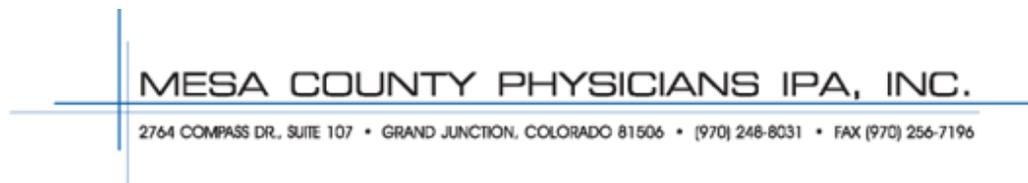
MESA COUNTY PHYSICIANS IPA, INC.

2764 COMPASS DR., SUITE 107 • GRAND JUNCTION, COLORADO 81506 • (970) 248-8031 • FAX (970) 256-7196

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Mesa County Physicians IPA, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Mesa County Physicians IPA has a corporate mission of physicians cooperating to deliver high quality health care to our community. We have been able to do this effectively as a result of our partnership with Rocky Mountain Health Plans.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Korrey Klein, M.D.

President, Mesa County Physicians IPA

Physicians Cooperating To Deliver High Quality Health Care To Our Community.

MESA COUNTY PUBLIC HEALTH
Working Together for a Healthy Community

P.O. Box 20,000
Grand Junction, CO 81502-5033
(970) 248-6900
www.health.mesacounty.us

July 24, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Mesa County Public Health, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA," which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations, and communities they serve.

Our mission, to *maintain and improve health through assessment of community health status, policy development to support effective programs, and assurance of high quality, effective education and service,* is the driving force behind our programming and community collaborations. The RAE is a perfect example of a collaboration that will positively impact the health outcomes of our community.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me at (970) 248-6974 if you have any questions regarding our support for this proposal.

Sincerely,

Jeff Kuhr, PhD
Executive Director

To Whom It May Concern:

We are writing to support Rocky Mountain Health Plans (RMHP) bid to continue in region one as the Regional Accountable Entity. We support RMHP bid in any other part of the state as well. Our experience with RMHP is direct as we are the member advisory council for the RCCO.

We have been working with RMHP since October of 2015. We feel strongly that as Medicaid clients we have a unique perspective that needs to be considered during program design, implementation and evaluation. We have unique abilities to be able to understand how clients may view communications, and also are the "eyes and ears" and share the community perception with RMHP.

We have been invited to participate beyond the council. We have a member that attends the PIAC. We have a member that is part of the Steering Committee of the Accountable Communities Project. We have a member that has been attending the MMP advisory council. We have been able to give input on several programs including "My Digital MD" and the "Crisis Project" that addresses the known gap in services for people who have Developmental Disabilities and behavioral health needs. We have a process for feedback when we make recommendations to assure that there is always a response. We have also met with providers in the area to have honest discussions about barriers and to try to figure out solutions. We even met with a Deputy Director of HCPF.

Our advisory council is an ongoing process of improvement. We are never silenced, they are genuinely happy to have our input, and they invest adequate resources in terms of staff and preparation to make this work for us as members. We receive ongoing training on various issues as well. We are supported to do activities in our local communities as desired.

Most important, we feel heard and believe that because of our relationship with RMHP that they understand disability cultural competence and the overall client experience in a way that cannot be easily replicated. We would hate to see our hard work and the progress we have made be halted with a different contractor. RMHP has trust in our community and we continue to do outreach as a team. If you have any questions please reach out to us at: rmhp-cac@googlegroups.com

Sincerely,

Karyn Anderson
Jason Armstrong
Rochelle Broughton
Ed Butler
Candice Chappell
Ian Engle
Henry Grater
Tim Hudner
Rochelle Larson
Ellinda McKinney
Kelly Parker
Ken Sapp

MidValley Family Practice

1450 E Valley Rd Suite 102 * Basalt, CO 81621
(970) 927-4666 phone * (970) 927-6623 fax

07/21/2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of MidValley family Practice am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

MVFP is working to increase access to care for many rural Coloradans regardless of their insurance. With the help of RMHP we are gaining ground.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Kristin Boronski
Midvalley Family Practice
Practice Manager

