COLORADO COMMUNITY HEALTH ALLIANCE

Regional Accountable Entity for the Accountable Care Collaborative

Technical Proposal

Region 6

RFP # 2017000265

CCHA, LLC dba Colorado Community Health Alliance (CCHA *Plus*)

The Colorado Department of Health Care Policy and Financing (Department)

Friday, July 28, 2017

Colorado Community Health Alliance | 1125 17th Street | Suite 1000 | Denver, CO | 80202 | 303.256.1717 | CCHAcares.com

July 26, 2017

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

Re: Response to RFP# 2017000265 for the Regional Accountable Entity for the Accountable Care Collaborative

Ms. Rapp:

CCHA, LLC dba Colorado Community Health Alliance is pleased to submit our response to **RFP# 2017000265 for the Regional Accountable Entity for the Accountable Care Collaborative.** For the purpose of this response, we will reference CCHA, LLC as CCHA *Plus*.

CCHA, LLC intends to bid on Regions 3, 6, and 7.

CCHA, LLC is an equal partnership established solely to promote the physical and behavioral health of ACC Members. Our foundation is CCHA, a peak performing RCCO with deep local roots including local primary care doctors, specialists and the largest hospital system in Colorado. To CCHA, we add Anthem, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. CCHA *Plus:* one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.

Per RFP Sections 4.3 and 4.4, our proposal package includes five (5) USB flash drives containing the following:

- *Technical Proposal*
- *Additional Attachments*
- *Confidential Ranking List*
- *Ownership/Controlling Interest*

Our proposal package also contains one (1) USB flash drive containing *Financial Information*, and one (1) USB flash drive containing *Confidential/Proprietary information*.

If you have any questions or would like to discuss our proposal, please contact me by phone at (720) 612-6744 or via email at Elizabeth.Baskett@cchacares.com.

With warm regards,

Elizabeth Baskett

Elizabeth Baskett
Executive Director, State Programs

Technical Proposal

COLORADO COMMUNITY HEALTH ALLIANCE

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Executive Summary

COLORADO COMMUNITY HEALTH ALLIANCE

EXECUTIVE SUMMARY

The Executive Summary must be factual and shall succinctly cover the core aspects of Offeror's staffing, methodologies and approaches to fulfill the Statement of Work within the solicitation. The name, phone number and email address for the Offeror's contact person for the Offeror's proposal. Also include the Offeror's CORE VSS number in the Executive Summary.

***CCHA Plus** is an equal partnership established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA *Plus* is much more than just the combination of a Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO). CCHA *Plus* is one organization, with one staff, one IT platform, and one goal: To successfully integrate physical and behavioral health while realizing the Colorado Department of Health Care Policy and Financing's (Department) vision to improve access and outcomes for Colorado Medicaid Members while supporting sound fiscal stewardship of scarce resources.

As our proposal will demonstrate, CCHA *Plus* has the local flavor, the talented team, the behavioral health integration expertise, the PCMP and behavioral health networks, and the expertise to grow with the Department as the Accountable Care Collaborative (ACC) Program advances.

The CCHA in CCHA *Plus*

CCHA, as an incumbent RCCO in Colorado, is the foundation of the new CCHA *Plus*. CCHA was formed in 2010 by bringing together the local expertise of:

- **Centura Health** — the largest hospital system and specialty Provider Network in Colorado
- **Physician Health Partners (PHP)** — a local management services organization known for their Care Coordination and practice quality improvement programs
- **Primary Physician Partners (PPP)** — a large group of local, independent primary care providers

Provider Testimonial

As a practice with multiple locations throughout the Denver metro area, our patients come to us from a variety of RCCOs throughout the area and we work regularly with multiple organizations. Our work with CCHA has truly been invaluable. The help and resources our patients and our office receive from other RCCOs throughout the area is quite frankly nonexistent and disappointing. I truly hope we will have the opportunity to continue the work we have begun with CCHA in the years to come.
Brian Gablehouse, MD, FAAP, Owner, Peak Pediatrics

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CCHA has delivered improved health outcomes, better managed care, and smarter use of State resources while serving as the RCCO for Region 6. CCHA has been a peak performer in the ACC and counts many successes working with Members, Network Providers, the Health Neighborhood, and Community.

For the past 6 years, the CCHA part of the new CCHA *Plus* organization has remained agile, supportive, and innovative as they partnered with the Department to help the ACC keep up with the ever-evolving health care system. Projects such as the Medicare-Medicaid Program, ePCMP, the State Innovation Model (SIM), the Colorado Opportunity Project, the Comprehensive Primary Care Plus (CPC+) initiative, and now the Primary Care Alternative Payment Model have kept CCHA consistently focused on working

with the Department toward more coordinated and integrated care for Members that increasingly rewards improved health outcomes.

As a RCCO, CCHA created a unique model specifically designed around the needs of Colorado Medicaid Members. CCHA has proudly served the Colorado Medicaid population with a history of strong performance outcomes, a large and established Provider Network, dedication to reinvestment in the community, and collaboration with the Department.

In 2016, CCHA saw a need to evolve along with the Department and the ACC Program to further enhance their services. ***They heard and strongly supported the Department's call to end the silos between physical and behavioral health, so they pursued a joint venture and formed a new organization with Anthem.***

The Anthem in CCHA *Plus*

Anthem has similar values to CCHA and also seeks to innovate within the Medicaid delivery system, making the best use of limited resources to drive value and realize integration. Anthem brings these values, innovative solutions, and experiences to CCHA *Plus.*

Anthem's significant experience managing integrated behavioral health includes serving Members who have complex physical, behavioral, and social support needs, such as those with serious and persistent mental illness (SPMI) and those with serious emotional disturbance (SED). ***Anthem received national recognition as an accredited Managed Behavioral Health Organization (MBHO) by NCQA,*** which demonstrates the success and proficiency Anthem brings to CCHA *Plus* across Quality Management, Care Coordination, Utilization Management, Credentialing, and Members' Rights and Responsibilities (all of which received scores of 100% on associated NCQA standards).

CCHA *Plus* will leverage Anthem's robust Medicaid behavioral health programs throughout the country, which use wraparound services for health, social, and alternative services, such as intensive case management, assertive community treatment, housing programs, peer support, and vocational services. CCHA *Plus* will also benefit from Anthem's extensive experience in managing 1915(b)(3) waiver services as well as their keen understanding of and experience in recovery and resiliency strategies. Anthem's programs have received many awards and industry recognition.

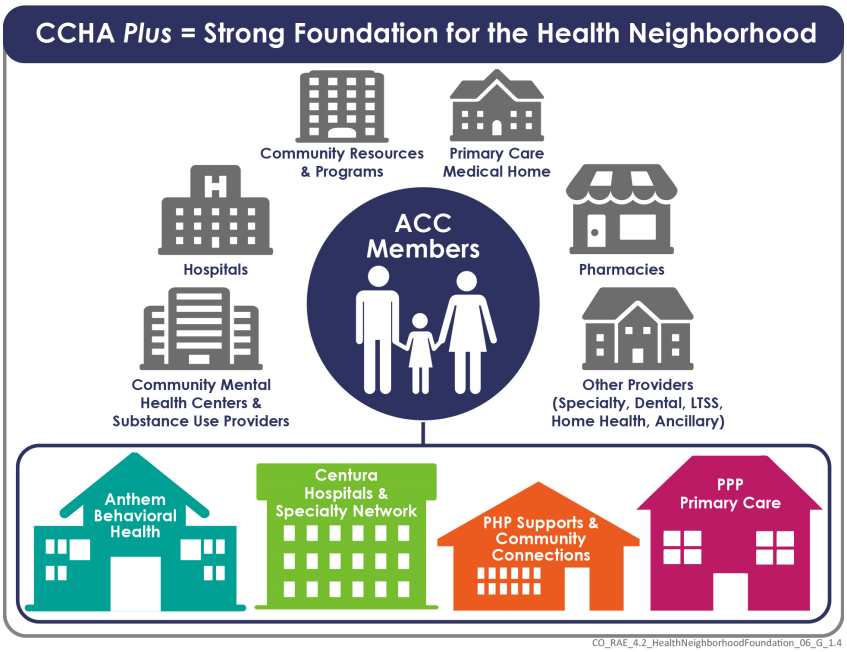
The PLUS in CCHA *Plus*

CCHA *Plus* is an equal partnership between Colorado Community Health Alliance, LLC (CCHA), and Anthem, Inc. (Anthem). We are excited by what this combination of knowledge, physical and behavioral health experience, and shared vision brings to the Department, and we look forward to an opportunity to serve as a RAE in Region 6. In the establishment of CCHA *Plus,* CCHA and Anthem have partnered under one roof to provide the unique and influential combination of Primary Care Medical Providers (PCMP), specialists, hospitals, and behavioral health services that lays the foundation for the Health Neighborhood and can deliver the value-based payment (VBP) models we need to create integrated, Team-based Care for ACC Members.

Throughout this response, CCHA Plus demonstrates our commitment, staffing, methodology, and approaches to serve Coloradans, to fulfill the Statement of Work, and to build healthy communities. We are thankful for the strong support of our Members, Health Neighborhoods, and Community in our bid to be a RAE.

A Fully Integrated Staffing Model

Our organizational and operational structure reflects our belief that health care solutions are most effective when developed and delivered locally while leveraging the vast national resources and expertise provided by our managing partners. Through our local and community-based staffing model, as well as our proven service operations delivery systems, our organizational structure gives us direct accountability to the Department, Colorado Medicaid Members, and Network Providers. Further, we focus on building a company culture and team of compassionate, collaborative employees who are committed to driving person- and family-centered care. ***Collectively, our organizations employ more than 23,000 Coloradans.***



Our staffing model will support a fully integrated RAE to meet all requirements outlined in the Statement of Work. Rather than simply combining resources on paper, we offer a truly integrated model so that services are seamlessly delivered to Members. The majority of our staff will share the same systems, offices, training, and structure. We believe all health care is local, and our structure assures that decision-making occurs at the local level. ***Our Care Coordinators, Practice Transformation Coaches, Network Relations Representatives, and Community Liaisons will spend 90% of their time in the communities meeting face-to-face with Members and Network Providers at primary care offices, hospitals, and other local establishments.***

Our local Colorado staff, including Key Personnel required in the Statement of Work, will be dedicated to day-to-day operations, management, and oversight of key functions. We will invest in our employees because they are our differentiator. We believe the quality of the services we provide is directly correlated to the quality of the personnel we hire. We take pride in the high-level talent within our organization. We will select employees for their role based not only on their technical skills but also, and just as importantly, for their dedication to innovative solutions for person- and family-centered care.

Our recruitment, interviewing, and hiring decisions will vet candidates to confirm they have the needed skills, credentials, education, and experience. We will offer employees a wide range of training to assure they understand the ACC Program, benefits, and populations served; acquire and develop skills and knowledge needed to perform their jobs in an exemplary manner; and continually meet our high organizational standards for excellence, ethical behavior, customer service, and timeliness. Most importantly, we will focus on hiring, retaining, and championing the professional development of employees who share our commitment to the communities we serve.

Methodology that Centers on Integration

As a RAE, CCHA *Plus* will bring more than 23 years of experience developing and integrating successful physical and behavioral health programs. We offer a range of programs, resources, and tools to meet the Department's goals for the next iteration of the ACC Program:

- 3.3.2.1 Join physical and behavioral health under one accountable entity
- 3.3.2.2 Strengthen coordination of services by advancing Team-based Care and Health Neighborhoods
- 3.3.2.3 Promote Member choice and engagement
- 3.3.2.4 Pay Network Providers for the increased value they deliver
- 3.3.2.5 Ensure greater accountability and transparency

Joining Physical and Behavioral Health Under One Accountable Entity (3.3.2.1)

We support the State's movement toward integration and the 5 critical success factors the Colorado Health Institute identified for implementing an integrated approach. We know that good mental health often equates to good physical health. With approximately 1 in 10 Coloradans reporting poor mental health in April 2015, and almost 20% needing behavioral health services at some point during the year[1], the necessity for integrated care is clear.

Including Anthem in our partnership brings new opportunity to the region to expand access to behavioral health care. As a RAE, we will seek to contract with all independent mental health and substance use providers available to serve Colorado Medicaid Members. We will include the Community Mental Health Centers (CMHC), leverage the services they provide, and collaborate closely with them in the Health Neighborhood. Independent behavioral health providers and Arapahoe House, the largest substance use provider in the State, will be treated equally alongside these CMHCs***. To truly address the behavioral health access issues in Colorado, all practicing behavioral health providers that meet the Department's standards must be recruited to participate in Medicaid and receive the support they need to serve Members and receive timely payments.*** CCHA *Plus* brings an exciting new opportunity to leverage Anthem's comprehensive experience building behavioral health networks in other Medicaid programs to help build a robust and integrated provider network statewide.

> We will not outsource our PH or BH program, which allows us to fully integrate PH and BH clinical staff.
>
> CO_RAE_PHBHProgram_12_COB_1.2

In addition, our integrated Care Coordination model will support delivery of seamless, integrated care to decrease fragmentation, improve service coordination, and meet the Member's identified health goals. We will not outsource our physical health or behavioral health program, which allows us to fully integrate physical and behavioral health clinical staff. Multidisciplinary teams of Care Coordinators will work together as a single unit to coordinate the delivery of integrated care. Our medical directors, service coordination directors and managers, and physical and behavioral health staff will discuss Member needs and develop real-time strategies and solutions to share with Members and their Network Providers.

Our community-based Care Coordination model supports Members across the full continuum of care delivery and in all life stages. Our integrated Care Coordination model will provide services that range from coordinating whole-person care in the community and patient engagement in the home, to fully co-located and integrated Care Coordination at Network Provider and community locations. We will also

[1] Colorado Health Institute, *New Models for Integrating Behavioral Health and Primary Care,* May 2015

collaborate with other agencies, Long Term Services and Supports (LTSS), and Network Providers to work as a community-based health team and avoid duplication.

CCHA *Plus* will drive the Health Neighborhood and Community towards a Team-based Care Coordination approach where each Member has a Lead Care Coordinator that coordinates behind the scenes with other team members, which may include PCMPs, behavioral health providers, and other Health Neighborhood providers like LTSS, as well as Community organizations like The Action Center or The Seniors' Resource Center to connect Members with services to address the social determinants of health. This integrated Care Coordination team will be established based on the unique needs and preferences of the Member and their family. We will work with the Member to set personal health goals. The CCHA *Plus* multidisciplinary Care Coordination team will work with providers and community organizations to adhere to the wishes of the Member when designating the Care Coordination team lead and encourage teamwork going forward to provide a more seamless experience for the Member.

Person-centered PH/BH Care Coordination improves new Member's health and quality of life

When Maria, our Care Coordinator, met new Member Eva, she knew Eva could benefit from our help. Eva has diabetes, weighs 650 pounds, and has an extensive history of physical and sexual abuse. She is unable to ambulate, living in her bed, and needs help with all activities of daily living. Her previous PCMP released her due to treatment non-compliance, and she had stopped outpatient mental health therapy.

Using motivational interviewing techniques, she listened to Eva's concerns and her goals for her mental health, weight loss, and quality of life. Maria arranged for a stay at a long-term acute facility for wound care and weight loss, and after 10 months, Eva's health and outlook had improved. She had lost 200 pounds, was reengaging with mental health services, and was ready to go home. And thanks to Maria's Housing First approach – stopping Eva's impending HUD apartment eviction – she returned home with PCMP home visits and home health services to continue on her path to better health and quality of life.

Anthem Member Centered

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In administering physical and behavioral health under one accountable entity, we can enhance the Member experience, identify underlying behavioral health needs of Members through whole-person care, identify and intervene for Members at risk for complications due to behavioral health and psychosocial needs, prevent exacerbations of behavioral health issues, and decrease costs by treating Members effectively and holistically.

Strengthening Coordination of Services by Advancing Team-based Care and Health Neighborhoods (3.3.2.2)

Traditional health care has been reactive and episodic, focused on solving the immediate issue rather than focusing on what it takes to keep people healthy. We support a collaborative, team-based approach and Health Neighborhoods so the Member consistently receives the services and supports to maintain health and wellness across his or her life stages. We will encourage Members to take care of themselves along the way and, with the Health Neighborhood, give them easy and convenient access to important checkups and screenings, education, information, and the supports they need.

By selecting CCHA Plus as a RAE, the Department will secure the foundation of the Health Neighborhood for the region with partnership and commitment of primary care, behavioral health, specialists, and the largest hospital system in the state. We are a partner to the providers and bring the relationships and expertise needed to help them continue to transform and evolve with the delivery system. Our vast relationships throughout the continuum of care and our experience bringing Medical Home services to wraparound primary and behavioral health care allows us to fill gaps quickly to get the Member the services they need. Our longstanding positive relationships and support of these providers

has opened the door to adding PCMPs for the ACC. CCHA as a RCCO has appreciated the provider resources that Centura Health has been able to add, including Centura Health specialists. Furthermore, they have responded to local community needs and filled in gaps in care for sparsely populated areas by bringing integrated primary care clinics to small mountain towns.

As a RAE we will count behavioral health and specialty providers, LTSS entities, hospitals, Non-Emergency Medical Transportation contractors, regional health alliances, Area Agencies on Aging, community-based resource organizations (such as food banks, shelters, and employment and job training centers), substance use disorder (SUD) providers, schools, faith-based organizations, community centers, and public health departments as our partners in providing a Health Neighborhood and a thriving Community for our Colorado Medicaid Members.

Integrating Hospitals

We understand very well that hospitals are an essential part of the health care delivery system. As a RAE, CCHA *Plus* will bring the commitment of **Centura Health** to participate in the region's Health Neighborhood. Centura Health, the largest hospital system in the state, brings many major hospitals in the Region and their vast specialty care resources to integrate with the ACC. With Centura Health as a partner, we bring the **Centura Health Physician Group** and **Centura Health's Urgency Centers** to ***expand access to much needed specialty care services, reduce unnecessary ER utilization, address super utilizers, improve care transitions, and engage in community efforts to promote the health and well-being of Members.***

We are excited about the opportunity the **Hospital Transformation program** offers to connect hospitals to Network Providers, the Health Neighborhood and Community, and align hospital incentives with the goals of the ACC Program. CCHA *Plus* will work with all hospitals in the region to help determine priorities for the program, and select projects, interventions, and performance goals.

In selecting CCHA Plus as a RAE, the Department acquires a high-performing RCCO with strong county and community partnerships, along with the largest hospital system in the state, to sit at the table and design a Hospital Transformation Program. In fact, Centura Health already has many partnerships with providers and the community that may be selected as integration projects for the Hospital Transformation Program.

Innovative & Collaborative

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Provider Testimonial

We are enthusiastic about the positive work CCHA and the ACC have accomplished and 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.
Peg Burnette, CPA, FHFMA, Denver Health

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We will continue to work closely with the Centura Health hospitals in Region 6: St. Anthony, St. Anthony North, Avista Adventist, and Longmont United. We will co-locate CCHA *Plus* Care Coordinators in the hospitals to reduce unnecessary ER utilization and coordinate with hospital care coordinators and discharge planners to improve transitions of care for Members. We will also continue our work with the other 28 hospitals located both inside and outside of our geographic boundary that serve Region 6 Members. As a RAE, we will seek to place more Care Coordinators in hospital settings and continue our work with key providers like Metro Community Provider Network, Denver Health, Clinica Family Health, Jefferson Center for Mental Health, and Mental Health Partners, as well as independent PCMPs, specialists, and LTSS partners to engage in Team-based Care and further integrate all hospitals into the delivery system. Several of CCHA's existing integration programs with these providers will lay the foundation for implementing the Hospital Transformation program in Region 6.

Centura Health Urgency Centers

Centura Health has implemented 7 urgency centers across Denver and the Mountain region. Members seeking emergency care are triaged to the appropriate level of care, avoiding unnecessary and expensive ER visits. While Members have the opportunity to receive ER care at the center, ***more than 70% of Members visiting these centers receive urgent care rather than ER care. This resulted in Members receiving the right care, at the right time and at the right place. CCHA Plus will promote these urgency centers with Members to encourage the appropriate care after hours in Region 6.***

Powerful Partnerships

CCHA *Plus* is proud to announce **two new Health Neighborhood partnerships** we will bring as a RAE.

Arapahoe House

As noted in the attached Letter of Support (Attachment 4.2-1), **Arapahoe House, *the state's largest substance use provider, is supporting CCHA Plus as a RAE*.** CCHA *Plus* is committed to improving the administrative experience for Arapahoe House, **reducing prior authorization bureaucracy,** including long wait times and limitations on critical services. Together we have committed to explore new opportunities to bring more providers into the statewide delivery system to provide much needed substance use services. Arapahoe House has a new and dynamic leadership interested in exploring opportunities to **co-locate substance use providers** in PCMP, hospital and other settings, as well as providing substance use services in non-traditional settings like community locations including shelters, county services buildings, or other locations. With CCHA *Plus*, the Department acquires new opportunities to **truly integrate substance use services** by embracing the significant value they can add to the ACC with support from Arapahoe House.

Provider Testimonial

As the largest substance use provider in the state, Arapahoe House needs the support of the RAE to expand access to critically needed substance use services to Medicaid Members. We believe CCHA brings a fresh opportunity to make the best use of state resources and collaborate with Arapahoe House and the Managed Service Organizations to connect Members with substance use services quickly and efficiently. We look forward to a more streamlined administrative process with CCHA for delivering these much-needed services. We are happy to participate in their Health Neighborhood Advisory to strengthen coordination among providers and the community and to make recommendations on how best to invest RAE incentive payments in the community.
Mike Butler, President/CEO, Arapahoe House

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Provider Testimonial

CCHA's approaches to building creative, effective collaborations to ensure whole-person care are well aligned with CHCO's work in engaging community partners to address social determinants of health. We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.
Annie Lee, Senior Director, Medicaid Strategies and Programs & Heidi Baskfield, Vice President, Population Health and Advocacy, Children's Hospital Colorado

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Children's Hospital of Colorado

CCHA *Plus* is also excited to announce a new partnership with **Children's Hospital of Colorado (CHCO),** a nationally recognized center for pediatric care. As a RAE, CCHA *Plus* will partner with CHCO to leverage their experience and expertise with serving children with complex and special needs and promoting the overall health and prevention services for the pediatric population. We will also increase efforts to integrate CHCO into the ACC Program. Specific opportunities, as detailed in OR 13, include **working with Network Providers to coordinate care for children treated at CHCO**. This includes the exciting new opportunity CCHA *Plus* brings for expanding access to behavioral health care, working with CHCO's School Nurse Program to **expand access to care in schools**, **integrating dental care in PCMP clinics** using CHCO's dental hygienists to establish dental programs within the clinics, partnering with CHCO on the **Hospital Transformation program,** and more.

Integrated Community Health Systems

As a RAE, we will pilot new approaches to propel ourselves into the next era of integrated community health systems, leveraging opportunities like the Accountable Health Communities grant, SIM, CPC+, and Colorado Opportunity Project to break down the silos between Medicaid, public health, and social services delivery systems. Our goal is to create a seamless experience for Members, where they are served by a lead Care Coordinator who consults with his or her multidisciplinary team of community service providers to connect the Member and family to the medical and non-medical services available to them.