1

Mountain Medical Center

A Limited Liability Company

07/24/2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Mountain Medical Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Over the past three years, Mountain Medical Center has worked closely with RMHP and their Practice Transformation team and programs in order to continually improve our processes and patient communication and outreach. We are always looking for ways to learn and grow and better serve our patients, and RMHP has been a key support component for us in this journey.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Josephine Scoville
MMC Administrator & Practice Manager
jscoville@ridgwaymountainmedical.com
970.626.7007

295 Sherman St. • Ridgway, CO 81432 • Phone: 970-626-5123 • Fax: 970-626-9783
www.ridgwaymountainmedical.com

North Colorado Health Alliance

July 19, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of the North Colorado Health Alliance, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

The Alliance is a formal collaborative established in 2000 to improve access to quality, affordable, integrated health care while working to address the social determinants of health and assist northern Colorado communities in becoming the healthiest region in the healthiest state in the nation. The Alliance and our provider partners have worked closely with RMHP as the historic RCCO for Region 1. Together we've contributed our collective wisdom and collaborative operations to achieve better care and better health outcomes.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

2930 11th Avenue, Evans, CO 80620 · 302 3rd Street SE # 150, Loveland, CO 80537
Phone: 970.350.4673 · Fax: 970.350.4696
northcoloradohealthalliance.org

NCHA
North Colorado Health Alliance

Please contact me if you have any questions regarding our support for this proposal.
Sincerely,

Mark E. Wallace, MD, MPH, CEO/CMO

northcoloradohealthalliance.org
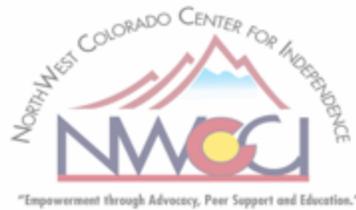
Ian Engle, Executive Director

To Whom It May Concern:

I am writing to support the proposal of Rocky Mountain Health Plans for the bid to serve as the Regional Accountable Entity in Region 1 for the Accountable Care Collaborative 2.0. I am the Executive Director of the Northwestern Colorado Center for Independence. We are the Certified Independent Living Center that covers Rout and Moffat Counties (CORRECT OR ADD) and the surrounding communities. As a certified Center for Independent Living we provide the five core services of

- Independent Living Skills Training
- Advocacy (systems and individual)
- Peer Counseling
- Information and Referral
- Transition Services

We also provide medical and non-medical transportation and engage in activities to assist consumers in pursuing identified goals for achieving freedom from isolation. We have an excellent working relationship with Rocky Mountain Health Plans (RMHP) over the past few years during the phase one of the Accountable Care Collaborative. I personally serve on the member advisory council, both as the Executive Director of a rural center and as consumer that uses the Medicaid Buy-In Program for Working Adults with Disabilities. As a person with a disability who is on the Medicaid Buy-In program, I am the Region 1 client representative on the Program Improvement Advisory Council. I have not seen most of the other RCCO's support a client member to participate and I hope this changes during ACC 2.0. We have seen RMHP support the needs of the disability community. We have worked with RMHP on outreach in our community and care coordinators to assist individuals in solving challenges with access to healthcare services. We appreciate the RMHP has listened to our community, understands and supports our desire for true independence and whole person care.

RMHP care coordinators work with medical providers in our community in the interest of better, more coordinated services. We often refer people seeking assistance with accessing healthcare services to RMHP care coordinators. We see RMHP as active members of the community we serve and are grateful for their presence. RMHP shares our value for real and meaningful client involvement and providing person centered services. We have worked cooperatively with RMHP and will be delighted to continue and strengthen this relationship throughout ACC 2.0. If you have any questions please feel free to contact me at (970) 871-4838 or ian@nwcci.org.

Signed,

Ian Engle, Executive Director

Empowerment through Advocacy, Peer Support and Education

1306 Lincoln Ave Suite A, Steamboat Springs, Colorado 80477
PO Box 771475, Steamboat Springs Colorado 80487
970-871-4838 Phone• 970-871-4841 Fax

![Pediatric Associates of Northern Colorado logo and letterhead: 1330 Oakridge Drive | Fort Collins, CO 80525 | p 970.484.4871 | f 970.482.4927 | www.pediatricassociatesnc.com]

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Pediatric Associates of Northern Colorado. I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Crystal Peterson
Practice Manager
Pediatric Associates of Northern Colorado
Office: 970-484-4871
Fax: 970-482-4927
crystal@pediatricassociatesnc.com

Pediatric Associates *Prof, LLC*

THOMAS D. WIARD, M.D.
MARY L. VADER, D.O.
ROMEO G. ICASIANO, M.D.
GREG SUCHON, M.D.
LIBA HARDEKOPF, M.D.
TEAL WARTHEN, D.O.
SCOTT SEMONES, CPNP
LAURA SCHLEY, PA-C
ELIZABETH BROWN, FNCP
RACHEL ANTHONY, CPNP

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Pediatric Associates Prof., LLC, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health (RH), an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers. RMHP and RH will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Pediatric Associates Prof., LLC's mission is to provide the highest quality care to all children zero to twenty-one years of age. Pediatric Associates history with RMHP throughout the years has been about helping clinics to be efficient, provide standards of care and improve the quality of care. This has been valuable to the Western Slope and surrounding areas. Without organizations like RMHP who value patient outcomes as a whole and reflect that knowledge and experience back to clinics to improve patient experiences Pediatric Associates would not be the clinic we are today.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Amber Hickert
Pediatric Associates Prof., LLC
Amber-peds@bresnan.net
970-249-2421

947 S. FIFTH ST.
MONTROSE, CO 81401
(970) 249-2421
FAX: (970) 249-8897

242 COTTONWOOD ST., SUITE 101
DELTA, CO 81416
(970) 874-7552
FAX (970) 874-7554

Pediatric Partners
OF THE
SOUTHWEST

Kim Caruso, MD • M. Cecile Fraley, MD • Brenda Huffman, MD
Amy Hurley, MD • Aimee Jacoby, PA-C • Betsy Kastak, CPNP • Jessica Marsh, MD
David MacLaurin, MD • Heidi McMillan, MD • Kelly Miller, MD • Savannah Porter, PA-C

7.10.2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Pediatric Partners of the Southwest (PPSW)**, Durango, CO we are thrilled to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health. Reunion Health (RH) is an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (RMHP-RH) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. Their collaborative approach with providers and communities has resulted in innovative and effective care for underserved populations. RMHP's work helps physicians to *create the future* -- with supports that meet the demands innovative practices grounded in their own communities need. Our partnership with RMHP has allowed us to create our PPSW Integrated Behavioral Health Program tailored to our rural southwest region. This program has served as a foundation for the development of our pediatric medical home trauma informed practice and a model for team based care including a care coordinator, medical nurse navigator, and Registered Dietitian. These building blocks allowed us to leverage our experiences into our specialty telemedicine partnerships and local school based health efforts.

In our experience RMHP demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational culture which enables it to partner creatively with a diverse array of community organizations and medical practices, and continuously learn from and grow within those partnerships. They have the unique ability to recognize the goals of partners as their own and allow western slope regions to "problem solve locally". RMHP routinely makes a big difference in the success of the people, organizations and communities they serve, including our own.

810 East 3rd Street, Suite 301 • Durango, CO 81301

970.375.0100 phone • 970.375.9210 fax
The names you know, the care you trust

These successes include smarter payment models, data sharing and analytic support, integrated behavioral health and the community "backbone" resources required to address the social determinants of health. RMHP has been a tremendous support as PPSW has worked to address gaps in behavioral healthcare with our local BHO, Axis Health. RMHP's attention to local Colorado communities is well-aligned with the Department's vision for Colorado Medicaid, but their ongoing, bold commitment to innovation and improvement in partnership is what sets them markedly apart from other competitors for the RAE regions. There is no other regional organization, with the innovative tools and *boots on the ground* positive relationships, that is as well positioned as RMHP-RH to support the phase two goals of the Accountable Care Collaborative.

We have partnered closely with RMHP for many years and feel confident in expressing full support for the continuation of the RMHP commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We firmly believe that having RMHP-RH continued and expanded representation of our RAE regions will greatly benefit our patients and our community.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

M. Cecile Fraley MD
CEO

PEDIATRIC PARTNERS

VALLEY VIEW

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Pediatric Partners of Glenwood, I am pleased to support Rocky Mountain Health
Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership
with Reunion Health, an integrated service delivery entity comprised of a comprehensive
network of Federally Qualified Health Centers and Community Mental Health Centers operating
throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint
Operating Agreement to maximize the clinical, operational, data and management integration
required to achieve ACC Phase 2 goals.