We will collaborate with local organizations to maximize the resources available and deliver a comprehensive set of medical and non-medical services customized for each Member and family based on the Member's unique needs, health condition, life stage, and circumstances.

Promoting Member Choice and Engagement (3.3.2.3)

Member Choice

We will guide Member access to care and services through development and maintenance of a comprehensive Provider Network, including expanded access to behavioral health care, as well as self-direction of personal care and services that reflect the diversity, geographic location, and preferences of our Members. CCHA *Plus* will bring extensive experience in building and supporting physical and behavioral health provider networks. We will deliver a comprehensive Provider Network so that **Members have a choice from a full range of providers**, including providers with specialized training and expertise across all life stages, levels of health and ability, gender identities, and cultural identities.

Federally Qualified Health Centers (FQHC) will continue to be a critical part of the health care safety net delivery network. Their importance in filling the gaps is balanced by recognizing that they are not positioned to provide sufficient access to the changing Medicaid population.

As a RCCO, CCHA has experience building an urban-based Provider Network in Jefferson County and parts of Boulder and Broomfield counties. CCHA also supported the participation of smaller practices in two sparsely populated mountain communities, where they have successfully facilitated access to primary care and helped those practices apply Lean workflows to increase service capacity. CCHA successfully contracted with nearly 1,100 independent providers and more than 260 practice sites in Region 6.

With the addition of Anthem to the CCHA *Plus* partnership, we will bring broad experience in developing comprehensive behavioral health networks and be fully equipped to address current Member access issues by including independent mental health and substance use disorder (MH/SUD) providers in the network. Anthem has comprehensive behavioral health networks in place in 18 states today, with more than 6,000 providers in the Medicaid and Medicare networks alone.

Member Engagement

Member engagement is effective only when Members are invited to participate in their own care and well-being in an active, person- and family-centered way. CCHA *Plus* will bring considerable experience involving Members in their care and influencing positive Member behaviors through a variety of initiatives both locally in Colorado, and on the national level. We will embrace and promote a system

that emphasizes Member-informed choice, independence, and engagement in all aspects of care and services.

We will use our established roots in local communities — our Care Coordinators living in and working in the Communities they serve, to make sure we understand the challenges Members face in achieving health and well-being. Our company-wide **no wrong door policy** will allow Members to connect with us through any avenue including our 24/7 phone line and referrals from Network Providers, family Members, or a Community partner. We will proactively seek out our Members, using our evidence-based and family-centered model to engage Members where they are and taking the time to listen and build a relationship of trust and mutual respect. Additionally, we look forward to innovation around Member engagement such as using new technologies like smartphone applications and meeting Members at trusted places in their Communities like the YMCA, churches, local events, or other locations.

INNOVATION

State Auditor Testimonial

CCHA defines "member engagement" as "person- and family-centered interactions which invite the member to participate in his/her healthcare." CCHA understands that engagement is not one-way communication; the member must "participate" in order to be considered engaged.
Health Services Advisory Group Auditor for the Department

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Because a strong support system is the foundation of resiliency, we work with the Member's natural supports to help create goals and meet his or her needs. During conversations with Members, we will determine their readiness to change, and we will encourage them to name their strengths and needs from their own perspective and will guide their care. This evidence-based and person-centered engagement methodology enhances the probability that Members develop self-directed care plans with achievable goals. We will leverage our Community partnerships to address health inequities and address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and other factors that serve as roadblocks for Members to achieve health and economic success at every life stage. Further, we will use a comprehensive health literacy strategy to support Members and their families in managing and making decisions about their health and care.

Our population health plan includes opportunities to partner with local community organizations such as local public health agencies to promote health through education on specific health related behaviors like smoking and alcohol use and assist Members in making informed choices. Health Neighborhoods and Communities statewide are rich with resources for Medicaid Members. Our role will be to make sure these resources are reaching Members and collaborating with local providers and organizations to provide Members with access to comprehensive health information, ongoing support, and innovative tools and resources. Through the CCHA *Plus* population health plan, we will engage Members in healthy behaviors and preventive services in the Community to reduce illness, help them become better informed health care consumers, and improve their quality of life. We look forward to partnering with schools, grocery stores, libraries, counties, jails and prisons, and other Community organizations to bring health literacy and healthy living education to Members.

Through our Quality Improvement programs and Provider Support program, we will manage and monitor Member satisfaction, well-being, and quality of life measures. We will use our Member Advisory Committee to engage Members to provide feedback on how to improve our programs and guide us in innovative new approaches to whole-person, integrated care.

Paying Network Providers for the Increased Value They Deliver (3.3.2.4)

As demonstrated by our many Letters of Support from Network Providers (Attachment 4.2-1), CCHA has been the leader among RCCOs in practice transformation, partnering and supporting Network Providers locally in the field to advance their performance, improve Member outcomes, and prepare for the transition to value-based payments (VBP).

INNOVATION As a RAE, CCHA *Plus* adds Anthem's national innovations in VBP arrangements and cutting-edge data systems and technology support that will be essential to support Network Providers in achieving the goals of the ACC, including the upcoming transition to the Primary Care Alternative Payment Model (APM). We will innovate with, invest in, and incentivize Network Providers to strengthen and broaden our Network to assure Members have access to the services they need. We are experts and strong believers in the use of VBP, including provider incentive programs to drive improvements in quality, access, and evidence-based clinical performance. We will reward Network Providers for clinical and quality excellence and will help them progress toward VBP.

Combined with our Provider incentive programs, our VBP programs align with State-specific quality and performance goals to optimize outcomes and results. Our goal is to drive improvements in the system through arrangements with our Network Providers that:

- Re-align the connection between price, cost-efficiency, and value with a focus on quality care and improved outcomes
- Embed payment for value in all reimbursement methodologies, not just pay-for-performance or risk-based arrangements
- Transform the economics of care delivery, moving away from a fee-for-service (FFS) model that rewards volume over health planning and right prevention investments
- Create the right incentives to foster and enable hospitals, health systems, and Network Providers to make the right health planning decisions based on Member needs and evidence-based standards of quality and appropriate care

Nationally, more than **3.7 million** of Anthem's Medicaid Members (approximately **58%** of Members) are attributed to a PCMP or other Network Provider who is participating in one or more performance-based models.

CO_RAE_PCMP_68_COB_DP_1.1

CCHA *Plus* will bring extensive experience with successfully supporting Network Provider performance improvement and transformation using VBP programs that align with the State goals. ***The CCHA Provider Incentive program is one-of-a-kind in the state and has resulted in increased Network Provider engagement with the RCCO and improved quality performance. It sets providers up for success with the APM.***

Ensuring Greater Accountability and Transparency (3.3.2.5)

Over the years as a RCCO, CCHA has fostered a culture of accountability, transparency, and partnership with the Department. ***As a RAE, CCHA Plus will foster a close partnership with the Department to help realize the goals of the ACC. We appreciate the expertise and experience Department staff bring to the program and know we are stronger by leveraging the assets and tools the Department brings to make the RAE successful.*** We will adhere to all Contract requirements and work collaboratively with the Department and stakeholders to assure accountability and transparency within the ACC Program. We look forward to leveraging the Department's stakeholder committees like the Program Improvement Advisory Committee (PIAC), as well as behavioral health and LTSS stakeholder forums, to help make our RAE better. ***Through our local staffing model, we are part of the community and provide the***

Department with seamless access to our leadership team, which promotes transparency, resolution of issues, and collaboration.

CCHA has been a trusted steward of Colorado State resources, and as a RAE CCHA *Plus* will add national expertise in delivering outcome-based, cost-effective health care services and achieving better and measurable outcomes. Over the past 6 years serving as a RCCO, CCHA's program deliverables have been cited as a State model by the Department's ACC staff. The CCHA Executive Director serves on the PIAC where she connects with the ACC community and the Department to identify new opportunities to better serve Colorado Medicaid Members. She has also served as a leader among RCCO colleagues to help set agendas and make meetings with the Department meaningful and productive. The ACC Contract Manager for Region 6 visits CCHA almost weekly to help strengthen the program, as well as attend CCHA staff meetings and other programming and policy meetings. The Contract Manager regularly rides along with CCHA Care Coordinators when they visit Members in the community, and also attends quality improvement meetings with CCHA Practice Transformation Coaches in the primary care setting. ***CCHA believes the transparent approach they have taken in working with the Department is one of the key factors that have led the RCCO to be one of the top performing RCCOs in the State.*** CCHA *Plus* will continue in this spirit of transparency and partnership with the Department as a RAE.

We recognize that establishing a deliberate planning process that leverages input from all stakeholders is required for a program to be successful. Open, continued dialogue beginning early in the program is crucial. Through our Member Advisory Committee and regional Program Improvement (Health Neighborhood) Advisory Committee, we will work with Members, families, caregivers, advocates, providers, community organizations, State agencies, and other stakeholders to involve them, listen to their input, and problem solve with them to achieve the ACC Program goals.

Lastly, our technology and management information systems will enable access to and analysis of large amounts of data to support our leadership team and the Department's needs. The ability to identify, execute, and analyze data through our reporting capabilities will help us and the Department evaluate, monitor, and manage the ACC Program's success.

Approaches to Fulfill the Statement of Work

We understand that integration is more than an operational change; it is investment and dedication to the whole system of care. CCHA *Plus's* managing partner Anthem has been a leader in physical and behavioral health integration for more than two decades. The passion of CCHA *Plus* to serve Coloradans extends beyond health care and into our communities. We will build strong partnerships with local service agencies and stakeholders to link Members to community resources and coordinate care across systems. We have the national experience and local expertise to meet our Members where they are, and we specialize in the needs of complex, high-risk populations.

Our goal is to facilitate easy and seamless connections between health care and social services to manage the health of the whole person – connecting Members quickly with a PCMP, enabling the PCMP's treatment plan with actionable data and supported practice transformation efforts, incentivizing better quality of care through tailored VBP arrangements, and providing support to Network Providers to transition to clinical integration. ***Our approach to integration will span all areas of the organization and will reach into the Health Neighborhood and Community. We will build the operational and systems infrastructure and partner with providers and community organizations to develop programs and services that promote integration and a holistic, person-centered approach to care.***

Integrated Population Health Strategies

As a RAE, CCHA *Plus* brings our comprehensive Population Health Management Strategy to address roadblocks Members and their families face to being healthy and economically secure members of society. ***First and foremost, we will work to be sure we understand our population.*** Like everything we will do at CCHA *Plus*, we will use data combined with our human interactions with Members and their families to understand their unique needs and preferences. Our sophisticated data and analytics system will be able to leverage the information from the Local Public Health Agency Community Health Needs Assessment, the Colorado Health Assessment and Planning Systems (CHAPS) tool, Colorado Health Information Dataset (CoHID), Behavioral Health Factor Surveillance System (BRFSS), and the Colorado Health and Environmental Data portal as a start to understanding the needs of the local communities we serve. Through integration of all of these data sources and the combined physical and behavioral health claims data, we will be able to see Members as unique individuals and implement Member- and family-centered strategies that account for Member's life stage, health conditions, health related behaviors, and social determinants of health.

Our Population Health Management Strategy will focus on engaging Members, coordinating with Network Providers, and collaborating with the Health Neighborhood and local community organizations to deliver a comprehensive set of medical and non-medical resources customized to each community's unique needs, population health conditions, life stages, and circumstances. We will capitalize on the resources of Health Neighborhood and Community partners such as local public health agencies to deliver health promotion and education services, as well as key community organizations like the Area Agencies on Aging, Aging and Disability Resources for Colorado, the local housing authority, Arvada Community Food Bank, The Action Center, City of Aurora Refugee Commission, and Seniors' Resource Center to connect Members with non-medical resources. ***By collaborating with Health Neighborhood and Community partners, we will create the opportunity to develop a Population Health Plan that addresses health inequities and disparities in the Region and make the best use of scarce resources while reducing duplication and waste.***

Risk assessment and stratification processes are integral to our Population Health Management Strategy and will build upon the Department's overall stratification framework. ***CCHA Plus will use multiple data sources to identify and stratify Member risk initially and on an ongoing basis.*** Our sources will include enrollment and demographic data and Health Needs Survey results provided by the Department; results from our internal risk stratification and predictive modeling tools; claims history; and referrals and feedback from Members, families, Network Providers, and internal staff such as Member Services and Utilization Management employees. We will also continue to use the risk scores from the Business Intelligence and Data Management System (BIDM) to identify high-risk Members for timely and proactive outreach, and targeted interventions. We will supplement the State's stratification system with our internal Chronic Illness Intensity Index (CI3) and other predictive modeling programs (described below) to proactively risk adjust Members and identify opportunities to assist them – and Providers – whether it is facilitating access to care, educating about benefits and services, identifying additional community supports, or identifying for Care Coordination and disease management. Our multifaceted approach will help assure we determine the most appropriate level of outreach and support.

Throughout our response, we provide information on our strategies to promote health and wellness, such as partnerships with local public health agencies to promote tobacco cessation, partnerships with schools to develop a healthy eating curriculum, and opportunities to partner with FQHCs and other community groups to deliver GED classes. We look forward to developing our Population Health Management Plan for the region in collaboration with Members, Network Providers, the Health Neighborhood, and Community partners and have proposed interventions that may include:

- Wellness website
- Crisis Center follow-up
- Outreach trigger follow-up
- Tobacco cessation (adults)
- Wellness mailings
- Tele-town hall
- Influenza vaccination campaign
- Gaps in care
- Community nutrition, exercise, and obesity initiatives
- Well-child check appointment reminders during a child's birthday month (pediatrics)
- Post-residential discharge follow-up for Child Mental Health Treatment Act children (pediatrics)

Predictive model identification leads to improved health, Member satisfaction, and quality of life

Christine, a 48-year-old Member, was identified as having complex needs through our predictive modeling tool. For almost 15 years, Christine suffered from complications related to gall bladder surgery, including bile duct leakage that caused chronic pain and discomfort and repeated infections that had a profoundly negative impact on her life. Her Care Coordinator, Vanessa, realized more could be done for her, so she accompanied Christine to her doctor's appointment to gain a clear understanding of her condition.

She coordinated a referral to a renowned liver and transplant specialist in June, and in July, Christine underwent surgery to repair the leakage and almost immediately her health improved. She is now healthy and a happy mom to her two children. When Vanessa recently talked with Christine's dad, he told her, ***"Thank you for giving us our daughter back."***

Anthem **Member Centered**

CO_RAE_OR3_Christine_11_COB_RS_2.1

As demonstrated in OR 15, many of our interventions align with and support **Colorado's 10 Winnable Battles** and the **State of Health.**

CCHA *Plus* is excited to continue the important work of the **Colorado Opportunity Project** to deliver evidence-based initiatives and community-based practices that remove roadblocks for all Coloradans, enabling everyone to have the opportunity to reach and maintain their full potential. As a RAE, we will build upon the solid foundation CCHA has built in Jefferson County and add Anthem's extensive supply of evidence-based interventions to **propel this work into the next era of integrated community health delivery systems.** We will engage in disruptive innovation efforts that will pilot new approaches to enrollment in and delivery of services. As a RCCO, CCHA has been integral to bringing community partners together and unifying them behind the goal of the Colorado Opportunity Project in Region 6. Awarding the RAE to CCHA *Plus* will help maintain the established relationship that holds these community partnerships together.

Integrated Care Coordination Model

As part of our Population Health Management Plan, CCHA *Plus* will employ CCHA's successful community-based Care Coordination model that supports Members across the full continuum of care delivery and in all life stages. ***Our goal is make sure Members are receiving the right care, at the right time, and in the right setting to eliminate duplication and over-utilization, and encourage better outcomes.*** Our integrated Care Coordination model provides services that range from coordinating whole-person care in the Community and patient engagement in the home, to fully co-located and integrated Care Coordination at Network Provider and community locations. We will also collaborate

with other agencies, LTSS, and Network Providers to work as a community-based health team, assign a Lead Care Coordinator, and avoid duplication.

We will start the process of delivering our Care Coordination activities by in-depth analysis of the Department's Health Risk Screening results, together with our internal predictive modeling tools. Additional information that will be analyzed includes sources such as the Business Intelligence and Data Management System (BIDM); claims; information from providers, hospitals, and community agencies; and referrals. We embrace a no wrong door approach to referrals and receive them from a variety of sources, including self-referral, families or caregivers, providers, and our Member-facing staff.

Our Care Coordination model puts the Member and family at the center of care regardless of the complexity of their health care needs and tailors interventions to their specific needs. Our holistic Care Coordination programs are accessible and designed to:

- Support the Member's goals in a culturally and linguistically appropriate manner that promotes Member choice and preference
- Improve Member experience and health outcomes
- Facilitate, communicate, and coordinate across all systems and Network Providers involved
- Reduce duplication of services by serving as Lead Coordinator to coordinate across systems
- Empower Members to increase engagement in their health and well-being
- Encourage Members to engage with their PCMP
- Provide Care Coordination at the point of care whenever possible
- Advocate for Members to protect their privacy
- Make sure Members' short- and long-term needs are met
- Identify underlying behavioral health needs in Members through whole-person care
- Assure those with Serious and Persistent Mental Illness (SPMI) have support and access to behavioral and medical services
- Bridge the gap between Members' health needs and social, spiritual, educational, and developmental needs by connecting them to their Health Neighborhoods and community resources

Gina's Story: Coordinated Care for Individuals and their Families

At 33, Gina is new to Colorado and has diagnoses of a seizure disorder, fetal alcohol syndrome, epilepsy, cerebral palsy, anxiety, and depression, and she has a great fear of needles resulting from being abused as a child. Now in her first trimester, Gina expressed her wishes to change PCMP, neurology and OB providers to our Care Coordinator, Maggie, and to connect with a BH provider. Understanding her concerns and wishes, Maggie dedicated herself to supporting Gina to reduce her fear of needles, communicate her needs to her providers, and develop a birth plan. So acting as her advocate, she accompanied Gina to 11 provider appointments, 3 blood draws, and 8 care conferences.

Together, they worked with her providers to discuss Gina's fears/trauma that could have had a significant impact on her delivery. Gina was able to have a natural delivery, did not experience a seizure during birth, and gave birth to a healthy baby boy, Sean.

Due to her severe trauma, Gina was having issues with taking Sean to his doctor visits. They set up a care team for Sean with no male providers and Provider-Extender visits, so Gina could get to know the provider and the co-located therapist. Through the Nurse Family Partnership Program, Maggie also arranged for Christine, a BH Specialist, to meet with Gina in her home weekly. Gina also was connected with a Precious Child and WIC and received a new car seat through Drive Smart and diapers through Haven's Hope.

Gina has successfully attended appointments with her and Sean's doctors and continues to meet with Christine weekly. ***Through person- and family-centered care coordination, support, and a caring approach that reflects her preferences, Gina has been surrounded with resources and feels confident in raising her son in a loving, nurturing, and safe environment.***

CCHA **Member Centered**

CO_RAE_OR16_Gina_20_COB_RS_3.4

We acknowledge that Members and families have unique and specialized needs based on their individual life circumstances, level of health, and stage of life. To meet these needs, we will offer a range of deliberate activities to organize and facilitate the appropriate delivery of health and social services. Our Care Coordination model is tailored to meet the specific needs the populations we serve. Our programs are designed to support our Population Health Management Interventions and include:

- Integrated complex Care Coordination
- Transitions of care/post discharge management
- Emergency room (ER) outreach
- Maternity
- Pediatrics
- Medicare-Medicaid Program
- Rising Star – behavioral health program
- Criminal Justice program
- Opioid Management program
- High intensity integrated team

The CCHA *Plus* Care Coordination programs will support each Member's unique needs, service preferences, and health care goals. As CCHA does now, we will proactively identify and integrate comprehensive services for Members with, or at risk for, complex conditions, as well as those in need of preventive and wellness services. Our model allows us to effectively support the relationships between Members and all of the providers in their Health Neighborhood, including primary care, behavioral health, hospitals, specialists, LTSS, community resource partners, and other organizations engaged in a Member's health such as counties, child welfare agencies, homeless shelters, food banks, and correctional systems. As a RAE, we will continue CCHA's practices of strong local presence and integration in the community, and establishing trust and respect with community partners, Providers, and agencies.

Care Coordinators spend **90%** of their time in the community meeting with Members.

CO_RAE_OR16_CareCoord_COB_DP_1.1

At the heart of the CCHA Plus Care Coordination model are our Care Coordinators. The Care Coordination team joins the Member on their journey to increased wellness and coordinates communication and increases collaboration across providers. Over the years serving as a RCCO, CCHA has hired a multidisciplinary team of Care Coordinators with a passion for serving Members. To continue with this model, the CCHA *Plus* Care Coordination team will be multidisciplinary, including social workers, nurses, community resource specialists, community liaisons, and behavioral health liaisons. We will retain our existing staff and recruit additional local Care Coordinators with expertise in specific areas that match the unique needs of the Members we serve.

CCHA *Plus* will expand CCHA's Care Coordination talent to bring additional local Care Coordinators that are trained to meet the needs of the population they serve, like correctional care and care for those with SPMI and serious emotional disturbances. ***As a RAE, we have a pivotal opportunity to combine physical and behavioral health Care Coordination efforts into one Total Health Care Coordination System.*** CCHA *Plus* will capitalize on this opportunity to delivery whole-person services and connect Members with all the medical and non-medical services they require to be healthy and self-sufficient. We will also seek to partner with independent behavioral health providers and CMHCs to incorporate local providers into the health team.

A terrific example of how Anthem's integrated care expertise can bolster the RCCO's Care Coordination System is through the Criminal Justice program. CCHA Care Coordinators have been stationed at re-entry points and connecting Members with physical health services. But with Anthem managing the behavioral health benefit, we will have direct access to connecting Members immediately with the behavioral health services they need upon release, including important medications. Our multidisciplinary Care Coordination team, including behavioral health liaisons and community resource experts, will work together to serve these Members and help ensure they don't fall through the cracks as has often happened in the past with the divided Care Coordination system for this population.

In our role as a RAE, CCHA *Plus* will continue CCHA's current practices of Care Coordinator co-location in Provider offices, hospitals, community agencies, and parole offices, and spending time in the community. We will continue to meet the Member where they are and work to meet their immediate

needs. If a Member prefers, we also visit them in their home. We will align with organizations that are important to the Member to create one health team and coordinate the Member-directed care plan.

Integrated Quality Improvement Program

As a RCCO, CCHA has taken performance improvement very seriously and has been quick, nimble and innovative to improve scores on the ACC key performance indicators (KPI), ***making CCHA one of the top performing RCCOs in the state.*** CCHA *Plus* doubles down on this commitment to quality performance, bringing new, innovative strategies proven successful in other Medicaid programs. As a RAE, CCHA *Plus* is confident we will be a peak performer in the State, partnering with the Department, Network Providers, the Health Neighborhood, and Community to improve health, driving value and reducing unnecessary costs in the ACC. The CCHA *Plus* board of managers will have the ultimate authority and responsibility for quality of care and services provided to Members and the approval of the Quality Improvement Program, Quality Improvement Work Plan, and Annual Evaluation.