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communities for over forty years. More importantly, RMHP continuously demonstrates
transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP is
able to partner creatively with a diverse array of community organizations, and continuously
learn from and grow within those partnerships. They have evolved a unique ability to "put
themselves in the background" and adopt the goals of partners as their own. RMHP routinely
makes a big difference in the success of the people, organizations and communities they serve.

RMHP has been very involved in the practice transformation efforts of numerous practices
including ours. They provide resources, data and support as practices work to improve and
move to the next level in patient centered care.

We support the Partners' commitment to whole person care, continuous investment in the
community, inclusion of the community in a decision-making process, and an authentic strategy
to address the social determinants of health. We look forward to opportunities for active
engagement in cooperative initiatives to support the goals of the Accountable Care
Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Brian McGill
Director Pediatric Partners of Glenwood

PeopleCare.
That's Valley View.

VVH.ORG   1905 Blake Avenue, Suite 201 | Glenwood Springs, CO 81601 | TEL 970.947.9999 | FAX 970.947.9226

**THE PIÑON PROJECT
FAMILY RESOURCE CENTER**

212 W. Montezuma Ave • P.O. Box 1510
Cortez, Colorado 81321
(970) 564-1195 • Fax (970) 564-9011
www.pinonproject.org

July 6, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of The Piñon Project Family Resource Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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The mission of The Piñon Project is to provide comprehensive services to children and families in Montezuma and Dolores Counties. As such, we provide strength-based programming and services that focus on the whole person and family. We support community partners with the same commitment and recognize RMHP as one of our essential partners.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Kellie Willis

Kellie Willis

Executive Director

A United Way Community Partner

QUALITY HEALTH N·E·T·W·O·R·K®

Improving care through shared technology

QualityHealthNetwork.org

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Quality Health Network, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Quality Health Network (QHN) is a not-for-profit community partnership organized 13 years ago as a quality improvement collaborative. QHN has enjoyed a close working relationship with RMHP since our inception. We facilitate the availability of information to optimize the health of our communities while improving economic efficiencies and outcomes of care.

QHN unites more than 90 percent of the region's many disparate providers and healthcare facilities into a single "virtual" electronic system to facilitate the sharing and use of health data to improve health and healthcare. Participants include medical providers, behavioral health providers, public health as well as social and human service agencies.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Richard Thompson,
Executive Director

744 Horizon Drive, Suite #210 • Grand Junction, CO 81506 • 970-248-0033

Rangely Family Medicine
225 Eagle Crest Dr.
Rangely Co 81648
Clinic Manager: Tammy Dunker
Ph: 970-675-2237 Fax: 970-675-2759

07-21-17

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Rangely Family Medicine, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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At Rangely Family Medicine our mission is to continually improve the quality of life of the individuals and communities we serve. We strive to exceed customer and community expectations by committing ourselves to excellence and to the careful management of resources entrusted to us.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Tammy Dunker
Rangely Family Medicine
Clinic Manager
225 Eagle Crest
Rangely,Co 81648
PH: (970)675-4262
Fax: (970)675-2759

Roaring Fork School Health Centers

Keeping our students healthy and ready to learn.

July 10, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Roaring Fork School Health Centers (RFSHC), I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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RFSHC is one of the 50 school-based health centers in Colorado and our mission is to provide School-based Integrated Health and Wellness services to students of the Roaring Fork School District RE-1, thereby creating a healthy educational environment in which to learn and succeed.

RMHP has been instrumental for our sustainable model. We were one of the first school-based health centers that joined their Regional Care Collaborative Organization (RCCO) network and that entailed flexible and innovating thinking due to our very specific model of care. More recently, their strong leadership and vision through out the Colorado State Innovation Model (SIM) Initiative has been proven invaluable for the success of the 1st cohort of which we are part.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Haidith Ramirez-Leon
Program Director
hramirez@rfschools.com
Direct: 970-384-6060
Fax: 970-384-6069

Main Office: 151 E. Cottonwood Drive - Basalt, Colorado 81621 - 970.384.6054 – 970.384.6069 (FAX)
This School-Based Health Center is a collaborative effort between Roaring Fork School Health Centers and Rocky Mountain Youth Clinics

Rocky Mountain Family Physicians, P.C.