Through a fully integrated Quality Improvement (QI) program that complies with 42 C.F.R., we will objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable physical and behavioral health services. Our QI program aligns with the Centers for Medicaid and Medicaid Services' definition of quality and meets all federal requirements for both the PCCM and PIHP. Further, our QI program aligns with the Department's Quality Strategy and will drive value in the health system, improving Member outcomes and experience, Network Provider performance, and cost-effectiveness. CCHA *Plus* managing partners participate in local and national quality improvement programs and bring significant quality improvement expertise to the RAE. ***We will embed quality in every aspect of operations, every interaction with Members, and every touchpoint with all Network Providers. We will use data and sophisticated tools like our Provider Performance Dashboards, to drive continuous quality improvement to achieve better health outcomes for Members.*** As an important part of our commitment to quality, we recognize that person- and family-centered care requires integrated physical and behavioral health services. We reflect this approach at all organizational levels, and each employee works to achieve the best outcome for Members.

As a RCCO, CCHA brings vast experience designing and conducting Performance Improvement Projects (PIPs) to achieve significant and sustainable improvement over time in clinical and nonclinical care areas.

INNOVATION

They have a successful track record of achieving results. For example in 2016, CCHA's PIP resulted in a 31% increase in follow-up behavioral health care after a positive depression screening. CCHA *Plus* will build upon CCHA's successes and add Anthem's significant quality improvement expertise to deliver a powerful QI program for the next iteration of the ACC Program. For example, Anthem brings wide-ranging experience in implementing innovative strategies to improve ER and inpatient utilization costs in the Medicaid program in Nevada and will bring this expertise directly to the center of our RAE efforts.

We know that mechanisms to detect and address over- and under-utilization of services is an important responsibility of the RAE. We will use data and analytics tools and the CCHA *Plus* Quality Management Committee to identify opportunities to intervene with Members to improve access to appropriate care, educate Members on appropriate use of the ER, identify Members who need extra help including Care Coordination, and implement personalized interventions so Members receive necessary services at the right intensity and level of care. Rather than simply prevent over-utilization, we will make sure Members receive the services and care they need. We bring new opportunities for the Department to consider to address over- and under-utilization of services, including programs to reduce inappropriate ER use, our behavioral health medication management program, and an opportunity to implement integrated pharmacy management. All of these tools can complement the Department's Client Over-utilization

Program and support Members in receiving the interventions they need to appropriately use the health care system.

As we implement many new and innovative approaches to population health, Care Coordination, and practice support, we will have a comprehensive evaluation strategy that uses data and analytics to monitor outcomes and costs and enables us to engage in continuous quality improvement. We will support Network Providers in the delivery of quality health care by providing information, guidance, meaningful and actionable data, and tools to help their patients make personal health choices and decisions. As the State evolves its data practices, CCHA *Plus* will also evolve our analytics to incorporate community data/public health trends in evaluation of ACC program performance.

Comprehensive Provider Network

CCHA *Plus* will bring significant experience in building and supporting physical and behavioral health provider networks fully equipped to serve Members and facilitate access to care. Additionally, with Centura Health as a partner, we bring the **Centura Health Physician Group** and **Centura Health's Urgency Centers** to help solve access issues in rural or sparsely populated areas.

Our comprehensive Provider Network will maximize Member choice, meet the unique needs of our Member population, assure sufficient capacity to serve Members with complex and specialized needs, and support participation of smaller practices.

Provider Testimonial

KPCO staff worked with CCHA as the RCCO for Region 6 over the last three years to address care coordination issues for our members to ensure members received the care they needed to maintain or improve their health. CCHA was a very good partner by keeping in regular communication with our team, focusing on solutions to expand access to services, and strengthening their care coordination program to treat the whole person.
Kathleen Westcoat, MPH,
Senior Director for Medicaid and Charitable Programs,
Kaiser Permanente

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Independent Providers

It is important to remember that independent physical and behavioral health Providers are a vital component of the Provider Network. According to the Colorado Community Health Network, Federally Qualified Health Centers (FQHC) only serve 24% of Medicaid enrollees statewide. While these numbers vary slightly by region, the fact is the majority of ACC Members are served by independent primary care Providers. Additionally, while local Community Mental Health Centers (CMHC) have provided the bulk of mental health services in the State, access to behavioral health services has been a significant challenge for Members. Independent mental health providers and substance use providers, even large providers like Arapahoe House, have not been leveraged to their full extent to provide much need services to Members.

CCHA *Plus* brings experience recruiting and supporting all types of providers to serve in the ACC network. Our Provider network development strategy for the ACC is informed by:

- Our local, on-the-ground experience of CCHA as a RCCO in Region 6 (for example, expected utilization of services, number and types of Network Providers required to furnish the covered benefits)
- Strong relationships built over the years with Providers, Community leaders, and advocacy groups in Region 6 to understand the challenges they face and to help develop solutions
- Continuous attention to and participation in the Community, so we can listen and learn from current and potential Members and their families about the challenges they face and address them (for example, social determinants of health impacting access to care)

As a current RCCO, CCHA has experience building an urban-based Provider Network in Jefferson County and parts of Boulder and Broomfield Counties, which consists of nearly 1,100 Providers and more than

260 practice sites and large Safety Net Providers including Denver Health and 3 FQHCs, as well as a large number of independent primary care practices.

Rural Health

CCHA also supports the participation of smaller practices in two sparsely populated mountain communities, where they have successfully facilitated access to primary care and helped them apply Lean workflows to increase service capacity. CCHA worked with Centura Health and Clear Creek County to open a new integrated primary care clinic in Idaho Springs. The **Centura Health Physician Group Primary Care Clinic—Idaho Springs** opens in July 2017 and will provide a one-stop shop for Members with limited transportation options to access physical and behavioral health care as well as county social services.

Community Partner Testimonial

As the incumbent RCCO serving Medicaid members in Region 6, CCHA has been an invaluable partner to our county and the approximately 1,175 men, women and children who are eligible and enrolled in Medicaid programs and services. Since its inception in 2011, CCHA has helped to improve access to basic care as well as providing care coordination; a difficult feat at times for our county residents who have been without Primary Care since October of 2011.
Randall Wheelock, Timothy Mauck, Sean Wood, Clear Creek Board of County Commissioners

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Telemedicine Support

INNOVATION As a RAE, CCHA *Plus* will offer an innovative LiveHealth Online telemedicine solution that provides Members with online access through two-way audio/video technology to Colorado-licensed, board-certified physicians and behavioral health providers for consultations for clinically appropriate conditions (such as a cough, cold, fever, flu) or behavioral health consultations. Members are able to access services through a video-enabled computer and secure internet connection or an app on their smartphone. LiveHealth Online providers can diagnose, make medical recommendations, and prescribe medications when necessary in accordance with State requirements. ***LiveHealth Online complements our continuum of options for Members to access health care services and expanded alternatives to the ER.***

INNOVATION To support PCMPs with helping Members with behavioral health conditions, we can also offer an innovative Psychiatry and Addictions Case Consultation (PACC) Project ECHO®. PACC offers remote case review with clinical case management for PCMPs who care for Members experiencing addictions such as opioid addiction, chronic conditions, and other behavioral health concerns. PACC was designed to expand the behavioral health and addictions care capacity of providers in remote or underserved areas in Washington through weekly online clinics and in-depth clinical case consultation with University of Washington psychiatrists and addiction experts. Additionally, we will explore similar options in Colorado such as Virtual Reality (VR) therapy as an alternative for pain management. Numerous studies have shown that VR Therapy can be effective in decreasing high levels of acute pain and help support Members in their addiction recovery.

CCHA has already helped Network Providers lead the State's BH integration efforts in primary care:
- **11 practices** have a fully-integrated BH Network Provider
- **30 practices** have a co-located BH therapist
- **94%** of high-volume practices report regularly screening for depression
- **77%** of high-volume practices report having a reliable BH referral process

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Provider Support for All Types and Sizes

A robust independent provider network is critical to ensuring Members have access to care. These independent providers do not have the resources of FQHCs and CMHCs, like Clinica, MCPN, Salud, Jefferson Center for Mental Health, and Mental Health Partners, and require significant practice support and transformation teams to help them reach ACC Program goals.

The **CCHA *Plus* Provider Support program** will be flexible to meet

the specialized needs of local independent physical and behavioral health providers to promote high-quality, integrated, and Team-based Care to Members and meet the goals of the ACC Program. Additionally, we offer a customized Provider Support program for providers including FQHCs and CMHCs to meet them where they are and help them improve their performance in key areas like the ACC Program KPIs.

Integrated Provider Support Program

At CCHA Plus, we place great emphasis on our role of delivering Network Providers support and practice transformation, as we know the goals of the ACC Program will not be realized unless we bring PCMPs and specialty behavioral health providers along for the journey. CCHA *Plus* will support Network Providers interested in integrating physical and behavioral health services and enhancing the delivery of Team-based Care by leveraging our unique experience and expertise to provide general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support.

Provider Testimonial

Having behavioral health co-location at Focus on Kids has been wonderful! Lynn, the therapist chosen for our practice, is great. Our patients love her, and our staff loves her. She is easy to work with, and it is so convenient that she is here. It really has improved the process of referring our patients for therapy. They are much more willing to go see a therapist after they realize how convenient it is for them, just having to come to our office.

Jolene Reini, Focus on Kids Pediatric

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CCHA *Plus* brings the sophisticated practice transformation capabilities of CCHA, Colorado leader in Practice Transformation, as demonstrated through KPI measures and the strong support received by Network Providers providing Letters of Support for our RAE proposal. CCHA *Plus* will expand the Provider Support program to encompass all Network Providers, including both PCMPs and specialty behavioral health providers. ***Each practice will be assigned a single point of contact, and we will add other roles to their Provider Support team, depending on the practice's needs and goals***. CCHA *Plus* Provider Support team members include Network Relations Representatives, Community Liaisons, Practice Transformation Coaches and Facilitators who specialize in physical and behavioral health integration, Behavioral Health Liaisons, Clinical Health Information Technology Specialists, and Care Coordinators. ***All positions on our Provider Support team will be located in the community, in provider offices, and will work to complement and enhance resources in the community rather than conflict or duplicate.***

With 76% of Colorado Medicaid enrollees being served by independent primary care practices, CCHA *Plus* is the partner the Department needs to realize the goals of the ACC, evolve to an integrated community delivery system, and implement VBP programs like the Primary Care Alternative Payment Model (APM). Independent providers do not have the same resources as large providers, such as FQHCs, and need support of the RAE to engage in integration efforts alone and effectively transition to VBP arrangements. ***We are a trusted partner of these independent Network Providers, and we bring the experience and expertise needed to support providers through the evolution of the health delivery system and payment transformations.***

As a RAE, CCHA *Plus* is poised to work with the Department, and provide the support the Network Providers and Health Neighborhood needs to implement other VBP arrangements in the ACC to drive integration, increase value, and improve health outcomes.

Integrated Technology and Systems

Data Management System

CCHA *Plus* will operate a sophisticated data management system as a key component for achieving improved health care access and outcomes for Coloradans while demonstrating sound stewardship of

financial resources. ***We understand that a critical component of our system will be the ability to process claims accurately and quickly and provide encounter data to the Department in a timely manner.*** Leveraging the experience of our managing partners, CCHA *Plus* employees bring substantial experience generating Medicaid encounter data. In 2016, Anthem assisted in the submission of more than 233.5 million encounters. They also have experience with multiple transmission standards and working with state-designated fiscal agents (like DXC) to submit Medicaid encounters following the State's preferences. CCHA *Plus* will continue the long history of success supporting transparency in reporting for which CCHA and Anthem are known.

Our integrated, **electronic Care Coordination Tool** will be the cornerstone of our Care Coordination model. Our Care Coordination Tool houses Member assessments and care plans and provides information about Member conditions, medications, and chronologically ordered progress notes. This tool will promote comprehensive Care Coordination of Member needs and issues, whether the driver is physical health, behavioral health, pharmacy, or other. All of our clinical staff involved in Member care will work in our Care Coordination Tool, enhancing clinical oversight, facilitating communication across departments, and reducing Member risk of fragmented care. We are excited to offer the tool to PCMPs who do not currently have an electronic Care Coordination tool.

Innovative Technology Platform

Data is a critical component of every aspect of truly integrated physical and behavioral health care delivery. CCHA *Plus* has designed an innovative technology platform to provide advanced data analytic capabilities that drive operational improvements and population health strategies. Our Member-focused, whole-person data platform will enable effective data sharing between Care Coordinators, Network Providers, the Health Neighborhood, and internal quality committees to see that we provide the right care at the right time and in the right setting. Through the integration of physical and behavioral health data with other data sources, including the Colorado interChange and BIDM system, we will use the data internally to inform our daily practices and share it with Network Providers and Health Neighborhood and Community partners to increase transparency, drive access and quality improvements, and steer integration at the point of care.

We look forward to interfacing with the Colorado interChange and BIDM to create direct file exchanges with the Department and leverage the analytics of the new BIDM system in all of our operations. We will integrate BIDM data and data from other sources like the Health First Colorado Nurse Advice Line and Colorado Crisis Services and use it internally and externally, sharing with Network Providers, Health Neighborhood, and Community partners to increase transparency around access to behavioral health, drive access and quality improvements around physical and behavioral health, and support our ongoing collaborative efforts in the Community to drive integration at the point of care. Our understanding of key cost drivers and clinical outcomes will guide development of reports to make certain we track trends that impact quality of care and financial impact, as well as support transparency with the Department.

With a wealth of reliable data and sophisticated analytic tools at our fingertips, our Quality Improvement (QI) team will track and trend performance over time and drive quality improvements, such as regularly monitoring changes in performance measures. Our tools will include:

- Analytics Platform
- KPI Reporting
- Member Management Dashboard and Reporting Tool
- Predictive Modeling Tool
- Care Coordination System
- Provider Performance Dashboards and Profile Tool

Our Future Together

We appreciate the trust the Department has placed in CCHA as a RCCO. We are proud of the partnership CCHA has built over the past 6 years and the innovations they have implemented together in the ACC. With the addition of Anthem, we are excited to bring the opportunity to develop a robust integrated physical and behavioral health network that highlights behavioral health access issues and works to address them. As stated above, **CCHA *Plus* is an equal partnership established as one organization, with one staff, one IT platform, and one goal: To successfully integrate physical and behavioral health while realizing the Department's vision to improve access and outcomes for Colorado Medicaid Members while supporting sound fiscal stewardship of scarce resources.**

We look forward to the opportunity to provide integrated, Team-based Care Coordination and Provider Support programs that use evidence-based interventions to meet Members and Providers where they are. We will capitalize on the strong Health Neighborhood and Community relationships we bring to the region to build and support an integrated community health system. We will engage with new partners like Children's Hospital Colorado and Arapahoe House and leverage new innovations like the Alternative Payment Model and the Hospital Transformation Program with the aim of truly integrating the health system. From integrated service delivery to collaboration on innovative health care solutions, CCHA *Plus* will continue the commitment to improve health for Members by delivering care in a seamless way. Our objective is to deliver exceptional service and the best health care solutions for our Members, Providers, and the Community.

We are energized by the opportunity that lies ahead of us. With the changing landscape of health care, more innovative solutions will be required around network solutions, provider payment models, health and wellness services, and Member engagement. CCHA *Plus* is a long-term, innovative partner committed to the success of the ACC Program.

Bidding Entity & CORE VSS Number:
CCHA, LLC d/b/a Colorado Community Health Alliance
VS50000000026694

Offeror's Point of Contact:
Elizabeth Baskett
(720) 612-6744
Elizabeth.Baskett@CCHAcares.com

Appendix C: W-9

COLORADO COMMUNITY HEALTH ALLIANCE

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.

Print or type
See Specific Instructions on page 2.

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

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

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ P
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

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

5 Address (number, street, and apt. or suite no.)
1125 17th Street Suite 1000

Requester's name and address (optional)

6 City, state, and ZIP code
Denver CO 80202

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
			–			–				

or

Employer identification number
8	2	–	1	8	5	3	4	2	3

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 01/05/2017

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.

Section 4.1

COLORADO COMMUNITY HEALTH ALLIANCE

Mandatory Qualifications

4.1 MANDATORY QUALIFICATIONS

OFFEROR'S RESPONSE 1

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

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

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

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

a. Offeror's Legal Name and Years in Business, Total Number of Staff, and Location(s)

CCHA, LLC d/b/a Colorado Community Health Alliance (CCHA *Plus*) was formed in 2017 solely to serve the Accountable Care Collaborative Program and its Members by bringing innovation and value to the Colorado Medicaid program as a Regional Accountable Entity (RAE). Although CCHA *Plus* is a new business entity, its managing partners include the 3 partners from Colorado Community Health Alliance, LLC, an existing Regional Care Collaborative Organization serving Colorado Medicaid, along with Anthem, Inc., to provide a fully integrated physical and behavioral health program.

CCHA *Plus* projects the need for approximately 116 employees directly allocated to the RAE program in in Region 6. Additionally, we anticipate additional partially allocated operational positions needed. The number of employees will vary based on factors such as Member attribution levels, additional scopes of work, and/or the number of regions awarded. CCHA *Plus* will work with the Department to finalize and provide an in-depth organization chart as outlined in 5.2.3.1. We are committed to staffing solutions that meet all requirements of the RAE Contract and the Department.

Colorado staff will operate out of the following location(s) regional and state offices:

11600 West 2 Place
Lakewood, CO 80228

1125 17 Street
Denver, CO 80202

100 Health Park Drive
Louisville, CO 80027

700 Broadway
Denver, CO 80273

b. Documentation of the Offeror's Licensure

CCHA *Plus* is currently in the process of obtaining a Health Maintenance Organization (HMO) Certificate of Authority license from the Colorado Division of Insurance. CCHA *Plus* submitted an application for an HMO license on July 24, 2017, and Figure 4.1-1 below shows a copy of the cover letter accompanying the application. CCHA *Plus* attests that the licensure will be obtained prior to executing a Contract with the Department.

Figure 4.1-1. Licensure Forms for CCHA Plus

COLORADO COMMUNITY HEALTH ALLIANCE

July 21, 2017

Ms. Cindy Hathaway, Director, Corporate Affairs
Colorado Division of Insurance
Corporate Affairs Section
1560 Broadway, Suite 850
Denver, CO 80202

Re: CCHA, LLC
Application for Certificate of Authority

Dear Ms. Hathaway,

CCHA, LLC respectfully submits the enclosed Application for a Certificate of Authority (Application) to operate as a domestic health maintenance organization in the state of Colorado. The Application being filed pursuant to Colorado Code § 4-7-1(6) and the requirements contained in the NAIC's Uniform Certificate of Authority Primary Application.

CCHA, LLC is pursuing its Certificate of Authority to participate as a Regional Accountable Entity (RAE) for the Accountable Care Collaborative (ACC) under a contract with the Colorado Department of Health Care Policy & Financing. CCHA, LLC currently plans to serve only individuals enrolled in publicly-sponsored health care programs through contracts with State and Federal agencies. If awarded these opportunities, we will bring together the strengths and stability of proven systems and technology, dedicated staff with vast public sector experience, operational infrastructure, and the resolve to meet the complex needs of our Colorado members. We will work collaboratively with State and local policymakers, advocates, providers and members to design and deliver the best care and service available.

CCHA, LLC appreciates the opportunity to submit this Application to the Colorado Division of Insurance (Division). We look forward to working with the Division and Colorado Department of Public Health and Environment (CDPHE) during the review process and going forward after the approval of our Application. If you or any of your colleagues have questions about this Application, please feel free to contact me at (805) 713-2332 or via email at suzanne.walker@anthem.com.

Thank you for your time and assistance.

Sincerely,

Suzanne Walker
Regulatory Oversight Manager, Regulatory Department

CCHA, LLC

c. Attestation That the Offeror Meets the Requirements of a PCCM Entity and a PIHP

Through the combined experience of our partners, CCHA Plus currently meets the requirements of a Primary Care Case Management (PCCM) Entity and meets the requirements of a Prepaid Inpatient Health Plan (PIHP).

Section 4.2

COLORADO COMMUNITY HEALTH ALLIANCE

Organizational Experience

4.2 ORGANIZATIONAL EXPERIENCE

OFFEROR'S RESPONSE 2

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

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

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA, LLC d/b/a Colorado Community Health Alliance (CCHA *Plus*) delivers an integrated health solution that will tap our local knowledge, deep experience and expertise, and commitment to the vision of the Colorado Department of Health Care Policy and Financing (Department) to improve access and outcomes for Colorado Medicaid Members in Region 6, while supporting sound fiscal stewardship of scarce resources.

Our History

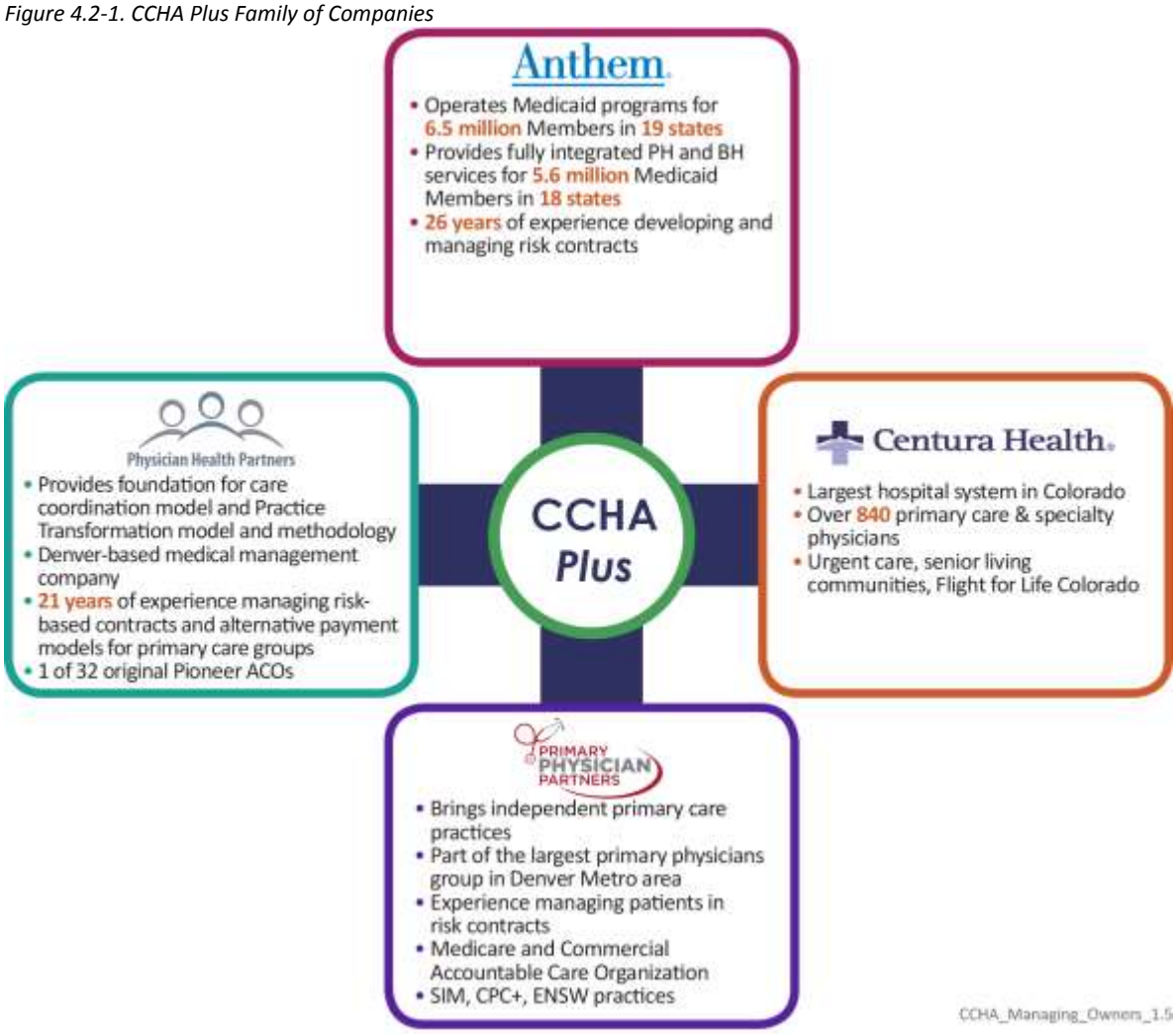
Colorado Community Health Alliance, LLC (CCHA) is the current Regional Care Collaborative Organization (RCCO) serving Region 6 as a Primary Care Case Manager (PCCM) entity in the Accountable Care Collaborative (ACC) Program. As a RCCO, CCHA created a unique model specifically designed around the needs of Colorado Medicaid Members. CCHA has proudly served the Colorado Medicaid population for the past 6 years with a history of strong performance outcomes, a large and established Provider Network, dedication to reinvestment in the community, and collaboration with the Department.

In 2010, CCHA was formed by bringing together the local expertise of Centura Health (the largest hospital system and specialty Provider Network in Colorado), Physician Health Partners (PHP) (a local management services organization known for their care coordination and practice quality improvement programs), and Primary Physician Partners (PPP) (a large group of local, independent primary care Providers). In 2016, CCHA saw a need to evolve along with the Department and the ACC Program to further enhance its services.

CCHA *Plus* Today

For the next iteration of the ACC, CCHA heard and strongly agreed with the Department's call to integrate physical health (PH) and behavioral health (BH) under one regional accountable entity (RAE). CCHA set out to find the right partner to expand access to BH care and bring proven experience delivering integrated PH and BH care to Medicaid Members. The RCCO conducted an exhaustive, nationwide search for the right partner and selected Anthem, Inc. (Anthem). Anthem has extensive experience managing capitated BH services for more than 5.6 million Members in 18 states, including Members with complex physical, behavioral, and social support needs.

Figure 4.2-1. CCHA Plus Family of Companies



CCHA Plus is a unique partnership that brings all the necessary expertise needed for a successful Medicaid program under one roof, with one vision, and in one collaborative organization, as illustrated in Figure 4.2-1.

Years of Experience (4.2 - 4.2.2.7)

The CCHA *Plus* combined organizational background provides us with 48 years of relevant experience. We are well over the 10-year requirement in providing, arranging for or being responsible for the delivery and coordination of comprehensive PH and BH care services spanning the continuum of care for both inpatient and outpatient services. This experience is recent and consecutive. Our experience includes the following:

Providing Care as a Primary Care Case Manager (PCCM) Entity (4.2.2.3): As a RCCO for the past 6 years, CCHA has served as the PCCM Entity with the responsibility of providing and arranging for the delivery and coordination of PH services across the continuum of care. CCHA *Plus* managing partner, PHP, also has extensive experience implementing and managing similar and aligned programs such as the Comprehensive Primary Care Plus (CPC+) Program, State Innovation Model (SIM) as a Practice

Transformation Organization, the Medicare Shared Savings Program, and the Pioneer Accountable Care Organization (ACO) program. Figure 4.2-2 outlines the years of experience as identified in section 4.2.2.2-4.2.2.7.

Serving Medicaid Covered Populations (4.2.2.4): CCHA *Plus exceeds the required experience of serving Medicaid covered populations for the past 5 years*, including children, adults, older adults, Medicare and Medicaid Members, individuals with disabilities, and individuals with multiple chronic, comorbid conditions. Additionally, few organizations have more experience serving the underserved and Medicaid populations as CCHA *Plus* managing partner Centura Health. Centura Health's founder, Sisters of Indiana, opened St. Anthony hospital in Denver in 1892. To this day, Centura Health continues to provide services to the Colorado community; in 2016 Centura Health provided $415 million in community benefits, such as free care.

Figure 4.2-2. CCHA Plus Partner Experience

CCHA *Plus* Managing Partners' Relevant Experience	Anthem	Centura	PHP	PPP	Total Years
Experience managing projects of similar size and scope	26	21	6	n/a	**53**
Consecutive years delivering comprehensive BH/PH services	23	21	6	n/a	**48**
Consecutive years providing PH administrative services as a Primary Care Case Manager Entity or similar non-capitated PH services contract	n/a	21	6	n/a	**27**
Years serving the Medicaid population	26	21	13	21	**81**
Consecutive years of experience administering managed care with Provider Network management, claims payment, performance evaluation, and quality improvement	26	10	21	n/a	**57**
Consecutive years of experience managing risk for covered services	26	21	21	21	**89**
Years of experience with Rural and/or Frontier health care delivery	26	21	6	n/a	**53**
Number of employees in Colorado	2,000	21,000	200	n/a	**23,200**

CO_RAE_OR2_CCHAPlus_6_COB_1.4

Administering Managed Care (4.2.2.5): The CCHA *Plus* managing partners ***easily exceed the required past 10 years of experience administering managed programs***, including innovative infrastructure development and implementation to improve access with large networks of Providers, managing and paying claims, putting systems in place to evaluate and monitor performance, and designing coordinated quality improvement initiatives. Anthem, a CCHA *Plus* managing partner, through its affiliated companies, currently administers integrated Medicaid PH and BH programs in 18 states and has proven outcomes and successes.

Managing Financial Risk (4.2.2.6): The CCHA *Plus* managing partners have more than the requirement of 10 years' experience in creating and managing health care contracts with financial risk for covered services. Anthem alone has 26 years of experience managing risk contracts and developing innovative payment and incentive models to encourage Provider participation and Member access.

Delivering Care in Rural and Frontier Counties (4.2.2.7): While we are not bidding on Region 1, 2, or 4, we do consider parts of Region 6, like Gilpin and Clear Creek counties, to be somewhat rural mountain areas that have unique issues with access to health care services. ***To these areas, CCHA Plus partners bring many years of experience delivering and coordinating health services in Rural and Frontier***

areas. As a RCCO, CCHA helped rural Clear Creek County who lost its only PCMP serving the area. CCHA worked with the County Public Health Department and provided $30,000 to fund interim transportation to other areas while helping them find primary care. Additionally in 2017, Centura Health opened a clinic in partnership with the County.

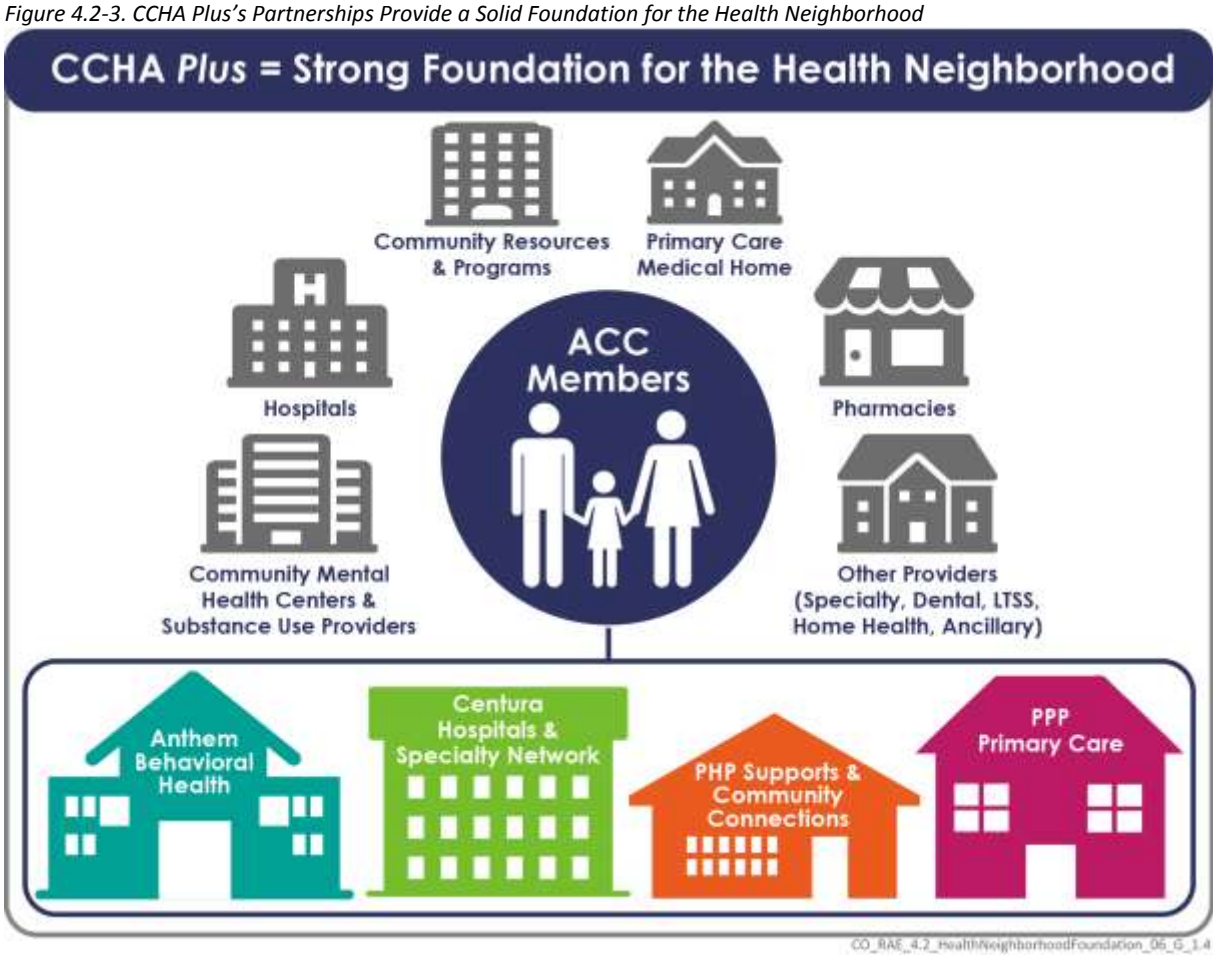
Demonstrated Behavioral Health Experience: CCHA *Plus* brings extensive experience building a BH network and supporting individuals with complex needs, including those with serious and persistent mental illnesses (SPMI), serious emotional disturbances (SED), as well as substance use disorders (SUD). Anthem's robust Medicaid BH programs throughout the country have utilized wraparound services for health, social, and alternative services, such as intensive care management, assertive community treatment, housing programs, peer support, and vocational services. Anthem brings strong experience in managing 1915(b)(3) waiver services, tapping deep expertise in recovery and resiliency strategies as well as an intense focus on integration between PH and BH services. Anthem takes pride in achieving integration strategies both at the *program* level as well as at the *practice* level. These programs have received many awards and industry recognitions. Most recently, ***Anthem's Opioid Over-utilization Management Program was recognized in March 2017 for "Excellence for Care Management Strategies"*** by the Pharmacy Benefits Management Institute. Several programs were cited in the 2016-2017 Best Practices Compendium by the Institute for Medicaid Innovation, including the Primary Care Integrated Screening, Identification, Treatment, and Evaluation (PC-INSITE) program as well as the COACHES program for youth transitioning from foster care to adulthood. ***In 2016, Anthem was among just 27 organizations recognized with the 2016 Disability Employer Seal by the*** National Organization on Disability.

CCHA *Plus* has all the tools needed to be a successful RAE in the next iteration of the ACC model. The following sets us apart from others:

- CCHA as a RCCO serves 135,000+ Medicaid Members in Region 6 and is among the top performers in the state by providing Member- and family-centered programs, support to Network Providers, and by collaborating with Health Neighborhoods and Communities. CCHA has received strong support to serve as a RAE from Members, Network Providers, and Community partners in the Health Neighborhood. Please refer to the attached Letters of Support.
- CCHA *Plus* will bring vast experience in PH and BH integration and management. Our model is to integrate rather than continue to keep separate these two integral pieces of health care.
- We are poised to implement new payment models, including risk-based models, and want to partner with the Department to use alternative payment methodologies as a tool to drive integration and value.
- Our goal is to collaborate, not duplicate, making the best use of scarce resources. We will continue our work with Network Providers and the Community to develop the Health Neighborhood and help make sure Member needs are met, while managing every health care dollar to maximum potential.
- We will remain locally focused and tailor our programs to the region, county, city, and Health Neighborhoods and Communities where Members reside.

No other organization in Colorado brings together the expertise and resources that CCHA *Plus* offers to the Medicaid population. As illustrated in Figure 4.2-3 on the next page, ***the CCHA Plus partnership of Primary Care, specialists, hospitals and BH will lay a solid foundation for the Health Neighborhood, promising engaged Providers with aligned incentives to achieve greater integration and reduce duplication and waste.***

Figure 4.2-3. CCHA Plus's Partnerships Provide a Solid Foundation for the Health Neighborhood



a. Managing Projects of Similar Size and Scope + b. Serving Medicaid Covered Populations

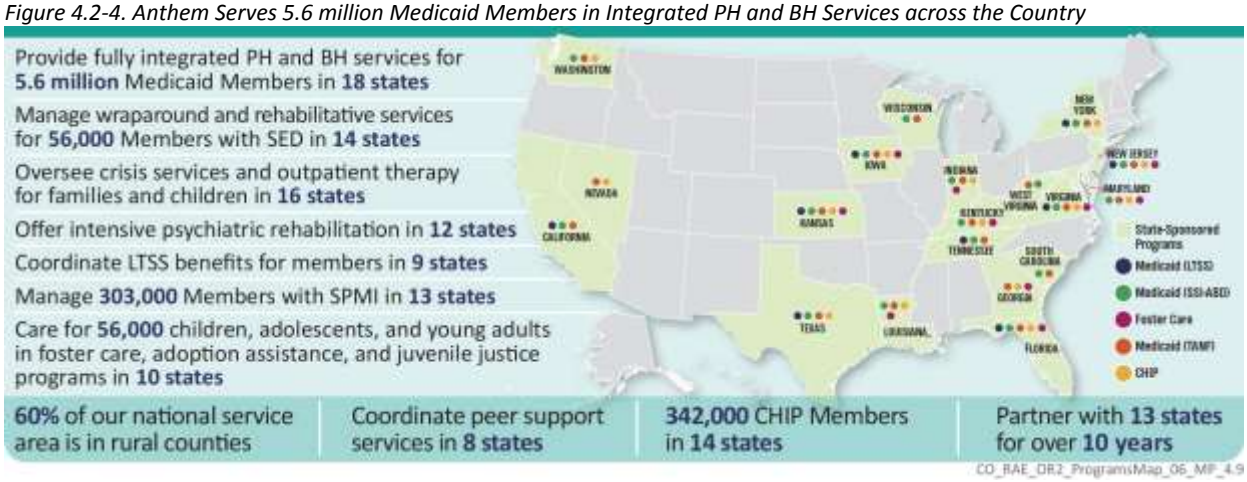
CCHA Plus brings 53 total years of combined experience managing projects of similar size and scope and 81 total years of combined experience serving Medicaid covered populations. Our managing partners have experience with serving rural (as well as urban) populations, improving access to care, enhancing Member engagement, robust Provider tools and resources, wraparound community supports, and track record of philanthropy and community reinvestment. They also have a significant breadth of experience serving the Medicaid population in various program and payment models, both locally in Colorado and across the country.

CCHA has operated as the RCCO for Region 6 for the past 6 years and serves the Colorado Medicaid population as a PCCM entity. Region 6 includes more than 135,000 Members in a diverse area that includes both urban and more rural mountain areas encompassing Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties. CCHA learned early in program development that a one-size-fits-all approach does not work and thus developed a successful model that uses data to identify the demographics and Members' and Network Providers' needs to create programs that are tailored and effective, such as the BH, Maternity, Corrections, Foster Child, and Medicare-Medicaid Programs.

Additionally, Anthem currently provides integrated PH and BH services to 5.6 million Medicaid Members in 18 state Medicaid programs across the country *and* ***has had a strong local presence in Colorado for***

75 years. Anthem's local health plan is also one of the few commercial health plans providing a product on the Colorado Health Insurance Exchange in urban and less-urban areas. The map below in Figure 4.2-4 demonstrates Anthem's national footprint serving Medicaid and other state-sponsored programs.

Figure 4.2-4. Anthem Serves 5.6 million Medicaid Members in Integrated PH and BH Services across the Country



***Through Anthem, CCHA Plus brings the expertise needed to improve and expand fully integrated BH care, including the 1915(b)(3) services*, including** managing crisis services and outpatient therapy for families and children in 16 states, intensive psychiatric rehabilitation in 12 states, and peer support services in 7 states. CCHA Plus will draw on our partner's extensive experience partnering with states to administer publicly funded SUD programs and currently provide SUD benefits in 18 states.

c. Administering Managed Care + d. Managing Financial Risk for Covered Services

CCHA Plus brings 57 total years of combined experience administering managed care and 89 total years of combined experience managing financial risk for covered services. The CCHA *Plus* managing partners bring an unparalleled record of success in improving access to care, strengthening Member engagement, improving the delivery and quality of health care services, and bringing robust Provider resources. We know it is important to provide high quality, coordinated care while protecting and administering State money effectively — that is what we will bring as a RAE.

Track Record of Success

As a RCCO, CCHA has been consistently near the top of ACC quality performance, and since 2016 they ***achieved an outcome of better or best in the state for 8 out of 9 metrics,*** far exceeding other RCCOs' performance of between 3 and 5. The success in the ACC Program is due in part to CCHA's flexibility and adaptability to changes to the health care system, Medicaid program, and Member needs. The CCHA model was created specifically around the goals of the ACC program, not forcing the program to fit into existing infrastructure. CCHA works with the Department, Network Providers, and the Health Neighborhood and Community to achieve the goals of the ACC Program and Key Performance Indicators (KPI).

Table 4.2-1 below is an example from the March 2017 ACC Management report that shows CCHA's performance is among the best across nearly all measured categories. As an example, ***CCHA's total cost of care is $6.22 per member per month less than the highest cost region***.

Table 4.2-1. KPI Performance All Regions, ACC Management Report, March 2017

Key	Best Performance	Better than Standards	Worse than Standards	Worst Performance

		RCCO 1	RCCO 2	RCCO 3	RCCO 4	RCCO 5	RCCO 6	RCCO 7
Current Program KPIs	ER KPI PKPY	616.54	721.85	704.07	711.05	762.35	662.02	749.37
	Post-Partum KPI Rate	80.36%	73.13%	66.49%	77.73%	61.54%	76.13%	78.56%
	WCC 3 - 9 KPI Rate	47.33%	44.10%	51.53%	41.93%	56.91%	51.64%	41.06%
Member Experience	30 Day Follow-Up Rate	44.80%	44.93%	43.81%	46.13%	42.52%	44.64%	44.17%
	PCMP Attribution % Rate	75.59%	81.30%	73.26%	82.67%	80.06%	76.70%	73.77%
Cost	TCC (3M Calculated) PMPM	$220.73	$224.57	$225.66	$217.41	$219.79	$221.82	$228.04
Retired KPIs	30-Day Readmissions PKPY	4.27	4.24	4.97	4.48	6.28	4.95	4.60
	High Cost Imaging PKPY	256.99	264.77	234.53	271.31	257.56	222.24	240.37
	Well-Child Check 0 - 21	46.47%	45.15%	50.10%	41.98%	55.40%	47.50%	42.02%

CO_RAE_5.14_CCHA(RCCO6)Performance_56_SSG_1.2

Anthem outperforms competitors on key NCQA behavioral health measures

Based on 2016 NCQA national benchmarks, Anthem Medicaid programs **outperformed 75%** of other Medicaid programs on these key behavioral health measures:

- Antidepressant medication management (acute and continuation phases)
- Diabetes monitoring for people with diabetes and schizophrenia
- Follow-up after hospitalization for mental illness (7 day and 30 day)
- Follow-up care for children prescribed ADHD medication (in all phases including initiation, continuation and maintenance)
- Initiation and engagement of alcohol and other drug dependence treatment
- Use of multiple concurrent antipsychotics in children and adolescents
- Use of first line psychosocial care for children and adolescents on antipsychotics

CO_RAE_OR2_OutperformsNCQABH_17_COB_DP_1.3

In addition to CCHA's performance as a RCCO, Anthem brings in-depth experience and expertise in MH and SUD services.

Anthem's Medicaid BH program has received national recognition as an accredited Managed Behavioral Health Organization by the National Committee for Quality Assurance (NCQA). This demonstrates adherence to evidence-based practices for providing high quality care, access, and consumer protections, and underscores Anthem's success in administrating a quality management program. ***Anthem has over 26 years of experience adopting BH HEDIS measures as performance indicators for clinical improvement.*** Anthem's Vice President of Behavioral Health and Physical Health Integration is a member of the National Quality Forum's committee to endorse BH performance measures that improve outcomes, particularly for MH and SUDs.

Anthem also brings a strong commitment to integration of BH services both at the program level and at the practice level. As a RAE, CCHA *Plus* will have PH and BH employees working side by side in regional, local, and combined offices. We will provide essential PH and BH functions locally and we will not subcontract these areas outside of our organization. We will have an integrated, team-based approach to care coordination. We will utilize our managing partners' strong experience at the practice-level, facilitating BH clinical staff into Primary Care practices, and will incorporate Primary Care clinicians into CMHCs (an example is BH-led health homes for people with serious mental illness.).

CCHA has been a peak performer among RCCOs. They have established a primary care network through robust support to independent primary care proivders. They have strengthened Health Neighborhood collaboration through sophisticated data sharing, documented referral processes and combined strategic planning efforts. Additionally, CCHA has convened Communities to collaborate when serving shared Members and started to break down the silos between medical and non-medical services. All of these efforts have resulted in improved Member and Provider experience, high quality performance and reduced costs in Region 6. Through CCHA's experience as the RCCO in Region 6 we know that the FQHCs and CMHCs in the region, while vital to the Medicaid system, are not able to fully support and provide access to services for Members. As a RAE, CCHA *Plus* will include these vital FQHCs and CMHCs and support them to improve quality performance and increased access to care, while also expanding the independent provider network and growing access opportunities. With CCHA *Plus* as the RAE, Members will maintain continuity of care and all Network Providers, not just FQHCs and CMHCs, will continue to receive top notch provider support services so they may continue to evolve with the ACC. The work CCHA has done with Health Neighborhood and Community partners in Region 6 will not be lost, but instead built upon.