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Rocky Mountain Family Physicians,** I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Kari Bettermann, Assistant Administrator

[email address illegible]
1124 E. Elizabeth St., Bldg. C
Fort Collins, CO 80524
p: (970)484-0798 f: (970)482-0679

SAN JUAN BASIN
public health

July 6, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of San Juan Basin Public Health, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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San Juan Basin Public Health advocates for those who have multiple needs that cannot be met by a single clinician or by a single organization. We believe in providing access and guidance to those who face barriers to health care and resources and we support a community-wide approach to reducing those barriers.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,
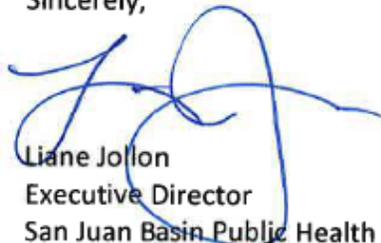
Liane Jollon
Executive Director
San Juan Basin Public Health

Performance-based solutions for behavioral health care

June 3rd, 2017

To Whom It May Concern:

Signal Behavioral Health Network is pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA," which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Signal, as a substance use disorder Managed Service Organization (MSO), provided the majority of publicly-funded SUD services to clients in this region in Colorado prior to Medicaid expansion. Since Medicaid expansion, it has been our goal to continue to provide access to services that are unavailable in the Medicaid benefit to Medicaid members.

Medicaid expansion allowed many more Coloradoans access to outpatient SUD services, but the entire continuum is not available in the benefit. Continuity of care is a critical gap for clients requiring SUD services. We are therefore encouraged to see the emphasis that Health Care Policy and Finance's Regional Accountable Entity RFP places on coordinating care between the RAE and MSO systems. The goal is to realize maximum opportunity for positive outcomes for consumers and an efficient use of State and Federal healthcare resources.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

We are looking forward to the opportunity to collaborate with RMHP to coordinate care and access to the

6130 Greenwood Plaza Blvd. Suite 150, Greenwood Village, CO 80111   Phone: 303.639.9320   www.signalbhn.org

Performance-based solutions for behavioral health care

entire continuum of substance use disorder services for Medicaid members, to ease the transition of patients entering and exiting Medicaid coverage, and to ensure that the process is seamless and is not disruptive to a patient's care.

Please feel free to contact me if I can provide further information. You can reach me at (720) 263-4858 or ddarting@signalbhn.org.

Sincerely,

Daniel Darting
Chief Executive Officer
Signal Behavioral Health Network

6130 Greenwood Plaza Blvd. Suite 150, Greenwood Village, CO 80111   Phone: 303.639.9320   www.signalbhn.org

Pediatric
Partners
OF THE
SOUTHWEST

Kim Caruso, MD • M. Cecile Fraley, MD • Brenda Huffman, MD
Amy Hurley, MD • Aimee Jacoby, PA-C • Betsy Kastak, CPNP • Jessica Marsh, MD
David MacLaurin, MD • Heidi McMillan, MD • Kelly Miller, MD • Savannah Porter, PA-C

As the Medical Director of Silverton Schools Tele-Health clinic, I am writing to offer my strong support of Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health. Reunion Health (RH) is an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (RMHP-RH) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. Its collaborative approach with providers and communities has resulted in innovative and effective care for underserved populations. RMHP's partnership with Pediatric Partners of the Southwest, which operates the Silverton Schools Tele-health clinic, has been fundamental in our ability to create a much-needed Tele-Health link with the frontier town of Silverton, CO, and develop our trauma-informed approach to the Medical Home.

In our experience, RMHP demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational culture which enables it to partner creatively with a diverse array of community organizations and medical practices, and continuously learn from and grow within those partnerships. They have the unique ability to recognize the goals of partners as their own and allow western slope regions to "problem solve locally". RMHP routinely makes a big difference in the success of the people, organizations, and communities they serve, including rural Southwest Colorado.