The following sections will give more in-depth descriptions of the strong track record and experience of CCHP *Plus* managing partners in focusing on and building upon these foundations:

- Medical management, care coordination, and Member engagement
- Claims payment and managing financial risk
- Network development and Provider support
- Health Neighborhood
- Quality improvement, accountability, and reporting

Medical Management, Care Coordination, and Member Engagement

As a RAE, the CCHA *Plus* pillars of organizational experience align perfectly with ACO goals — a health system with a Network of physicians, hospitals, and other Providers along with a managing company to monitor treatments and cost. Our RAE model will help make certain that Members are receiving the right care, at the right time, and in the right setting. We will add value to the Medicaid system by managing costs while serving Member and Provider needs and achieving the Quadruple Aim.

Provider Testimonial

Peak Pediatrics has worked very closely with CCHA over the last two years, and we have been so impressed with the support they have provided to our patients through social work and nursing support, as well as through quality improvement coaching for our practice as a whole. Their dedication to improving the overall health of their members has been impressive, and we strongly support their bid to serve as a RAE in 2018.
Laura Johnson, BSN, RN, Clinical Manager, Peak Pediatrics

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The CCHA *Plus* model is based on the similar and complementary values and approaches of both CCHA and Anthem to meet the unique needs of the Medicaid population and improve outcomes, achieve performance goals, enhance Member experience, and control costs. The program centers on the Medical Home with the PCMP (or a BH-led health home with a CMHC) and manages the care delivery system across the entire care continuum.

The CCHA *Plus* person-centered approach to care planning will

engage Members based on where they are in their recovery and wellness journey. We recognize Members as the primary contributors in their care. Individualized care plans address PH, BH, and social determinants of health such as resources to meet individual needs, proactive strategies to mitigate or manage crises, and day-to-day flexibility to respond to ever-changing needs. We use a trauma-informed engagement approach based on strategies of recovery and resilience. This approach features motivational interviewing and connects Members with peer support or community health workers when needed.

We will use ***a multi-disciplinary care coordination team of social workers, nurses, and community resource specialists to work in the community and meet Members where they are.*** Care Coordinators, including BH-focused Care Coordinators, will not be just telephone-based. For example **CCHA Care Coordinators currently spend 90% of their time in the community.** CCHA Care Coordinators are currently co-located or embedded in 10 Primary Care practices, 4 hospitals, 1 county parole office, and community resources such as The Action Center and The Giving Tree of Denver. We will expand this further and also include embedded Care Coordinators in CMHCs and SUD programs. In these settings, social workers bring an added layer of expertise, understanding, and alignment that practices or facilities cannot immediately provide. The remainder of the care coordination team rotates throughout the community to work with Members in the setting of their choice.

Some of the most successful Member outreach efforts have taken place directly in a residential area where CCHA has identified large concentrations of attributed Members, such as apartment complexes. Methods included using AmeriCorps volunteers for direct and targeted outreach, and working with food bank trucks to coordinate visits to apartment buildings with CCHA Care Coordinators who then provide Members with extra supports.

The team of telephone and in-person Community Resource Specialists develop relationships with community partners that include county agencies, Long-Term Services and Supports (LTSS) organizations, transportation providers, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), to name a few. Through these relationships, CCHA develops bi-directional referrals and meet Members where they receive other services. This helps avoid duplication of services and gives Members exactly what they need without visits to multiple places.

The care coordination programs use data to determine the greatest need across every life stage. These programs include focus on the following:

- General care coordination
- Complex care coordination
- Transitions of care coaching program
- Maternity
- Medicare-Medicaid Program
- Pediatrics
- Emergency room (ER) recall
- BH
- Corrections population
- Member attribution to a PCMP or BH-led health home

These care coordination programs are an integral part of overall medical management and drive Member engagement, improve health outcomes, and lower costs to Medicaid***. During the 2016 State program audit, CCHA scored 97% on care coordination chart reviews.***

Anthem will support the CCHA *Plus* Care Coordination program by bringing expertise with the 4 quadrant model, which makes sure that people with varying levels of physical, behavioral, and social needs are matched with the right level of support. In particular, we will tap Anthem's experience serving individuals with serious mental illnesses, serious emotional disturbances, and SUDs and apply a whole-person and person-centered approach to their care.

Claims Payment and Managing Financial Risk

Through Anthem, CCHA *Plus* will have sophisticated claims processing systems as well as proven strategies for managing financial risk for covered services.

Claims Payment

CCHA *Plus* will use effective technology and experienced employees to deliver consistent, prompt, and accurate claims payment. Anthem has the proven ability to process large volumes of claims timely. In 2016, they processed:

- Total BH Claims: 682,692
- Average Turnaround Time: 8.25 days
- Percent Paid in 30 Days: 96.5%
- Percent Paid in 60 Days: 97.8%
- Percent Paid in 90 Days: 98.8%

In 2016, Anthem's claims payment accuracy (number of claims) averaged 99.39% and financial accuracy (claim dollars) averaged 98.99%. In 2016, Anthem submitted more than 233.5 million encounters to their state Medicaid partners.

Managing Financial Risk

CCHA *Plus* will collaborate with the Department to implement financial risk models for covered services in the Colorado Medicaid ACC Program. ***CCHA Plus has the financial reserves and experience to bring new and innovative payment models to the Department that have proven successful in other states or payer models.***

Anthem has been managing financial risk for Medicaid and other state-sponsored programs for 26 years. Over this time, they have developed deep expertise in multi-pronged strategies for managing financial risk, which encompasses the following:

- Underwriting and actuarial analysis.
- Predictive models that identify Members at high risk for high medical costs coupled with effective and innovative Care Coordination programs.
- Cost of Care Tracking System: Strategies for managing cost and quality of care are implemented and closely tracked using the Cost of Care Tracking system. They are based on in-depth analysis to create interventions that will address underlying cost and quality drivers. A variety of cost-trend and dashboard reports track all levels of costs of care, including inpatient, ER, outpatient, and pharmacy. These costs are broken out by type of care, geography, time period, specific Member populations, and other variables. The Cost of Care Tracking system allows for identification, sharing, and leveraging of best practices.
- Expansion of the Provider Network to include alternatives to BH inpatient and ER levels of care, such as psychiatric urgent care facilities or mobile crisis teams.
- Value-based payment (VBP) model: This experience spans all lines of business, including Medicaid, Medicare, and commercial programs. These innovative payment models incentivize Providers of all types including PCPs, ACOs and large health systems, obstetrical and BH Providers and facilities, and include performance-based programs for LTSS Providers. ***Nationally, more than 3.7 million Medicaid Members are attributed to a PCMP or other Provider who participates in one or more of Anthem's performance-based models. More than 3.1 million Medicaid Members (approximately 48% of total Medicaid Membership) are currently associated with PCPs who are participating in Anthem's Provider Quality Incentive Program (PQIP), shared savings/shared risk, or delegated risk total cost of care (TCC) programs.*** Nationally across all lines of business, the aggregated spend in value-based

contracts (including both TCC and Pay for Value (P4V) models) is approximately 58% of total medical spending, and 43% under TCC programs only.

Additionally, PHP and PPP have 21 years of experience as a management organization and a physician group developing and managing payment models such as budget models, capitation (risk), fee-for-service (FFS), percentage of premium, per member per month ACO model, shared savings, and various combinations of these payment models. Their experience engaging Providers to participate and support innovative payment models will aid in the success of CCHA *Plus*.

Network Development and Provider Support

CCHA *Plus* managing partners participate in or have created Accountable Care Organizations (ACOs), which have led to more integrated and value-based care in a hybrid managed care model. As successful ACOs across Medicare and commercial populations, our partner organizations have vast experience in meeting the following goals:

- Managing care across the care continuum and integrating across settings
- Conducting performance and quality measurement across Providers
- Organizing and managing Provider Networks to meet Members' needs
- Setting standards, scoring, and evaluating performance
- Controlling the total cost of care
- Achieving the Quadruple Aim

Additionally, CCHA has a track record of developing and supporting the provider network to meet the needs of Members. At the time CCHA began serving Region 6 as a RCCO, the 3 ***Federally Qualified Health Centers*** (FQHC) in the region, Salud Family Health Centers, Metro Community Provider Network, and Clinica Family Health, ***only served about 20% of the Medicaid population in Region 6.*** CCHA worked to quickly build a Primary Care Network that would provide access and choice to Members beginning with partner organizations, the physicians in Centura Health Physician Group and PPP. From there, they built relationships and contracted with practices already accepting Medicaid. To encourage practices to increase their panel size to serve more people, CCHA provided education about the value of the ACC Program and the services CCHA would bring to their practice. The next phase included recruitment of practices that had not previously accepted Medicaid.

Through these efforts, CCHA has established one of the largest Primary Care Networks in the ACC Program and provides exceptional access and choice to Members. CCHA's network management model meets practices where they are and works collaboratively to help improve quality, control costs, and enhance Member experience. Each practice has varying mixes of payers, understanding of Medicaid, and a background in serving the Medicaid population. This is why CCHA's model is flexible to fit the needs of every practice to help improve care.

The CCHA letters of support in Attachment 4.2-1 illustrate that Primary Care practices in Region 6 have embraced this model.

The CCHA *Plus* model will include the following components:

- Assignment of a **single point of contact** to each practice to provide care coordination services and additional help and resources.

- A sophisticated Provider Support program that includes **Practice Transformation Coaches, including Behavioral Health Transformation Coaches,** to implement Quality Improvement teams. The coaches help improve practice operation, including process improvement, KPI workflows and planning, proper billing and coding, Member access, electronic health record assistance, systems training, data and analytics, and transition to Member-centered care.
- Supplying practices with **free Member education tools** and materials geared toward the Medicaid population. Many CCHA *Plus* materials will help Providers start conversations about depression or avoidable ER utilization with their patients. As a Member education tool, we will offer the Online Wellbeing Program, a free, value-added benefit. This program is a web and mobile self-help resource that helps Members get active in their PH and BH health.
- Offering the CCHA *Plus* **Practice Incentive Program** to encourage Providers to provide quality, Member-centered care. Providers can earn $7,500 to $10,000 per year by engaging with the CCHA *Plus* Practice Support team and achieving ACC KPI goals. The program will also include a Behavioral Health Quality Incentive Program for independent behavioral health providers and CMHCs.
- Sharing **timely updates** on changes from the Department and helping them with systems changes, revalidation, or other requests.
- Creating opportunities for sharing **best practices** through Medicaid Provider Update meetings held twice a year.

Innovative BH Payment Incentive

Our Behavioral Health Quality Incentive Program (BHQIP) will offer additional reimbursement to community MH agencies and other high-volume BH Providers to improve the coordination and quality of Members' physical and behavioral health care through annual incentive payments. To qualify, Providers must meet or exceed quality targets, such as reduction in BH inpatient readmission rates, decrease in unnecessary ER utilization, and increase in PCP visits, follow-up after discharge for treatment of a MH disorder, antidepressant medication management, and initiation and engagement in alcohol and drug dependency treatment.

CO_RAE_OR_2_BQHIP_68_COB_1.3

BH/PH practice-level integration

Additionally, CCHA *Plus* will continue to work with Providers and the CMHCs to integrate **BH and Team-based Care into the Primary Care setting,** allowing for bi-directional referrals and increased access to BH care. This experience and Provider trust sets a foundation for CCHA *Plus* as a RAE to fully integrate PH and BH services. We will work to integrate Primary Care into BH settings for creation of BH-led health homes. Anthem has extensive experience in multiple states creating BH homes to serve people with serious mental illness. For example, in Georgia, 33 Providers in the Anthem Network are Joint-Commission certified as BH homes, which recognizes Providers that are making certain that individuals with SMI or SED have access to the full array of integrated, coordinated BH and Primary Care services.

State Auditor Testimonial

From inception, CCHA and its network providers have participated in all grants and special program opportunities presented through the Department, citing examples of the SIM, COP, Comprehensive Primary Care (CPC+), and AmeriCorps programs. In addition, CCHA has partnered with the Department to pursue Center for Medicare and Medicaid Innovation (CMMI) grant funds to obtain technical assistance on value-based payments to support integrated care for pregnant women. Simultaneously, CCHA has identified regional priorities through CCHA's community partnerships, resulting in CCHA participation in an estimated 10 to 15 initiatives in each county of the region.

Health Services Advisory Group Auditor for the Department

CO_RAE_HlthSrvAdvGroupAuditor10_6_COB_TST_10.1

Health Neighborhood

As a RAE, CCHA *Plus* will take a local approach to tackle the sometimes fragmented and volume-driven health care model by promoting evidence-based programs and collaboration throughout the Health Neighborhood.

For the past 6 years, CCHA has worked to grow an integrated community delivery system that improves health outcomes, better manages care, and uses State resources wisely. They have partnered closely with the Department to develop an iterative

program that has continuously evolved over the years. CCHA has capitalized on opportunities like the Medicare-Medicaid Program, the Colorado Opportunity Project, and the State Innovative Model (SIM) to enhance their program and move toward a more coordinated and integrated system that rewards improved health outcomes.

CCHA *Plus* will strive to fill gaps and create a more seamless system of coordinated care for Members while eliminating duplication of services. CCHA has established many partnerships across the Health Neighborhood that CCHA *Plus* plans to build on in phase 2 of the ACC. CCHA regularly meets with the community to facilitate collaboration among the many organizations that serve the Colorado Medicaid population. This includes the CCHA Health Neighborhood Advisory Committee, Colorado Opportunity Project, local public health agency, and Delivery System Reform Incentive Payment (DSRIP) meetings, JeffCo Hotspotting Alliance, and the Mile High Health Alliance.

Establishing a Health Neighborhood starts with hospitals, specialists, and Primary Care Network. CCHA has collaborated and fostered relationships with community partners to give Members community services and supports to improve health and quality of life. These relationships include:

- Specialty care Providers
- LTSS Providers
- CMHCs
- SUD and rehabilitation facilities
- Dental Providers
- Public Health agencies
- Health and Human Services
- Criminal justice systems
- Hospitals
- Urgent care centers
- Long-term care and skilled nursing facilities
- PCMPs
- FQHCs
- School districts
- Social determinant community resource agencies providing services such as transportation, housing, and food
- Foster programs
- Churches and community centers
- MH advocacy organizations such as NAMI
- MH clubhouses and drop-in centers
- Other RCCOs

Each investment with community partners comes with an agreement to collaborate so investments improve health and quality of care and reduce costs. CCHA has invested in county public health and human services efforts, each of the 4 community health alliances in the region, FQHCs, and CMHCs. Investments have also been made in projects to share data with many Health Neighborhood partners to enhance collaboration efforts to fill gaps and improve coordination to create a seamless system of care for Members.

Quality Improvement, Accountability and Reporting

As a RAE, CCHA *Plus* will bring extensive experience implementing and maintaining a comprehensive Quality Improvement program, with a focus on accountability and reporting. We are excited to offer the combined expertise of CCHA as the current RCCO for Region 6 and Anthem's long, successful history with quality improvement initiatives for BH.

Quality Improvement

CCHA is currently participating in various programs with the Department to improve quality of care for Colorado Medicaid Members. As demonstrated in the most recent reports from the Department, CCHA is one of the top performing RCCOs in the ACC. This is a result of CCHA's Quality Improvement program, which continuously assesses performance on all KPIs and other key ACC measures.

Over the course of the Contract, CCHA's Quality Improvement program has resulted in achievement of 2 out of 3 current KPIs and maintaining top performer status on retired KPIs. Currently, the team is

focused on the final KPI that CCHA and all other RCCOs have yet to achieve: well-child checks (WCC). CCHA is improving performance more than most other RCCOs.

Anthem also brings a strong background in improving quality of care for Medicaid Members and is proud of their accreditation by NCQA as a Managed Behavioral Health Organization. Organizations earn their NCQA accreditation by proving their proficiency across 5 standards: quality management and improvement, Care Coordination, utilization management and credentialing, and Members' rights and responsibilities. ***Anthem Medicaid scored 100% on the associated standards.***

The following example from Anthem's Nevada health plan illustrates Anthem's approach of using data analysis and trend spotting to inform innovative solutions to reduce BH inpatient and ER visits. Anthem reviewed monthly BH admit and readmit trends by facility as well as reviewed trends for Members with the highest utilization. Discharge plans were analyzed to address these trends and how to better coordinate aftercare with Care Coordinators and hospitals. They then developed creative solutions, such as partnering with community Providers to develop and provide housing for Members with high inpatient utilization, SUD, and outpatient non-adherence. Anthem also partnered with community Providers to create Psychiatric Urgent Care Facilities to optimize diversions from the ER. These strategies made a big impact in reducing BH inpatient and ER visits:

- 25% decrease in BH ER visits from peak in 2016 to January 2017
- 1,600 ER diversions
- 1,000+ Psychiatric Urgent Facility assessments
- 20% decrease in BH inpatient readmissions from peak in 2016 to January 2017

Accountability and Transparency

CCHA *Plus* will foster a culture of accountability, transparency, and partnership with the Department to achieve ACC goals. We will adhere to all of the Department's deliverable requirements in the Contract and strive to exceed expectations for timeliness and thoroughness.

As a RCCO, CCHA has remained accountable and collaborative with the Department and maintained a good relationship in the following ways:

- Program deliverables have been cited as a State model by the Department's ACC staff.
- The CCHA Program Officer serves on the Program Improvement Advisory Committee (PIAC) with the ACC community and the Department to identify new opportunities to serve Members better. She has led her RCCO colleagues and helped to set agendas and make meetings with the Department meaningful and productive.
- The ACC Contract Manager for Region 6 visits CCHA almost weekly to learn about the CCHA model, participates in staff meetings to get to know the teams and regularly rides along with Care Coordinators when they visit Members in the community setting, allowing for relationship building between CCHA and the Department and best practice sharing.

Anthem also brings experience in accountability and assures good stewardship of taxpayer resources. An example that illustrates Anthem's approach relates to reducing BH fraud, waste, and abuse. For one Medicaid plan, they analyzed 12 months of BH outpatient data and identified BH Providers who were out of compliance with billing, documentation, and utilization standards. Anthem provided coaching and education to these Providers, which included education on best practices in these areas and prevention of unnecessary utilization and poor quality of care. This initiative achieved 4.4% savings in total outpatient BH spend. It was identified as a best practice and is currently being replicated and expanded in 7 Medicaid state health plans.

As a RAE, CCHA *Plus* will use all of the approaches highlighted above to manage the cost and improve the quality of health services for the Colorado Medicaid population.

CCHA *Plus* Will Meet All Section 4.2 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 2, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 4.2 that are not detailed in our response.

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.

CCHA *Plus,* through our managing partners, has extensive experience delivering and coordinating comprehensive physical health (PH) and behavioral health (BH) services both in Colorado and proven models outside of the state. Specific examples of this experience, listed in Tables 4.2-2 and 4.2-5, demonstrate the breadth of our organizational expertise providing, arranging for, or otherwise being responsible for the delivery and coordination of comprehensive PH and BH services.

CCHA Plus will leverage this extensive experience and resources to effectively integrate BH and PH for Coloradans enrolled in Medicaid in the next iteration of the ACC program.

Additionally, our managing partners have a wealth of experience providing and arranging for successful alternative payment models, including varying levels of risk. As a Regional Accountable Entity (RAE), CCHA *Plus* will bring to the region local knowledge, large primary care, specialty and hospital networks, and proven BH programs. We are confident our programs will provide a more integrated patient experience and improved health outcomes, as well as save money for the Colorado Medicaid system.

As a current Regional Care Collaborative Organization (RCCO) for Region 6 of the Accountable Care Collaborative Program (ACC Program), CCHA has direct experience developing successful programs to serve the Colorado Medicaid population as a Primary Care Case Management (PCCM) Entity for the past 6 years. CCHA continues to successfully achieve the goals of the ACC Program to combine the PCCM model with characteristics of an Accountable Care Organization (ACO) model to:

- Better understand Members' health and social needs
- Manage and integrate the continuum of care across different settings including primary care, inpatient care, and post-acute care
- Conduct performance measurement
- Prospectively plan budget and resource needs
- Develop and organize Provider Networks

CCHA *Plus* looks forward to working with the Colorado Department of Health Care Policy and Financing (Department) to build upon the successful base of the ACC Program to truly integrate BH and PH. We agree with the Department that the key drivers in Medicaid reform are to invest directly in the

Community and Regions to hold the people and organizations providing care accountable for the quality, outcomes, and cost of care. The CCHA *Plus* model will promote Member-centered, evidence-based, efficient care that deters volume-based and avoidable costs from fragmented care by joining PH and BH systems.

For us, integration is more than just a buzzword; we will build our programs to promote a person-centered, integrated model. By taking a whole-person approach to our in-house, local utilization management, care coordination, and disease management across PH, BH, and community services, we will keep high-quality care efficient and cost-effective and encourage Members to take increased responsibility for their health care. Many Members face co-occurring PH and BH conditions, and we know these cannot be addressed in silos. ***Collaboration with our Care Coordination team will include working with each primary care medical provider (PCMP) to detect and treat common BH conditions, as well as reduce gaps and inappropriate care.*** We will team with Network Providers, local county resources, and community resources to wrap supports around Members.

Our organizational experience in delivering community-based BH care to support Medicaid Members with serious and persistent mental illness (SPMI) and emotional disturbance, enabling them to manage symptoms, adhere to treatment, improve their quality of life, and achieve recovery and resilience, is evident through experience highlighted below. CCHA *Plus* programs will provide health, social, and community resources such as intensive care coordination, housing support, and medication management, to support Member goals of living in the community. As a RAE, we will integrate PH and BH to advance Team-based Care and Health Neighborhoods, promote Member choice and engagement, pay Network Providers for increased value, and foster better accountability and transparency.

a. - i. Experience

For 6 years as a RCCO, CCHA directly has served the ACC Medicaid population, including children, adults, older adults, Medicare and Medicaid Members, individuals with disabilities, and individuals with multiple chronic, co-morbid conditions. CCHA prides itself on being one of the highest-performing RCCOs in the State per the ACC Management Report and offering one of the largest Primary Care Networks to Region 6 Members. In the first iteration of the ACC Program, CCHA started down the path of PH and BH integration and worked closely with the community mental health centers (CMHC) in Region 6 to help drive access for Members and alignment with primary care. As a RAE, CCHA *Plus* looks forward to building on those relationships and further expanding an integrated offering to Colorado Medicaid Members.