These successes include smarter payment models, data sharing and analytic support, integrated behavioral health and the community "backbone" resources required to address the social determinants of health. RMHP has been a tremendous support as PPSW has striven to address significant gaps in the delivery of behavioral health care by our local BHO, Axis Health. RMHP's attention to local Colorado communities is well-aligned with the Department's vision for Colorado Medicaid, but their ongoing, bold commitment to innovation and improvement in partnership is what sets them markedly apart from other competitors for the RAE regions. There is no other regional organization, with the innovative tools and *boots on the*

810 East 3rd Street, Suite 301 • Durango, CO 81301

970.375.0100 phone • 970.375.9210 fax

The names you know, the care you trust

ground positive relationships, that is as well positioned as RMHP-RH to support the Phase Two goals of the Accountable Care Collaborative.

We have partnered closely with RMHP for many years and feel confident in expressing full support for the continuation of the RMHP commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We firmly believe that having RMHP-RH continued and expanded representation of our RAE regions will greatly benefit our patients and our community.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Kim Caruso, MD
Medical Director, Silverton Schools Tele-Health
Pediatric Partners of the Southwest

Southwestern Colorado
AHEC
Area Health Education Center

pathways to health

701 Camino del Rio, Suite 316
Durango, Colorado 81301
(970) 426-4284

July 10, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Southwestern Colorado Area Health Education Center (SWCAHEC)**, I am pleased to give strong support to Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

The mission of SWCAHEC is to improve quality and accessibility of health-related education and community and public health programming for students, professionals, and community members. SWCAHEC has a special emphasis on serving underserved populations and on promoting collaboration with existing health resources while filling gaps that affect the health of the community. By working collaboratively with RMHP, we have significantly increased our community health impact. RMHP has been committed to working with us to improve and expand integration of quality healthcare delivery in our region through our program, *Care Coordination Central* (CCC), since its inception in 2013. As a member of the CCC advisory board, RMHP offered expertise and support in meeting CCC goals. In 2016, RMHP provided community integration funding to allow us to continue the work of supporting care coordination efforts across the region and at the same time, allow the CCC to remain autonomous.

I have had the opportunity to work with RMHP on initiatives since 2009 and support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. I look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative. Please feel free to contact me if you have any questions regarding our support for this proposal.

Sincerely,

Kathleen McInnis

Kathleen McInnis, RN, MS
Executive Director

SWCAHEC is an affiliate of the Colorado AHEC Program and the
University of Colorado Denver Anschutz Medical Campus.

University of Colorado
Anschutz Medical Campus

Southwest Center for Independence

07/05/2017

To Whom It May Concern:

Southwest Center for Independence (SWCI) supports the proposal of Rocky Mountain
Health Plans for the bid to serve as the Regional Accountable Entity in Region 1 for the
Accountable Care Collaborative 2.0. SWCI is the Certified Independent Living Center that
covers the Southwest part of Colorado, including the two Reservations. As a certified
Center for Independent Living we provide several core services, including

- Independent Living Skills Training
- Advocacy (systems and individual)
- Peer Counseling
- Information and Referral
- Transition from Nursing Facilities
- Transition from youth to adult lives in the community
- Diversion from Nursing Homes

We are expanding to provide medical and non-medical transportation thanks to generous
funding from the Colorado Health Foundation.

We have had an excellent working relationship with Rocky Mountain Health Plans (RMHP)
during the phase one of the Accountable Care Collaborative. RMHP supports the needs of
the disability community. Our employees and consumers with disabilities have been
supported to serve on the member advisory council. RMHP has supported three events
here to do outreach and training on Medicaid issues for people with disabilities. We
advised the trainers of the disability cultural competence training about issues unique to
the Four Corners. We are now working with RMHP to develop a pilot program to
empower our consumers to be part of making improvements in the behavioral health
system in our region. RMHP has listened to our community, and supports our desire for
true independence and whole person care. Their care coordinators work well with our staff
and the consumers we send them.

We have worked cooperatively with RMHP and will be delighted to continue and strengthen
this relationship throughout ACC 2.0. Please feel free to contact me at 970-903-5848

Sincerely,

Martha Mason
Martha Mason
Executive Director

People with disabilities providing supports & training for the disability & aging communities to live the lives they want in southwest Colorado.

DURANGO	CORTEZ	
3473 Main Avenue, #23	925 S. Broadway, #160	www.swindependence.org
Durango, CO 81301	Cortez, CO 81321	info@swilc.org
Phone (970) 259-1672	(970) 570-8001	Fax (970) 259-0947

July 21, 2107

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Southwest Medical Group I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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Southwest Medical Group is the major provider of care to residents of Montezuma County and is committed to developing a sustainable model of integrated health care for our community.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,
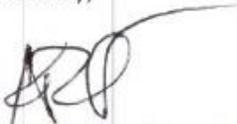
Ken Boucher, MS, MHS, CMPE
Southwest Medical Group
kboucher@swhealth.org

7-6-2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Summit community Care Clinic School Based Health Centers,** I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Erin Major

Erin Major
School Based Health Director
Summit Community Care Clinic
970.423.8831
970.333.1974
emajor@summitclinic.org
www.summitclinic.org

360 Peak One Drive #100 | PO Box 4337 | Frisco, CO 80443
Phone: 970-668-4040 | Fax: 970-668-6699
summitclinic.org

summit community
CARE CLINIC

July 6 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of **Summit Community Care Clinic,** I am pleased to support Rocky Mountain Health Plans'
proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion
Health, an integrated service delivery entity comprised of a comprehensive network of Federally
Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP
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inclusion of the community in a transparent decision-making process, and an authentic strategy to
address the social determinants of health. We look forward to opportunities for active engagement in
cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Erin Major

School Based Health Director
Summit Community Care Clinic
970.423.8831
970.333.1974
emajor@summitclinic.org
www.summitclinic.org

TELLURIDE
REGIONAL MEDICAL CENTER

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Telluride Regional Medical Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. It is my understanding that RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals. We support the direction that the Partners are taking for the Region 1 RAE.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

As we have worked with RMPH over the past years to develop our integrated care model in preparation of a Value Based Payment System, we believe that they are the best candidate for the Region 1 RAE.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,
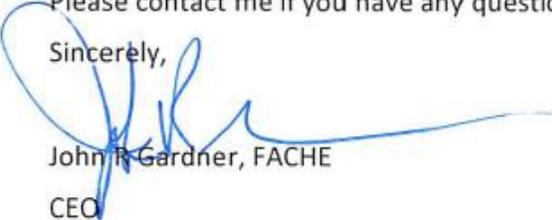
John R Gardner, FACHE
CEO

uchealth

Fort Collins Family Medicine
Residency Program

1025 Pennock Place
Fort Collins, CO 80524

O 970.495.8800
F 970.495.8891

uchealth.org

July 7, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of the Fort Collins Family Medicine Center and Residency Program, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

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The highly successful Medicaid Accountable Care Collaborative in Northern Larimer County, which has a team of multiple providers supporting intensive case management for the highest needs Medicaid clients in our region, with its grassroots origins and multiple highly engaged partners is a perfect example of such a collaborative effort which has benefitted our practice and our patients greatly. We are proud to have partnered with RMHP on this project and hope that we can continue to work with them in the new RAE for Region 1.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Janell Wozniak, MD
Residency Program Director
Fort Collins Family Medicine Residency Program
1025 Pennock Place
Fort Collins, CO 80524
O (970) 495-8855
F (970) 495-8891
Janell.Wozniak@uchealth.org

uchealth

Fort Collins Family
Medicine Center

1025 Pennock Place
Fort Collins, CO 80524

O 970.495.8800
F 970.495.8820

July 6, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Fort Collins Family Medicine Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data, and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Fort Collins Family Medicine Center has a dual mission to care for the underserved patients in Larimer County and to teach family medicine residents. Rocky Mountain Health Plans has been an excellent partner in our endeavors to work with the underserved community in Larimer County. In joint cooperation between Associates in Family Medicine, Salud and our clinic, Rocky Mountain Health Plans helped facilitate the formation of our MACC (Medicaid Accountable Care Collaborative) team. This team of care coordinators, social workers and nurse practitioners has been instrumental in providing quality, cost effective care in our region. Without the support of Rocky Mountain Health Plans in Larimer County, the negative impact to our community would be immeasurable.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Mark A. Schifferns, CPA
Director of Operations
Fort Collins Family Medicine Center
970-495-8819
mark.schifferns@uchealth.org

uchealth

UCHealth Community Health
Improvement Department

1025 Pennock Place, Suite 107
Fort Collins, CO

O 970.495.7537
F 970.495.7617

uchealth.org

July 5, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of UCHealth and the Community Health Improvement Department, we are pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP is uniquely qualified and committed to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved an exceptional ability to provide a functional platform and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