CCHA has built a large primary care Network of more than 1,000 Providers encompassing independent Providers, Safety Net Providers, and Advanced PCMPs. They are among the top performing RCCOs according to Department reports, achieving 8 out of 9 performance metrics. As you will see in Attachment 4.2-1: Letters of Support, CCHA is a convener, collaborator, and coordinator among Members, Providers, and the Community that has created a program tailored to population needs that is continually evolving to meet changes in Medicaid, the ACC program, and Members.

CCHA *Plus* managing partners know through extensive experience that many Members with multiple diagnoses and treatment regimens are unable to achieve recovery goals because open communication is lacking among PH and BH providers, facilities, and community resources. ***By closely coordinating with Providers, hospitals, and other community supports, we will decrease readmissions and recurring, unnecessary emergency room (ER) visits, as well as improve Member experience, while increasing quality and holistic person-centered care.*** We will also provide targeted interventions that our

managing partners have successfully implemented in other programs, such as crisis intervention and stabilization, psychosocial rehabilitation, and therapeutic behavioral on-site services.

CCHA Colorado Medicaid Experience

Table 4.2-2. Project Experience

Colorado Accountable Care Collaborative Program (ACC Program) Colorado Region 6 – Boulder, Broomfield, Clear Creek, Gilpin & Jefferson counties	
Population Served	Medicaid Members enrolled in the Colorado ACC Program in Region 6
Number of Covered Lives	135,000+
Primary Health Care Services Included	CCHA is responsible for developing and managing the Health Neighborhood network, including primary care, BH, specialists, hospitals, Long-Term Services and Supports (LTSS) Providers, public health agencies, and resources to combat social determinants of care. CCHA also provides direct care coordination services to Medicaid Members. You will find the full scope of services in OR 2 and throughout this proposal.
Level of Managed Care and Financial Risk	CCHA performs functions as a PCCM Entity, providing non-capitated PH services. This is a primary care incentive model with no downside risk or shared savings. CCHA conducts managed care activities, such as ER reduction strategies and maternity programs, which help control costs and improve outcomes. CCHA has laid the groundwork for CCHA *Plus*, which is ready and able to take on various payment models and risk, including management of the capitated BH program. We look forward to collaborating with the Department to explore other payment and incentive methodologies.
Activities in Rural and Frontier Areas	While Clear Creek and Gilpin counties are not formally recognized as Rural or Frontier, their lack of health care and transportation availability mimics rural counties. CCHA has been successful in bringing transportation and primary care to these underserved counties.
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	Benjamin Harris Benjamin.Harris@state.co.us 303-866-2399

State Innovation Model (SIM) Colorado	
Population Served	Medicaid and Commercial Members
Number of Covered Lives	None
Primary Health Care Services Included	CCHA is a Practice Transformation Organization (PTO) providing Practice Facilitators and Clinical Health Information Technology Advisor (CHITA) support to practices. CCHA helps practices with PH and BH integration efforts. Efforts include coordinated services with external BH Providers, co-located BH services, or fully-integrated/staffed BH Providers in primary care offices. CCHA Practice Facilitators help practices with ongoing quality improvement team activities, assessments, practice coaching, and SIM deliverables. CCHA also has one of the few CHITAs among the RCCOs and uses it to help practices use data and technology more efficiently to serve the needs of their Members.

State Innovation Model (SIM) Colorado	
Level of Managed Care and Financial Risk	None
Activities in Rural and Frontier Areas	None
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	Barbara MartinBarbara.Martin@state.co.us 303-724-9525

Physician Health Partners Experience

CCHA *Plus* managing partner Physician Health Partners (PHP) has 21 years of experience in successful and Colorado-based programs. The tables below (4.2-3) comprise a sampling of PHP's background in Medicare programs, as well as innovation models such as the Comprehensive Primary Care Plus (CPC+) model.

Table 4.2-3. Project Experience

Pioneer ACO Denver Metro Area	
Population Served	Medicare fee-for-service (FFS) Members in Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties
Number of Covered Lives	24,000+
Primary Health Care Services Included	PHP was responsible for all primary care services as well as specialist Network maintenance and referrals.
Level of Managed Care and Financial Risk	PHP was selected as one of 32 Pioneer ACOs across the country by the Center for Medicare and Medicaid Innovation. This program was one of the first Accountable Care models in the country and set the stage for commercial payers and state Medicaid programs to follow. PHP had more than 300 PCMPs across the Denver metro area participate in the contract to adopt financial risk over a 3-year period for the Medicare population. In this program, primary care physicians were tasked with coordinating all care and helped Members navigate the health care system. During PHP's tenure in the program, they exceeded expectations on the extensive list of quality measures and were 1 of the lowest cost ACOs in the country. The program began with a shared savings payment model, gradually moved to a shared savings and shared risk model, then finally to a population-based payment model with financial risk. PHP was responsible for working across all Providers and hospitals to lower costs and improve the quality of care in this population.
Activities in Rural and Frontier Areas	None
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	Lyla Nichols Lyla.Nichols@cms.hhs.gov 303-844-6218

Managing UnitedHealthcare AARP Medicare Complete Medicare Advantage Program Denver Metro Area	
Population Served	Medicare Advantage Members in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson counties
Number of Covered Lives	28,000+
Primary Health Care Services Included	PHP, along with their client, PHPprime, provides utilization management/prior authorization, specialist network management/ development, primary care services, facility management, care coordination, and in the past, claims processing and payment.
Level of Managed Care and Financial Risk	Over the 21 years of UnitedHealthcare delegating services for their Members to PHP and PHP's clients, PHP has managed various payment models, including both fully capitated risk and, currently, a professional risk contract. This program is a managed care program where the Member must select a primary care provider and there is a contracted network of specialists, hospitals, ancillaries, and other facilities for Members to choose from. Prior authorizations are required before receiving services. PHP provides extensive specialist management and negotiations to help control costs and outcomes for this population. Through mergers and plan changes, UnitedHealthcare has continuously looked to PHP to provide services to their Members. UnitedHealthcare contracts with PHPprime, an Independent Practice Association (IPA) primary care client managed by PHP, and services are rendered from PHP. PHP's management of the Medicare Advantage population highly esteem both locally and across the country because of their program cost controls and quality improvement successes.
Activities in Rural and Frontier Areas	None
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	George Young George_M_Young@uhc.com 303-714-2894

Medicare Shared Savings Program (MSSP) Denver Metro Area	
Population Served	Medicare FFS Members in Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties
Number of Covered Lives	24,000+
Primary Health Care Services Included	PHP is responsible for all primary care management and care coordination.
Level of Managed Care and Financial Risk	The MSSP program is a shared savings model that uses a benchmark set annually for each participant. PHP was selected to participate in the Centers for Medicare and Medicaid Services (CMS) MSSP program to provide managed primary care services to Medicare FFS Members. PHP has the lowest costs and highest quality outcomes of any MSSP participant in their region.

Medicare Shared Savings Program (MSSP) Denver Metro Area	
Activities in Rural and Frontier Areas	None
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	Lyla Nichols Lyla.Nichols@cms.hhs.gov 303-844-6218

Comprehensive Primary Care Plus (CPC+) Program Denver Metro Area	
Population Served	Medicaid, Medicare, and commercial populations in Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson counties
Number of Covered Lives	150,000+
Primary Health Care Services Included	PHP is contracted through practices by their client, PHPprime, to enhance the practices' primary care functions and advance the primary care medical home model.
Level of Managed Care and Financial Risk	This is a primary care incentive program with no downside risk. PHP represents 20 practices with more than 100 Providers participating in the CMS CPC+ program. CPC+ is an advanced primary care medical home model where CMS offers practices per member per month (PMPM) incentives. These incentives are distributed by CMS to enable practices to make appropriate investments to improve the quality of care patients receive, improve patients' health, and spend health care dollars more wisely. PHP supports practices through integrated care coordination, practice transformation coaching, BH integration, population health, Member engagement, and reporting assistance.
Activities in Rural and Frontier Areas	None
Corrective Action Plans	None
Adverse Contract Actions and/or Litigation	None
Project Contract Manager	Emilie Buscaj, MPH, PCMH CCE Ebuscaj@healthteamworks.org 303-475-8344

Anthem's Integrated PH and BH Experience

Anthem, Inc. (Anthem) is one of the national leaders in integrated PH and BH programs. Anthem and its affiliates provide coordinated PH and BH programs in 18 states and have the experience and local expertise to meet Members where they are – specializing in the needs of complex, high-risk populations. Anthem's programs currently serve more than 5.6 million Medicaid members in fully integrated programs. More than 1 million of Anthem's Members have BH needs: across the country, they serve more than 303,000 Members living with Severe and Persistent Mental Illness (SPMI), including approximately 57,000 Members living with Severe Emotional Disturbances (SED). Anthem supports specialized SPMI programs in 14 states, including: Florida, Georgia, Iowa, Indiana, Kansas, Kentucky, Louisiana, Nevada, New York, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

In addition, Anthem has been committed to serving Coloradans for more than 75 years, and currently serves more than 1 million members in Commercial, Federal Government Solutions and Medicare programs.

Figure 4.2-8 illustrates Anthem's extensive organizational experience coordinating various state-sponsored programs and services for Medicaid populations.

Figure 4.2-8. CCHA Plus's Partner Anthem Administers Integrated PH and BH Services to 5.6 Million Medicaid Members

In Table 4.2-4, we provide a more detailed description of Anthem and its affiliates' experience delivering and coordinating integrated services in similar programs in the following states – Indiana, Florida, Kansas, Nevada, and Washington – as examples of the capabilities and programs they have successfully implemented. Experience and expertise includes infrastructure to improve access to care, build and manage a provider network, pay claims, manage capitated payment and financial risk, evaluate Provider performance, and implement quality improvement initiatives. We are confident their expertise and successes will be a welcome addition to the Colorado Medicaid landscape.

The CCHA *Plus* integrated model will coordinate services and supports across Systems of Care and emphasize Member choice, preference, access, wellness, independence, and responsibility. Anthem's programs, processes, and tools will provide valuable insight to our integrated model, especially in the critical areas of BH and LTSS. As a RAE, we will offer a truly integrated care coordination model and will not separate the management and delivery of acute and primary care services from BH or social services and supports. We will not subcontract any Member, Provider, or program elements of our model, giving us true consistency and quality control across the care continuum.

Table 4.2-4. Project Experience

Hoosier Healthwise and Healthy Indiana Plan (HIP) Indiana – Statewide	
Population Served	Medicaid Members enrolled in the Hoosier Healthwise and HIP programs: Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Uninsured Adults
Number of Covered Lives	355,000+
Primary Health Care Services Included	Responsible for the provision of PH, BH, dental, vision, and non-emergency medical transportation Services
Level of Managed Care and Financial Risk	Under the contract, Anthem receives a premium capitation payment on a PMPM basis. This premium payment is intended to cover both direct medical services and costs to administer the contract requirements.
Activities in Rural and Frontier Areas	More than 52% of Anthem's Indiana Medicaid service area is located in rural counties. They employ an array of strategies to improve rural access, such as leveraging relationships with independent practice associations and other Provider organizations to recruit additional

Hoosier Healthwise and Healthy Indiana Plan (HIP) Indiana – Statewide	
	physicians; collaborating with Network Providers to open or expand offices in rural areas, offer additional needed services, and provide after-hours and weekend appointments; creating awareness of existing telemedicine capabilities, as well as identifying and funding additional opportunities through partnerships with Providers and organizations; working with PCPs and specialists to expand use of physician extenders, including financial incentive programs that provide opportunities for additional, upfront reimbursement that can be used to expand service; coordinating transportation for Members to see necessary Providers outside their access area; and referring Members to out-of-network Providers for care through single case agreements. As an example of their commitment, Anthem provides financial support for the expansion of telemedicine. Working in collaboration with the Indiana Rural Health Association, Upper Midwest Telemedicine Resource Center, and the Indiana Primary Health Care Association; they have provided a total of $30,000 to $50,000 in grant funding to date in 2017 to support expansion of telemedicine in rural areas and in school-based settings. The money will go toward establishing presentation sites, refining telemedicine capabilities, and educating Members and Providers using telemedicine in rural and school based settings. Funds may be dispersed in the form of individual grants to school-based clinics and school systems, rural health clinics, and FQHCs, based on evaluation of specific proposals. Grants could be used to fund the costs of technology, connectivity, and other infrastructural investments needed to implement telemedicine capability, as well as provide broader awareness and education related to telemedicine.
Corrective Action Plans	In the last 7 years, Anthem has had 5 corrective action plans and all are currently closed. When there is an area of non-compliance, they work diligently on its prompt resolution.
Adverse Contract Actions and/or Litigation	Anthem has not been involved in any adverse contract actions and/or project-associated litigation (including terminations and/or cancellations). They have been involved in some litigation matters in the regular course of business which are not within the scope of this request, and we would be happy to provide additional information about those matters.
Project Contract Manager	Vickie Trout, MPA Director, Quality & Outcomes Vickie.Trout@fssa.in.gov 317-234-3804

Medicaid and Nevada Check Up Managed Care Program Nevada – Urban, Clark, and Washoe Counties	
Population Served	Medicaid Members enrolled in the Nevada Medicaid and Check Up Managed Care Program: TANF; CHIP; Aged, Blind, and Disabled (ABD)
Number of Covered Lives	193,000+
Primary Health Care Services Included	Responsible for the provision of PH, BH, LTSS, dental, vision, and pharmacy Services
Level of Managed Care and Financial Risk	Under the contract, premium capitation payments are received on a PMPM basis. This premium payment is intended to cover both direct medical services and costs to administer the contract requirements.
Activities in Rural and Frontier Areas	100% of the service is located in urban counties.

Medicaid and Nevada Check Up Managed Care Program Nevada – Urban, Clark, and Washoe Counties	
Corrective Action Plans	In the last 7 years, they have had 2 corrective action plans and both are now closed. When there is an area of non-compliance, they work diligently on its prompt resolution.
Adverse Contract Actions and/or Litigation	Amerigroup Nevada has not been involved in any adverse contract actions and/or project-associated litigation (including terminations and/or cancellations). They have been involved in some litigation matters in the regular course of business which are not within the scope of this request, and we would be happy to provide additional information about those matters.
Project Contract Manager	John Whaley, Chief of Business Lines Jwhaley@dhcfp.nv.gov 775-684-3691

Statewide Medicaid Managed Care; Managed Medical Assistance and Long Term Care AHCA Contract Florida – Statewide	
Population Served	Medicaid Members enrolled in the Managed Medical Assistance (MMA) and LTSS programs: TANF, ABD, Dual Eligible Medicare and Medicaid Enrollees
Number of Covered Lives	350,000+
Primary Health Care Services Included	Responsible for the provision of PH, BH, long-term care, LTSS, dental, vision, pharmacy, and non-emergency medical transportation Services
Level of Managed Care and Financial Risk	Under the contract, premium capitation payments are received on a PMPM basis. This premium payment is intended to cover both direct medical services and costs to administer the contract requirements.
Activities in Rural and Frontier Areas	They employ an array of strategies to improve rural access, such as leveraging relationships with independent practice associations and other Provider organizations to recruit additional physicians; collaborating with Network Providers to open or expand offices in rural areas, offer additional needed services, and provide after-hours and weekend appointments; creating awareness of existing telemedicine capabilities, as well as identifying and funding additional opportunities through partnerships with Providers and organizations; working with PCPs and specialists to expand use of physician extenders, including financial incentive programs that provide opportunities for additional, upfront reimbursement that can be used to expand service; coordinating transportation for Members to see necessary Providers outside their access area; referring Members to out-of-network Providers for care through single case agreements
Corrective Action Plans	In the last 7 years, they have had 8 corrective action plans. The most recent was in 2015 and all are closed. When there is an area of non-compliance, they work diligently on its prompt resolution.
Adverse Contract Actions and/or Litigation	In 2013, Amerigroup Florida filed an arbitration action against the Florida Agency for Health Care Administration regarding a dispute over the amount of premium to be returned to the agency for members in hospice care. Amerigroup Florida has been involved in some litigation matters in the regular course of business which are not within the scope of this request, and we would be happy to provide additional information about those matters.
Project Contract Manager	Abby Riddle, AHCA Deputy Secretary Abby.Riddle@ahca.myflorida.com 850-412-4000

Kansas Department of Health and Environment for Managed Care for Medicaid and CHIP Programs (KanCare) Kansas – Statewide	
Population Served	Medicaid Members enrolled in the KanCare program: TANF, CHIP, ABD
Number of Covered Lives	133,000+
Primary Health Care Services Included	Responsible for the provision of PH, BH, dental, vision, and non-emergency medical transportation services
Level of Managed Care and Financial Risk	Under the contract, premium capitation payments are received on a PMPM basis. This premium payment is intended to cover both direct medical services and costs to administer the contract requirements.
Activities in Rural and Frontier Areas	Approximately 84% of the Kansas Medicaid service area is located in rural counties. Kearny County Rural Health Initiative is a collaboration between Kearny County Hospital/RHC and Amerigroup Kansas (Anthem affiliate) to provide enhanced outreach and Care Coordination in that traditionally underserved area that has had difficulty recruiting physicians. Key activities include focused outreach to Members in the ER to offer information and assistance regarding the Nurse On Call program; how to schedule PCP appointments, arrange transportation, and identify available specialists and services; focused campaign to provide consumer information in the RHC setting regarding ER use, alternatives, selecting a PCP, and other educational pieces; collaborative rounds and peer-to-peer discussions among their Medical Directors and respective care management staff; focused transitional care support to better help Members with chronic health conditions to successful return to their home from the hospital. Amerigroup Kansas employs an array of strategies to improve rural access, such as leveraging relationships with independent practice associations and other Provider organizations to recruit additional physicians; collaborating with Network Providers to open or expand offices in rural areas, offer additional needed services, and provide after-hours and weekend appointments; creating awareness of existing telemedicine capabilities, as well as identifying and funding additional opportunities through partnerships with Providers and organizations; working with PCPs and specialists to expand use of physician extenders, including financial incentive programs that provide opportunities for additional, upfront reimbursement that can be used to expand service; coordinating transportation for Members to see necessary Providers outside their access area; referring Members to out-of-network Providers for care through single case agreements.
Corrective Action Plans	In the last 7 years, they have had 1 corrective action plan that will close at the end of 2017. When there is an area of non-compliance, they work diligently on its prompt resolution.
Adverse Contract Actions and/or Litigation	Amerigroup Kansas has not been involved in any adverse contract actions and/or project-associated litigation (including terminations and/or cancellations). They have been involved in some litigation matters in the regular course of business which are not within the scope of this request, and we would be happy to provide additional information about those matters.
Project Contract Manager	Michael Randol, Director, Division of Health Care Finance, KDHE mrandol@kdheks.gov 785-296-3512

Managed Care Contract - Apple Health Washington – currently serving 36 out of 39 counties in the state	
Population Served	Medicaid Members enrolled in the Apple Health program: TANF, CHIP, ABD, Medicaid Expansion
Number of Covered Lives	149,000+
Primary Health Care Services Included	Responsible for the provision of PH, BH, LTSS, vision, and pharmacy services
Level of Managed Care and Financial Risk	Under the contract, premium capitation payments are received on a PMPM basis. This premium payment is intended to cover both direct medical services and costs to administer the contract requirements.
Activities in Rural and Frontier Areas	Approximately 60% of the Washington Medicaid service area is located in rural counties. Amerigroup Washington (Anthem affiliate) employs an array of strategies to improve rural access, such as leveraging relationships with independent practice associations and other Provider organizations to recruit additional physicians; collaborating with Network providers to open or expand offices in rural areas, offer additional needed services, and provide after-hours and weekend appointments; creating awareness of existing telemedicine capabilities, as well as identifying and funding additional opportunities through partnerships with Providers and organizations; working with PCPs and specialists to expand use of physician extenders, including financial incentive programs that provide opportunities for additional, upfront reimbursement that can be used to expand service; coordinating transportation for Members to see necessary Providers outside their access area; referring Members to out-of-network Providers for care through single case agreements. For example, to support the collaboration and coordination of integrated PH and BH models of care for Members, Amerigroup Washington partners with the University of Washington (UW) and their innovative Psychiatry and Addictions Case Consultation (PACC) Project ECHO™. This offers remote case review with clinical case management for PCPs who care for Members experiencing addictions, chronic conditions, and other BH concerns. The heart of the PACC is its knowledge-sharing networks, led by expert teams using multi-point videoconferencing to conduct virtual clinics with community Providers. PACC was designed to expand the BH, mental health, and addictions care capacity of Providers in remote or underserved areas through weekly online clinics and in-depth clinical case consultation with UW psychiatrists and addictions experts. To promote and expand Provider access, Amerigroup Washington pays for hardware such as in-office webcams, enabling Providers to remotely communicate with the program. They contract with the UW's Partnership Access Line (PAL), a telephone-based children's mental health consultation system for PCPs. They also have relationships with tele-mental health partners, including FasPsych, that currently contract with Washington Providers and facilities to offer remote tele psychiatry consultations from Provider offices as an alternative to staffing BH clinicians in remote locations.
Corrective Action Plans	In the last 7 years, they have had 6 corrective action plans that are all closed. When there is an area of non-compliance, they work diligently on its prompt resolution.
Adverse Contract Actions and/or Litigation	Amerigroup Washington has not been involved in any adverse contract actions and/or project-associated litigation (including terminations and/or cancellations). In 2012, the Community Health

Managed Care Contract - Apple Health Washington – currently serving 36 out of 39 counties in the state	
	Plan of Washington and Molina Healthcare of Washington, Inc. filed a Complaint against the Washington State Health Care Authority. Amerigroup Washington, Inc. intervened in this case but was not adverse to the state. In addition, Amerigroup Washington was recently notified that is was an apparently successful offeror in the State of Washington. In connection with that award, bidding parties filed open record act requests for information from the state, which resulted in Amerigroup Washington having to file a Complaint for Injunctive Relief and Declaratory Relief under the Washington Public Records Act to prevent the disclosure of its proprietary and confidential information. That case is pending in King County Superior Court and the State of Washington Health Care Authority is one of the defendants. Amerigroup Washington has been involved in some litigation matters in the regular course of business which are not within the scope of this request, and we would be happy to provide additional information about those matters.
Project Contract Manager	Alison Robbins, Managed Care Contracts/Patient Review and Coordination Alison.Robbins@hca.wa.gov 360-725-1634

The above are just some examples of the breadth of experience CCHA *Plus* will leverage to serve the Colorado Medicaid population. Anthem has additional experience developing forward-thinking programs that we will deploy to serve the Colorado Medicaid population as a RAE. Collectively, we will also leverage their experience managing and creating commercial, Medicare, and Medicare Advantage programs. As a RAE, CCHA *Plus* has the opportunity to bring innovative experience to the regions we will serve.

Experience delivering community BH care that supports individuals with SPMI and SED (4.2.2.2.1)

Anthem has extensive experience managing delivery of community-based BH care to support individuals with SPMI and SED. As indicated above, Anthem affiliated health plans currently serve more than 1 million Members with special care needs, including 303,000 members living with SPMI and approximately 57,000 members living with SED. Their programs embrace the principles of recovery and resiliency focused on managing symptoms, adhering to treatment care plans, and improving functional capacity and the quality of life. Those programs are community-based and feature many health, social, medication management, and alternative services. Some frequently used alternative services include intensive case management and help with housing and social supports, and are designed to wrap around and support individuals living in the community.

CCHA *Plus* will use Anthem's expertise in programs that use telephonic and field-based supports for these Members as well as engaging Providers and their services for them. These Members are frequently known in the community for excessive ER use, interactions with police, and homelessness. We will encourage them to be involved in drop-in centers, as we recognize the power of the peer supports. Additionally, the SPMI and SED populations will always have a follow-up call after contact with Colorado Crisis Services. When there is a denial of care involving a child, we will call the family to make sure that they understand what the next steps are. For SED Members, all prescribed medications will be carefully reviewed and a psychiatric medication consultation administered. When pharmacy data is available, it will be actively reviewed for the medication of all children under 12 to find opportunities to provide consultation.

One such program used for individuals with SPMI in numerous states where Anthem operates is the Rising Star program. This program is designed around Members and their chosen Provider supports of home hospital and psychiatrist. This program supports the tenets of self-directed care while promoting recovery and resiliency. By giving Members a choice about their use of services, the process of self-management of their condition can be initiated. The process is started by re-establishing trust. Many Members are surprised and appreciate that their voice is valued in the process, as they are accustomed to being pushed aside by the health care system. Members then become accountable to their health team for compliance with medications, appointments, and beginning to address barriers, such as homelessness, vocational interests, and even transportation.

In another state where Anthem is using this program, the hospital system has embraced the process and willingness to transfer the Member back to their home hospitals. In addition, Anthem has over time engaged the mobile crisis teams to understand the program, and they have been proactive during the transportation to call to find out whether a Member had a home hospital. This is a program that starts small but grows over time as the community begins to embrace it when they see how it is helping Members on their road to recovery.

Anthem also addresses barriers and needs such as homelessness, vocational interests/challenges, and transportation. ***The program has been a success because it offers consistent treatment, reduced - readmissions, improved quality of life, and a consistent physician contact.*** Table 4.2-5 highlights individual successes in the program:

Table 4.2-5. The Individual Stories behind the Rising Star Program Numbers

Individual Before	Individual After the Rising Star Program
Female Participant: 18 psychiatric hospitalizations 17 ER visits in under 10 months Two failed interventions	**Female Participant after 29 months in Rising Star:** 5 hospitalizations 5 ER visits Actively involved with her child and has a healthy relationship with her husband
Male Participant 12 psychiatric hospitalizations Disabled, living in supervised housing	**Male Participant after 15 months in Rising Star:** No hospitalizations Regular attendance at outpatient facilities Receive an award for improvements in function from a Provider organization for SPMI clients.

As a RAE, CCHA *Plus* will use and customize these sorts of programs to meet the needs of each Region.

CCHA *Plus* Will Meet All Section 4.2 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 3, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 4.2 that are not detailed in our response.

Section 5.1

COLORADO COMMUNITY HEALTH ALLIANCE

Contractor's General Requirements

5.1 CONTRACTOR'S GENERAL REQUIREMENTS

CCHA *Plus* Will Meet All Section 5.1 Requirements

CCHA *Plus* acknowledges that there are no Offeror Response questions associated with the requirements set forth in Section 5.1. We affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.1, specifically noting our obligations to the Department in:

- 5.1.1 Acknowledgement that the Department will contract with only one organization per region
- 5.1.2 Acknowledgement that CCHA Plus may be privy to confidential information
- 5.1.3 Collaboration with key Department staff to ensure completion of the Work
- 5.1.4 Informing the Department on current healthcare trends/issues and new technologies
- 5.1.5 Maintenance of complete and detailed records of information related to the project
- 5.1.6 Deliverables, as detailed in 5.1.6.1-5.1.6.7
- 5.1.7 Stated Deliverables and Performance Standards, as detailed in 5.1.7.1
- 5.1.8 Communication Requirements, as detailed in 5.1.8.1
- 5.1.9 Business Continuity, as detailed in 5.1.9.1-5.1.9.4
- 5.1.10 Federal Financial Participation Related Intellectual Property Ownership (5.1.10.1-5.1.10.11)
- 5.1.11 Performance Reviews, as detailed in 5.1.11.1-5.1.11.5
- 5.1.12 Renewal Options and Extensions, as detailed in 5.1.12.1-5.1.12.2
- 5.1.13 Department System Access, as detailed in 5.1.13.1

Section 5.2

COLORADO COMMUNITY HEALTH ALLIANCE

Personnel

5.2 PERSONNEL

OFFEROR'S RESPONSE 4

Provide all of the following:

a. **Description of the internal organizational structure, including a delineated management structure. The organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various components and departments of the organization, and be easily understood and accessible by those interfacing with the organization. Describe how the organizational structure facilitates creative thinking and innovative solutions.**

b. **An organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure.**

c. **A list of Key Personnel and their resumes. Identify which Key Personnel has the majority of their work experience in behavioral health.**

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA *Plus* will be fueled by the multi-faceted and dynamic combination of its managing partners. By merging the experience of a local primary care-focused organization, a hospital system that is one of the largest employers in the State of Colorado, and a behavioral health organization with national expertise, as well as a strong local presence, we have created the optimal structure to support person-centered quality care and wellness to help Members achieve their best possible health and life outcomes.

a. Organizational Structure (5.2-5.2.3)

We are a firm believer in the maxim that **"all health care is local,"** and we have aligned our physical health (PH) and behavioral health (BH) organizational structure so that decision-making, staffing, and communication occurs at the local level. Our Colorado-based employees, including the Program Officer and other Key Personnel, will have full ownership of the program and see that decisions about service delivery and administration are made at the community level. ***CCHA Plus will be a single entity accountable for promoting PH and BH and will have a single approach to serving Members and Providers, the Health Neighborhood, and Community. We will have a single phone number for Members and providers to reach us, and a single structure driven by our governing board and Key Personnel roles.*** As the Department, Members, and providers interface with CCHA *Plus*, they will work with one entity and one brand including claims information, reports, educational materials, letters, and phone correspondence.

Regional Office(s) and Community Support (5.2.1.2)

We understand the importance of being active members of the community we serve. We will have physical offices located in Region 6 and will evaluate the needs of the region to determine future office locations. ***The majority of our Member and Network Provider interactions and services will occur in the community or within the CCHA Plus regionally-based offices.*** As a current Regional Care Collaborative Organization (RCCO), CCHA employs Care Coordinators who not only provide telephonic care

coordination, but also work in the community and emphasize face-to-face contact with Members, Network Providers, and Community partners. They are often embedded, or co-located, in facilities such as primary care practices, community resource partner sites, and correctional facilities. As a Regional Accountable Entity (RAE), CCHA *Plus* will continue this model across both PH and BH services.

Defined Lines of Responsibility

Our fully integrated approach to PH and BH will include extensive organizational resources. CCHA *Plus* projects the need for approximately 116 employees directly allocated to the RAE program. Additionally, we anticipate additional partially allocated operations positions will be needed. The number of employees could vary based on factors such as Member attribution levels, additional scopes of work, or the number of Regions awarded. CCHA *Plus* will work with the Department to finalize and provide an in depth organizational chart as outlined in 5.2.3.1. We are committed to staffing solutions that meet requirements of the RAE Contract and the Department.

The responsibility, authority, communication, and coordination for the organization will come from the CCHA *Plus* Program Officer, along with the Board of Managers and other Key Personnel identified. Our annual strategic plan will encompass the entire organization and will focus on continual improvement to successfully and innovatively integrate our PH and BH programs to better serve Members and create value for the Colorado Medicaid program. Our mission, along with direction from the Program Officer and the strategic plan, will drive goals and communications across all CCHA *Plus* dedicated staff.

We will incorporate many communication methods to ensure all CCHA *Plus* designated staff are receiving direction at both a departmental and direct management level as well as an overall organizational level. Some of these methods will include:

- Quarterly “all staff” meetings
- Intranet platform
- Workgroups and committees

Our BH and PH employees working with Members, providers and Community partners will not operate individually without interaction, but rather will be housed together in the same Colorado or region-specific offices and share direction, be cross-trained, and operate within the same structure. Our staffing approach is to hire and dedicate employees exclusively to manage integrated services for all Member and Network Provider contact roles. We will leverage our managing partners’ expertise with industry-leading technology platforms and data analytic tools to benefit the State and Members. We will have local dedicated information technology professionals to assure seamless integration and optimization into our local office. The existing CCHA RCCO infrastructure will provide a strong foundation to build upon to serve the Colorado Medicaid population and enable a quick start-up for CCHA *Plus* as a RAE. In Region 6, Members and Network Providers will receive seamless services as the State transitions from RCCOs to RAEs.

By integrating our CCHA *Plus* RAE care coordination model, including co-location of our care coordination team that includes both PH and BH clinicians throughout the community and region, we will seek to reduce gaps in care, end occurrences of inappropriate care, and effectively control costs. Care Coordinators, Practice Transformation Coaches, Network Relations Representatives, Community Liaisons, and potentially other positions will be predominantly based in the communities we serve within primary care offices, hospitals or other facilities, and community resource locations. Administrative functions that do not impact Member care, such as claims administration and accounting, could occur at centrally located offices.

As shown in our organizational chart with delineated management structure (Figure 5.2-1), all roles preliminarily identified for our work as a RAE will report up through Key Personnel roles to our Program

Officer. By taking a whole-person approach to our in-house, local utilization management, care coordination, and disease management across PH and BH and community services, we will keep high-quality care efficient and cost-effective, and encourage Members to take increased responsibility for their health care. We recognize that many Members have co-occurring PH and BH conditions that cannot be addressed without interaction, because they often impact one another. Our employees will be cross-trained to meet Member needs across the entire health care continuum. When Members call us, regardless of the reason, they will use one phone number to get the information they need under the principles of first call resolution.

We will work closely with Providers, community programs, State and local agencies, and other stakeholders to help achieve the Department's objectives and meet Members' needs. Additionally, we will drive accountability through shared goals and values that are built into each employee's annual performance evaluation, which fosters a highly collaborative team approach in meeting our organizational strategy and program objectives.

Facilitating Creative Thinking

Our staffing model will offer employees quick access to their managers within their specific functional area of responsibility. This structure will enable us to emphasize a culture of coaching and development. Supervisors can spend more time with their employees, providing direction, development, and growth opportunities. ***To facilitate creative thinking and innovative solutions, we will structure our organization and our teams to cultivate an environment of collaboration, trust, and empowerment.*** The CCHA *Plus* structure will be specifically designed to:

- Create teams composed of employees with diverse backgrounds, experience, and disciplines.
- Promote communication among all levels of the organization and provide formal and informal mechanisms for transparent communication between managers and their employees.
- Foster a decision-making process that incorporates feedback from all employees, enabling them to contribute to the success of the organization. For example, as a RCCO, CCHA engaged all employees in the strategic planning process by asking them to help identify high-priority initiatives and goals.
- Implement lean project teams that focus on improving the value we offer to Members, Network Providers, and the Department, while improving efficiency. These teams will help promote a culture where employees are given ownership of their work and the ability to act.

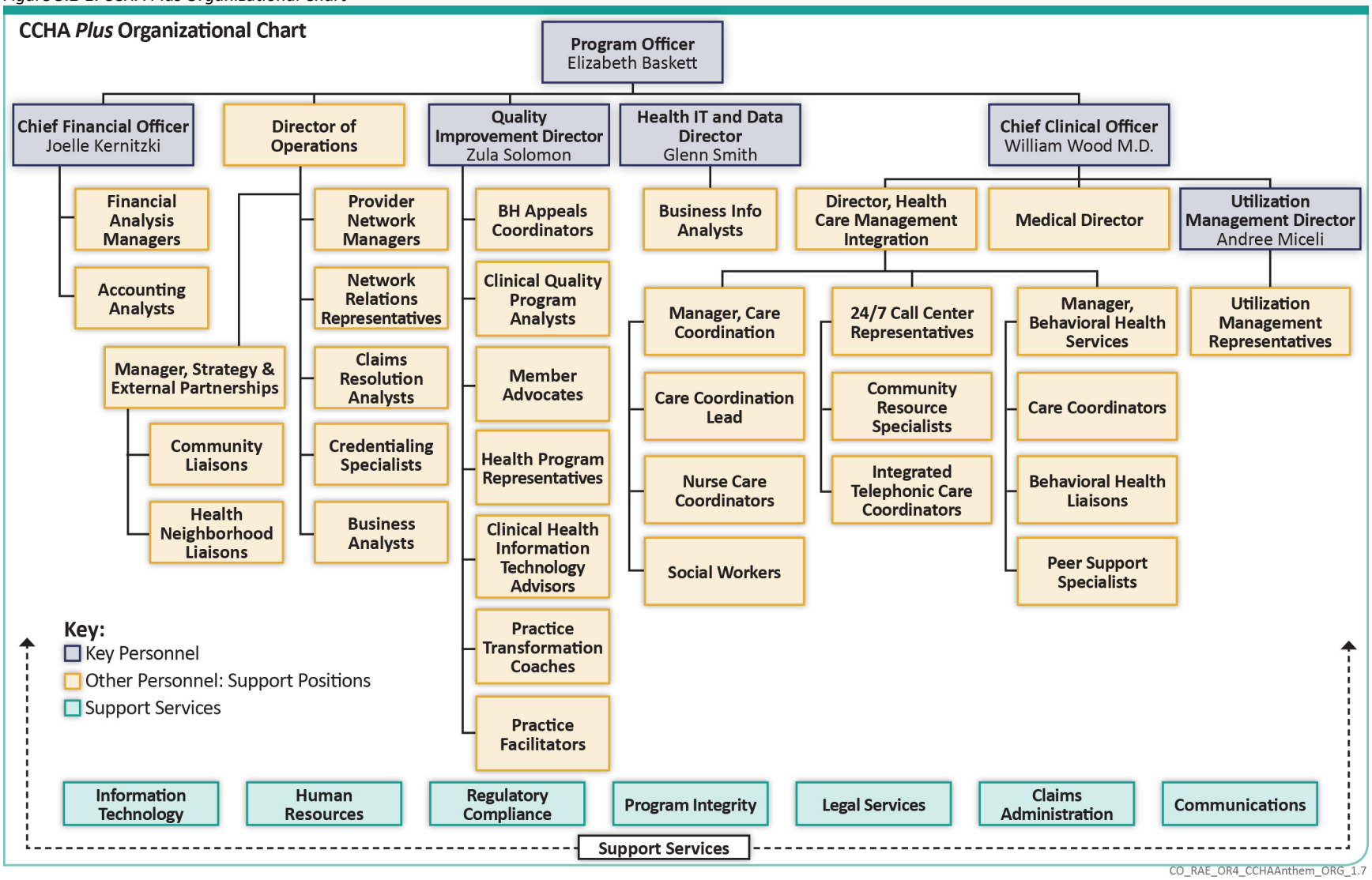
Our team will include individuals with expansive knowledge and experience serving those with PH and BH needs, including adults, children, and persons with co-occurring and complex conditions. ***We are knowledgeable in providing integrated PH and BH programs to the Medicaid population using unified staff reporting structures.*** Our BH functions will not be managed by a separate business unit of the company nor managed by a subcontracted external entity. We will provide adequate staffing levels and employee training programs to achieve and exceed the goals of the Department.

b. Organizational Chart (5.2.1-5.2.10)

In Figure 5.2-1, we have included an organizational chart that lists all positions (not only FTEs) responsible for the performance of any activity related to the Contract, their hierarchy, and reporting structure. Upon Contract award, CCHA *Plus* will provide to the Department a list of individuals assigned to the Contract within 5 business days of the Contract effective date. This will include Key Personnel assigned. We will also provide an organizational chart within 30 days of the Contract with all positions responsible for the performance of the RAE with hierarchical reporting structure, names, and emails where applicable. If changes need to be made to Key Personnel, the organizational chart, or assigned individuals, we will notify the Department and seek its approval prior to hire with notification of the resume and qualifications of the suggested new employee.

This organizational chart does not denote individual positions, but rather all departments with employees dedicated to the RAE. We anticipate an expected 116 FTEs dedicated to the CCHA *Plus* RAE for Region 6. Additionally, the Shared Services column shows resources that support all functional and operational areas of the RAE that will be housed regionally, locally in Colorado, or, in the case of functions such as claims administration, nationally. These positions are not all allocated in the abovementioned numbers. We are confident in our ability to staff and operate a fully integrated RAE.

Figure 5.2-1. CCHA Plus Organizational Chart



c. Key Personnel and Resumes (5.2.5-5.2.12.2)

Our Key Personnel are listed in Table 5.2-1 below and includes names, positions, whether the majority of their work experience was in behavioral health, total years of relevant health care experience, and location of the position. Resumes of our Key Personnel are included as Attachment 5.2-1. All Key Personnel have the required qualifications and will be accountable for the particular functions as detailed throughout 5.2.12. The Program Officer will be located in the Regional office. All other key personnel will be based in Colorado and will maintain office space within the Regional office to assist with implementation and ongoing operations of the RAE.

We will not replace Key Personnel positions without notifying the Department prior and seeking approval for the replacement. We will provide the candidate's resume, pertinent credentials or certifications and licensure information. All Key Personnel positions will be filled by separate individuals. As shown in Table 5.2-1, two of our identified Key Personnel have the majority of their work experience at BH organizations, including at least 5 years' experience in a leadership role administering BH programs. Our Chief Clinical Officer and Utilization Management Director have both had the majority of their work experience in BH.

Table 5.2-1. CCHA Plus Key Personnel

Key Personnel Name	Position Title	Majority of Work Experience in Behavioral Health?	Years of Total Health Care Experience
Elizabeth Baskett	Program Officer	No	15
Joelle Kernitzki	Chief Financial Officer	No	25
William Wood, M.D., Ph.D.	Chief Clinical Officer	Yes	39
Zula Solomon	Quality Improvement Director	No	16
Glenn Smith	Health Information Technology and Data Director	No	17
Andree Miceli	Utilization Management Director	Yes	15

Program Officer – Elizabeth Baskett

The Program Officer is a full time dedicated senior management position and will serve as the primary point of contact to the Department, including participation in Department-led meetings, and drive the RAE operations and Contract performance. This position will be located in the Regional office where we are contracted. The Program Officer is responsible for adequate staffing levels, program monitoring and completion, program development, and organization wide strategy.

As Program Officer, Elizabeth Baskett brings more than 15 years of health care policy, Medicaid program administration, and government relations experience. She holds a bachelor's degree in family and consumer sciences and a master's degree public administration. She recently served 5 years at the Department as Manager of Program Innovations, and for the last 2 years has been the Executive Director of CCHA as a RCCO. Her regulatory and Medicaid program experience at federal, state, and local levels, including at the Department and the local RCCO program, is invaluable to CCHA *Plus* as we become a RAE.

Chief Financial Officer – Joelle Kernitzki

The Chief Financial Officer (CFO) is a full time dedicated senior management level position who is accountable for the administrative, financial, and risk management operations of CCHA *Plus*. This position participates in the CCHA *Plus* Audit, Compliance, and Finance Committee and helps drive strategy, metrics, and development of reports and control systems that drive our Medicaid program.

They will ensure financial compliance and oversee budgets, accounting, risk management operations, and monitoring and reporting systems.

As CFO, Joelle Kernitzki brings 25 years of experience in managed health care, financial operations, and accounting systems. She holds a bachelor's degree in finance and economics and a master's degree in accounting. She is the Senior Vice President of Finance and Administration and serves the role of CFO for the CCHA RCCO. In this role, she has worked with the Department on deliverables including budgets, staffing models, and data needs that help drive the success of the ACC Program.

Chief Clinical Officer – William Wood, M.D., Ph.D.

The Chief Clinical Officer (CCO) is a full time dedicated senior management level position who defines the clinical vision and direction for CCHA *Plus,* bridging both the physical and behavioral clinical operations. This role will oversee clinical direction for network management, quality improvement, utilization management, and credentialing as well as provide medical oversight and leadership for the delivery of coordinated health care for Members. They will help drive strategy and implementation of all clinical programs and interventions within the Health Neighborhood as a RAE. This role has the majority of their experience in behavioral health organizations with at least 5 years of leadership administering Medicaid behavioral health programs.

As Chief Clinical Officer, Dr. Wood brings 34 years of extensive senior leadership experience in public and private mental health care with a focus on integrated care and mental illness recovery. Dr. Wood is currently the National Medical Director for Behavioral Health Medical Management, Government Business Division of Anthem and is responsible for Medicaid Behavioral Health Programs in multiple states. In his corporate role, he was responsible for development and clinical oversight of the program for integration of medical and behavioral health services within the company and coordination of this program with the affiliate health plan. He leads the development of BH programs and standardization, utilization management, government relations, and quality standards. Dr. Wood has extensive experience with evidence-based practices, coverage policies, and social determinants of health. He holds a Ph.D. in Biochemistry and an M.D. licensed in Psychiatry by the American Board of Psychiatry and Neurology.

Quality Improvement Director – Zula Solomon

The Quality Improvement Director is a dedicated full time management level position who is accountable for the direction and development, implementation, assessment, and measurement of all CCHA *Plus* quality improvement programs. They will ensure alignment of our programs with state and federal guidelines and recommendations and set internal performance goals and objectives.

As Quality Improvement Director, Zula Solomon brings more than 16 years of health care experience with 11 of those years working directly with local, state, and federal programs to develop and implement quality programs. She holds a bachelor's degree in biology and a master's degree in business administration-health administration. She has served the role of Quality Improvement Director for the CCHA RCCO for the past 5 years. Prior to this, she was with the Colorado Department of Public Health and Environment (CDPHE) where she worked on policy and change to promote prevention and disease management and was the primary contact between the Department and CDPHE. Her expertise in compliance and regulation, as well as accreditation standards, such as National Committee on Quality Accreditation, and performance standards, such as HEDIS, will bring CCHA *Plus* in-depth quality improvement programming.

Health Information Technology (Health IT) and Data Director – Glenn Smith

The Health Information Technology (Health IT) and Data Director is a dedicated full time management level position who will facilitate data sharing between CCHA *Plus*, the Department and Network Providers. They will identify areas to improve workflows and data systems and ensure we have the tools required to implement and operationalize the work as a RAE. This role will work with Network Providers to maximize electronic health record utilization and the Colorado Regional Health Information Exchange Organization (CORHIO). They will drive strategy and operations related to client enrollment spans, capitation payments, encounter data, health needs surveys, admit/discharge/transfer data, and BIDM system data.

As Health IT and Data Director, Glenn Smith brings more than 17 years of health care technology experience focused on technology platforms, Network Provider and practice support, and data analytics. He holds bachelor's and master's degrees in business administration. He has served as the Director of Technical Program Management for the CCHA RCCO for the past 3 years and has worked closely with the data and technology platforms needed to effectively manage the ACC Program. He has extensive experience working with CORHIO and implementing innovative technology platforms to bridge the information gap between Network Providers and streamline care to Members.