The mission of UCHealth is to improve lives and with a focused vision of "health care to health," we look for partners that effectively work with us so that together, we deliver the highest quality care for those we serve.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative. We support the past and current efforts by RMHP to remain engaged within our region.

Please contact us if you have any questions regarding our support for this proposal.

Sincerely,

Colette Thompson, Director
UCHealth Community Health Improvement
Colette.thompson@uchealth.org

Grace Taylor, Senior Director
UCHealth
Grace.Taylor@uchealth.org

INDIAN HEALTH SERVICE

UTE MOUNTAIN UTE HEALTH CENTER
P.O. BOX 49
TOWAOC, COLORADO 81334
(970) 565-4441
FAX (970) 565-4784

July 7, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Ute Mountain Ute Health Center, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have any questions regarding our support for this proposal.

Sincerely,

Lucy Lansing, Business Office Manager
P.O. Box 49
Towaoc Colorado 81334
970-565-4441 ext. 206

WESTERN VALLEY FAMILY PRACTICE, P.C.
REDLANDS AFTER HOURS
www.westernvalleyfp.com
281 N. Plum, Fruita, Colorado 81521   Phone (970)858-9894 Fax (970)858-1331
2237 Redlands Parkway, Grand Junction, Colorado 81507   Phone (970)243-1707 Fax (970)858-1331

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Western Valley Family Practice, I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

Western Valley Family Practice is a private, physician-owned practice in Western Colorado that serves both a rural and urban population. Our 6 physician practice has been actively involved in Practice Transformation efforts, starting with RMHP's "Foundations" program. We have participated in other state and national programs that have been administered, at least in part, by RMHP, including Medicaid Prime and CPC+. We feel RMHP is a leader and innovator with medical practices, including smaller practices such as our own.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Sincerely,

Korrey Klein, MD
Owner, Western Valley Family Practice

Yampa Valley
MEDICAL ASSOCIATES, P.C.

July 21, 2017

To the Colorado Department of Healthcare Policy and Financing,

On behalf of Yampa Valley Medical Associates, P.C., I am pleased to support Rocky Mountain Health Plans' proposal to become the Regional Accountable Entity (RAE) in Region 1, in partnership with Reunion Health, an integrated service delivery entity comprised of a comprehensive network of Federally Qualified Health Centers and Community Mental Health Centers operating throughout Region 1. RMHP and Reunion Health (the Partners) will implement a Joint Operating Agreement to maximize the clinical, operational, data and management integration required to achieve ACC Phase 2 goals.

Rocky Mountain Health Plans (RMHP) has contributed to the health and well-being of Colorado communities for over forty years. More importantly, RMHP continuously demonstrates transparency, flexibility, innovation and constructive irreverence for the status quo. RMHP has a rare organizational "DNA", which enables it to partner creatively with a diverse array of community organizations, and continuously learn from and grow within those partnerships. They have evolved a unique ability to "put themselves in the background" and adopt the goals of partners as their own. RMHP routinely makes a big difference in the success of the people, organizations and communities they serve.

We support the Partners' commitment to whole person care, continuous investment in the community, inclusion of the community in a transparent decision-making process, and an authentic strategy to address the social determinants of health. We look forward to opportunities for active engagement in cooperative initiatives to support the goals of the Accountable Care Collaborative.

Please contact me if you have questions regarding our support for this proposal.

Sincerely,

Matthew M Walton, MBA, CAPPM, EFPM
Practice Administrator, CFO
Yampa Valley Medical Associates, P.C.
(970) 879-3327 Phone
(970) 870-3499 Fax
mwalton@yvma.com

970-879-3327 • Fax 970-870-3499 • www.yvma.com
940 Central Park Drive, Suite 100, Steamboat Springs, Colorado 80487

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