Utilization Management Director – Andree Miceli

The Utilization Management (UM) Director is a dedicated full time management level position who will lead, develop, and manage the CCHA *Plus* UM program, medical review, and authorization processes. They will oversee the medical appropriateness of services, analyze and monitor UM trends, and identify and improve upon problem areas to find resolutions. This role has the majority of their experience in behavioral health organizations with at least 5 years of leadership administering Medicaid behavioral health programs.

As Utilization Management Director, Andree Miceli brings over 25 years of experience in behavioral health clinical therapy, administration, supervision, quality improvement, care management, disease management, and program development; 11 years in managed care; and 9 years in Utilization Management responsible for clinical and administrative operations for multiple lines of business. She led and implemented the first integration program for behavioral health and physical health for one of the largest employer groups in Georgia and developed a dedicated behavioral health team to manage the group. She is a Licensed Clinical Social Worker, holds a master's degree in Social Work, and is based in Colorado.

We are firmly committed to the success of the Colorado ACC Program and will dedicate all resources necessary to convene partners in the community and build success into this next phase of the program. In addition to the identified Key Personnel, we will dedicate many specific roles to serving the needs of Members, Network Providers, and the Department.

Personnel Availability (5.2.11-5.2.11.6)

As a RCCO, CCHA is a proven and dependable partner to the Department, and CCHA *Plus* looks forward to continuing this relationship as a RAE. We will have Key Personnel and other essential personnel dedicated to attending in person and actively contributing to Department meetings, committees, and workgroups to help continually move the work of the ACC Program forward. These employees will have the authority to represent and commit us to planning, resolutions, and program development. We will have a single point of contact that the Department can reach at any time, including outside of regular business hours, to respond to any needs within one business day. We will provide all deliverables

requested by the Department, including lists of individuals assigned to this Contract, full organizational chart, Key Personnel names and licensures, and any Subcontractors that will be used.

CCHA *Plus* Will Meet All Section 5.2 Requirements

In addition to detailing how *CCHA Plus* will meet the requirements that address OR 4, we also affirm that *CCHA Plus* will comply with all the requirements listed in Section 5.2 that are not detailed in our response.

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.

The CCHA *Plus* organizational and operational structure reflects our belief that health care solutions are most effective when developed and delivered locally while leveraging the vast national resources and expertise provided by our managing partners. Through our local and community-based staffing model, as well as our proven service delivery systems, our organizational structure will allow us to be directly accountable to the Department, Members, and providers. Further, we focus on building a company culture and team of compassionate, collaborative employees committed to driving person- and family-centered care. Developing a strong company culture helps us recruit and retain top employees and minimizes turnover and vacancies. As part of our approach, we will:

- Incorporate additional specialty roles we think are important — going beyond contract requirements for staffing and Key Personnel — such as CCHA *Plus* Strategy and Health Neighborhood Liaisons and Community Liaisons
- Champion professional development and make certain employees keenly understand the ACC Program, Contract requirements relevant to their role, and other key functions via training, tools, and support
- Fill vacancies quickly and appropriately to avoid gaps in productivity

a. Ensuring Adequate Essential Personnel

We will prioritize staffing the ACC Program based on State-specific requirements, cultural and geographic nuances, Member population health, and social needs. We will maintain the best team for the Program by:

- Combining a well-staffed and expertly led local operation with deep roots in the community, extensive local experience, national support, evidence-based best practices, and functional support
- Engaging and collaborating with network and community-based providers to support the Department's quality and efficiency goals
- Attracting, hiring, and retaining experienced and locally knowledgeable leadership and staff
- Adhering to comprehensive policies and procedures that clearly guide our employees to help Members meet their personal goals and preferences

Our Partners Consistently Earn Workplace Recognition

PHP has been named to Denver Post's Top Workplaces in Colorado for five years and in 2015 was the **overall number one mid-sized workplace in Colorado.**

Anthem was named as one of **America's Best Employers by Forbes in 2015;** and as one of the World's Most Admired Companies by Fortune Magazine every year from 2007-2014.

CO_RAE_OR5_WorkplaceRecognition_5_COB_1.3

To build and maintain staffing levels that meet the evolving needs of the program, we will use proven time estimating methods. When estimating time requirements, we will use our data driven process that analyzes various sources, including:

- CCHA's experience as a RCCO in Colorado and the experience and best practices of Anthem in other states with similar populations and deliverables to establish a baseline staffing model
- System-generated data (such as call center reports on average handle time for phone calls)
- Continual assessment of capacity through performance discussions to make sure employees are on target for goal completion and have sufficient resources

When new service delivery protocols are developed, we will work with seasoned employees to develop reasonable time expectations for completion of the revised or new process. Combining anticipated volume with reasonable time estimates will allow us to maintain staffing levels that are responsive to Membership-driven or task-based intensity changes. Our staffing plans will include identifying and using additional cross trained employees and resources to address any increases in volume. We will base our staffing plan on a scalable model that is sufficiently flexible to support rapid response to any change in volume, program design, or Department need. Our success will be a function of our initial capacity planning and ongoing review of staffing needs.

As the current RCCO, CCHA developed specific roles and championed their staff to develop specialized skills tailored to the ACC Program. They allocated and re-allocated staff to maintain efficiency and effectiveness in delivery services in accordance with the Contract. As Membership grew and the Department instituted additional measures and deliverables, they quickly adapted the staffing model to accommodate these changes. For example, they created a Senior Care Coordinator position to cross-train others on best practices. Further, ***when CCHA's membership increased by 36,000 in 2014, they successfully increased their staff by 50% in a short period of time to minimize any disruption in services.***

As the RAE, CCHA *Plus* will build on this already well-defined organizational structure and provide staffing models to make certain adequate personnel carry out the Contract. In the event of change, our established staffing processes will enable us to adjust personnel quickly. We will follow all Contract requirements related to personnel, which includes making sure that Key and Other Personnel are available for meetings with the Department to represent CCHA *Plus* on work planning, problem resolution, and program development topics.

We will continually review staffing levels in light of quality and service performance to identify where we may need to make staffing adjustments to best support Members and Network Providers. Managers will routinely review their areas of responsibility to determine sufficiency of current staffing. Managers will use analyses to refine existing staffing plans, find additional resources that can be rapidly mobilized, provide required training, and work with other departments to streamline processes.

b. Training and Supporting Personnel

From their first day and throughout their tenure with us, we will support our employees, making sure they have the resources, tools, training, and assistance they need to fulfill their roles and the functions of the Contract successfully. We will provide employees a range of training from initial orientation to ongoing annual training to make sure they understand the Colorado Medicaid Program, benefits, and populations served; acquire and develop skills and knowledge needed to perform their jobs in an exemplary manner; and continually meet our high organizational standards for excellence, ethical behavior, customer service, and timeliness.

Once CCHA *Plus* commences implementation as a RAE, our **Colorado Medicaid Training Academy (Academy)** will act as a powerful vehicle that facilitates a robust, uniform, consistent, compliant, and comprehensive approach to training for our employees, Network Providers, community partners, and other stakeholders who serve Members. The Academy streamlines the development, delivery, and reporting of training into one, easy-to-use, scalable system. It incorporates multi-modal training and mechanisms for tracking, monitoring, and alerting, as well as reporting compliance and training completion.

Through the Academy's comprehensive features, we will offer required, regionally identified, population specific, and culturally competent training as needed, and update our instruction to remain relevant and topical. We will customize all training based on the specific needs of our Members and Department

requirements, and will continue to make updates based on staff interaction with Members, Network Providers, and stakeholders. Our training platform is flexible and we offer training based on best practice through our extensive Academy library. To ensure the content is accessible to different audiences or types of learners, we will offer training though multiple methods including in-person (classroom and mentorship), tailored webinars, online courses, and written communication.
To train and support our employees, we will offer:

- **New Hire Orientation,** which provides training specific to the demographics and unique needs of our Members in **Region 6** and delves into the RAE's values, goals, mission, and vision for serving Members and Network Providers (Members of the executive team will deliver the majority of new hire orientations. As a RCCO, CCHA has solicited feedback from these orientations, and has consistently earned high marks for their executives' participation.)
- Mandatory **initial and annual refresher training** on Cultural and Disability Competency, HIPAA, CMS Fraud and Abuse, Discrimination and Harassment, and Security
- Opportunities for employees to sharpen their skills via more than 3,500 **free online courses** and 19,000 e-books
- **Tuition reimbursement** available for approved undergraduate and graduate college courses taken as part of the employee's degree program at an accredited institution in addition to approved continuing educational expenses
- **Specific training** through Mountain States Employers Council, the Department, and CMHCs (For example, CCHA has partnered with Jefferson Center for Mental Health to conduct daylong training on Mental Health First Aid for all Care Coordinators and customer service representatives. CCHA *Plus* looks forward to building on these established partnerships.)

Table 5.2-1 highlights the CCHA *Plus* Medicaid Training Academy that includes new hire trainings, Member Services training, Care Coordination training, Colorado specific trainings, and Cultural and Disability Competency trainings. Care Coordinators will receive ongoing and additional training tailored to Colorado and ranging from disease education topics, to Department webinars, to community partner presentations. Our management team will also receive additional training to meet the specific challenges of supervising a team.

Table 5.2-1. CCHA Plus Medicaid Training Academy New Hire Training

Medicaid Training Academy Program	
General Orientation for All Employees	
Concepts of Managed Care	Customer Service
System of Care Model	Records and Information Security
Introduction to CCHA *Plus* and Colorado Medicaid Operations	Colorado Medicaid Program Cultural Competency Plan
Introduction to Colorado Medicaid and ACC	Cultural Competency and National CLAS Standards
Colorado Medicaid and ACC Program Basics	Integrated Care Model
Covered Populations in Colorado Medicaid Program	Emergency Response Procedures
General Colorado Medicaid Basics Contract Provisions	Compliance Orientation
Covered Services and Benefits in Colorado Medicaid Program	Member Rights/Advance Directives
Introduction to Fraud and Abuse (including False Claims Act)	Utilization Management Principles, Processes, Tools (including Systems)
Ethics, Privacy, Information Security, and Compliance (including HIPAA)	Basic System Tools for Communications and Data Search

Lean Process Improvement Training (facilitates our culture of quality throughout the organization)	Management Training
Member Services Staff Training	
Assisting Members with Limited English Proficiency with Special Consideration to Prevalent Non-English Languages in Colorado	Eligibility Policy for the Colorado Medicaid Program
Positive Behavior Support; Person-Centered Practices	Compliance/Fraud and Abuse Program and Member Rights and Responsibilities Hearing
Medicaid, Medicare, and Managed Care	Value Added Benefits
Complaints Grievances, and Appeals Process	Assisting Members in Making PCMP Changes
Appointment Availability/Access Standards	Handling Crisis Calls
Community Inclusion and Importance of Maintaining Independence in the Community	Disabilities and Responding to Members with Communication Difficulties or Challenging Behaviors
Systems Training/Online Resource Tools	Non-Capitated, Community, and Social Services
Balance Billing, Cost-Sharing, and Liability Inquiries	Identifying and Reporting Critical Events or Incidents such as Abuse, Neglect, or Exploitation
Systems Training/Online Resource Tools	Training Calls, Caller Verification Process
Locating a Provider/Disseminating Provider Information	Call Monitoring and Quality Management
Care Coordinator Staff Training	
Predominant Chronic Conditions in Colorado: Asthma, Diabetes, Obesity, Hypertension	Care Coordination Theory and Practice Under a System of Care Model
Social Determinants of Health Care in Colorado: Education, Health Literacy, Infant Mortality, Food Insecurities	Care Coordination Processes and Tools (Including Core Operations Systems (COS) and Mobile Technology to Support Field Work, Case Documentation, and Information Sharing)
Working with Other Case Managers (First Step, Foster Care, Adoption Assistance)	Legal and Ethical Issues in Care Coordination (Abuse, Neglect, Exploitation, and Prevention Including the Detection, Reporting, Investigation, and Remediation Procedures and Requirements)
Colorado Regional Strengths and Challenges	Quality Management Program
Colorado Community-Based Resources	Integrated Approach to Care
Medical Necessity	Clinical Practice Guidelines for PH and BH
Predictive Modeling and Risk Stratification	Member Assignment to Risk Levels: Low (Health Promotion and Resources), Medium (Care Coordination), High (Complex Care Coordination)
Services, Supports, and Resources Available at Each Risk Level	Initial and Ongoing Health Risk Screening and Health Risk Assessment
Intensity Level of Telephonic and Face-to-Face Contact Based on the Member's Needs	Collaboration and Coordination with Providers, State Agencies, and Other Stakeholders
Member Multidisciplinary Team	Member-Centered Care Planning
Monitoring Member Progress in Care	Discharge Planning from Higher Levels of Care
Addressing Inappropriate Emergency Room Utilization	Programs for Members with Specialized Health Care Needs (ID/DD, Pregnancy, Substance Use Disorder)
Value Added Benefits	Integrated Care Coordination Model
Documenting and Sharing of Clinical Information	Discharging Members from Care Coordination
Motivational Interviewing Training	

Through the Academy, all CCHA *Plus* employees will have access to self-directed training modules such as Integrated Care Planning, Introduction to Trauma Informed Care, and additional offerings as listed in Table 5.2-2. The courses will be available for our staff, Members and caregivers, providers, and other stakeholders. We require employees to take a number of self-directed training modules based on position.

Table 5.2-2. Self-Directed Training

Self-Directed Training Modules	Description
Incorporating Recovery Principles and Practices into Mental Health Treatment	This course will help define recovery and outline ways to use recovery tools without additional cost or time. Just as each person's recovery journey is unique, so is each clinician's expertise or treatment approach.
Integrated Care Planning	This course highlights crucial elements of a care plan and the fundamentals behind forming a care team. As participants navigate through this course, they will learn why creating a complete and thorough plan is a vital piece of the treatment puzzle, and the consequences of not having one.
Best Practices in Substance Use Treatment Engagement	This course provides information on the stages of recovery and treatment compliance, as well as caring for special populations. Based on content from the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA).
Person-Centered Planning	This course provides information on what makes person-centered care different from traditional treatment planning. It covers the significance of distinguishing between what is important to an individual and what is important for the individual, as well as how to promote the individual's active involvement in identifying their strengths, desires and needs. Through interactive lessons, personalized planning strategies, and descriptive examples, participants will learn how to implement the person-centered approach to significantly enhance recovery success.
Motivational Interviewing	This course provides information on our motivational interviewing approach to help trainees understand how to match an intervention to the individual's stages of change to improve the likelihood of success. In addition to examining the principles of MI, they will learn specific skills and techniques that will support the primary goals of MI, which include establishing rapport, eliciting change talk, and establishing commitment language.
Chronic Disease Management: Approaches to Self-Management Support	This module addresses effective approaches to working with Members. In addition, the module covers system changes that enhance support for Members with chronic conditions. Additional topics include mental and emotional health concerns, and low health literacy's effect on sustaining behavior change.
Research-Informed Practices to Treat Children and Strengthen Families	Evidence suggests that despite recent advancements in evidence-based child mental health service models, engaging children and their families in care to achieve positive mental health outcomes remains a serious challenge in "real world" outpatient clinics. One promising innovation, referred to as the 4Rs and 2Ss treatment framework, centers on a curriculum-based approach that systematically incorporates critical research findings on effective treatment for conduct difficulties in children. The 4R's refers to treatment focused on strengthening family Roles, Responsibilities, Respectful Communication, and Relationships. The 2Ss emphasize directly addressing family Stress and promoting Social Support. Adult caregivers and children work together on these areas via a multiple family group (MFG) format.
Supporting Everyday Lives for People with Disabilities	Participants learn to recognize the difference between supporting a Member to make decisions versus directing services and making decisions for them. Participants will learn Member-centered planning approaches, tools, and strategies, including self-determination and self-direction. After learning about effective Member-centered planning tools, participants will learn implementation strategies for a personalized approach to services.

Self-Directed Training Modules	Description
Disaster Trauma: Promoting Resilient Individuals, Organizations, and Communities	Mental health and SUD providers and community organizations play a significant role in recovery. This workshop provides an overview of specific strategies and approaches to address individual needs following an adverse event. These same approaches apply in prevention and early intervention. Strategies include training staff on mental health first aid and trauma informed care; teaching mental health first aid and trauma informed care to others in the community (with the support of a certified trainer), and setting up effective systems in organizations to support those with SUD and mental health issues.
Introduction to Trauma- Informed Care	This course covers various types of trauma, the long-lasting consequences of trauma, and providing care through a trauma-informed lens. Through interactive practice scenarios and detailed examples, participants learn the scope of their role and responsibilities when serving individuals with histories of trauma. We examine best practices and analyze practices to avoid that may perpetuate trauma or re-traumatize.
The Power of Personal Outcome Measures®	This course will present in-depth knowledge on defining quality, outcomes, and Personal Outcome Measures® and their role in an organization's quality enhancement program. We will use blend of didactic information and experiential exercises to give a clear understanding of the person-centered approach to quality.
Crisis Intervention for Individuals with Developmental Disabilities	This course gives an overview of managing crisis situations and how to teach coping skills. Participants investigate the phases of a crisis process and explore crisis prevention by identifying situations that can evolve into a crisis, and strategies to prevent or lessen the impact of a crisis. Participants will also examine post-event teaching strategies that support people after a crisis and help prevent future crises.
Disabilities Overview	This course looks closer at the term disability and provides an overview of types of disability one likely encounters as a direct support Provider, including basic supports regaining independence and increasing participation. Topics include physical and sensory impairments, learning and communication disorders, brain injury, and a section on developmental disabilities.
Working with the Homeless: An Overview	This course covers the physical and mental health disparities individuals who are homeless face, as well as the everyday dynamics of homelessness that complicate an individual's involvement with service providers.

Continual Emphasis on Training

Our ongoing training and mentorship opportunities will help improve employees' professional skills and ability to assume added responsibilities as appropriate. Within this process, these proficient employees can help train others, take on new and diverse assignments, learn new skills, and grow professionally. Capable and experienced employees are our most valuable resource when we are mentoring new hires. Our extensive training and support will make certain that employees understand their role, our RAE, the Colorado Medicaid program, region-specific needs, and specific Member needs within this population. For many positions, we will hire experts, so the learning curve is minimal.

Monitoring for Completion and Comprehension

We will maintain documentation to confirm internal staff training, curricula, schedules, and attendance. We will submit a quarterly training report to the Department identifying training activities for our call center employees. Trainees will demonstrate their competency throughout the training process. All training programs and plans will include timeframes for completion and tests for individual and organizational comprehension. Depending on the particular training and mode of delivery, monitoring mechanisms for completion may include one or more of the following:

- Completed training schedules from managers who maintain records of required employee training
- System records of web-based trainings that are kept in our training database
- Pre- and post-test scores

- In-process audits during and after training (for example, ongoing audits of a newly trained Care Coordinator to measure the frequency of any errors made during the opening of a Member's care evaluation with the goal of correcting the issue early on)
- Process audits (for example, monthly audits of our Care Coordinators' activities through a review of their notes in our Care Coordination system applying NCQA criteria)

c. Filling Personnel Vacancies to Meet Contract Requirements

We understand the cost and disruption of employee turnover, not only to the company, but also to the Network Providers and Members we serve each day. Therefore, ***we plan for change. Our success as a RAE depends on qualified, stable staffing at all levels of the organization, and responsive policies and procedures that enable us to scale resources as circumstances dictate. We will replace Key Management Personnel and other management staff quickly and efficiently*.**

Building upon CCHA's local experience and reputation, CCHA *Plus* will be able to recruit strong local talent. Additionally, we will leverage Anthem's successful deployment experience implementing new contracts. For example, in 180 days Anthem staffed 583 FTEs for a new Iowa Medicaid contract for an on-time implementation. In addition to an established, local infrastructure, our recruitment process will enable us to quickly fill personnel vacancies. Our recruiting and pre-screening process will emphasize the value we place on finding the right fit for both employees and for the organization. Our recruitment, interviewing, and hiring decisions will focus on vetting candidates to confirm they have the skills, credentials, education, and experience necessary to be successful in our organization. We will develop pipeline hiring to make sure candidates are readily available to go through our hiring process and fill any open vacancies seamlessly, without disruption. For example, as the RCCO, CCHA rapidly and successfully filled the role of Liaison for the Colorado Opportunity Project at the Department's request to have a very tenured person from the community, who could hit the ground running.

CCHA *Plus* believes that the quality of our services correlates directly to the quality of our personnel. We take pride in having high-level talent within our organization. We will select employees for their roles based not only on their technical skills, but also, and just as importantly, for their dedication to developing innovative solutions for integrated, person- and family-centered health care. Our staffing model will reflect both our Members' needs and our contractual obligations to the Department.

Allocating Additional Resources When Necessary

We will continually review our staffing levels and quality of service standards to determine whether we need additional employees to support Members, Network Providers, and the Department. Each manager will routinely reviews their specific responsibilities and determine the capacity of the current department by monitoring any changes in volume, membership level, program updates, and service delivery to adjust staffing levels to meet our Members' needs.

In the unlikely event that CCHA *Plus* is at risk of not meeting performance standards or our staffing model does not accurately predict our needs, we will immediately deploy additional resources to correct the deficiency. Our leadership pipeline strength means we can deploy experienced resources quickly and provide any necessary training while we work to acquire additional qualified employees. By using cross-trained staff, we will transition functions seamlessly, minimizing the impact on Member care and daily operations. We will also temporarily fill vacant positions with employees from other parts of the organization, if necessary.

Our well-tested and proven approach to adequate staffing will include:

- Cross-training employees to serve as designated back-ups for each key position and those with direct Member contact

- Quickly mobilizing back-ups to provide needed services
- Training managers to keep their knowledge and skills current so that they are able to provide the same services as frontline staff, in the event of unexpected changes, such as spikes in volume
- Requiring employees to keep detailed documentation of service and activities that can be easily followed by others as needed

Our contingency plans will include identifying and using additional employees and resources to address any increases in volume. ***We will base our staffing plan on a scalable model that is sufficiently flexible to support rapid response to any changes in volume, program design, or Department needs.*** We will begin the process by building a staffing model based on whether each position is fixed, variable, or semi-variable in relation to the projected membership.

We will augment staffing based on increases in membership, Member make-up, and specific level of care needs, as well as other volume-dependent activities, such as Provider Relations positions. Semi-variable positions are a combination of fixed and variable positions, such as Credentialing Specialists. All of these factors will be built into our staffing model, which will enable us to flex the projected headcount as staffing assumptions change. For example, our staffing plan will take into account actual membership, as well as populations and benefits covered.

When key or other management personnel depart, we will be prepared. As policy, we will maintain an ongoing list of qualified candidates for various key positions. These qualified replacements will be identified through a number of modalities, including:

- Short-listed candidates for each position
- CCHA *Plus* employees in similar positions who are interested in making a change
- Qualified individuals referred to us by Network Providers, community leaders, and other stakeholders
- Known subject matter experts who may be interested in working with CCHA *Plus*

We will use succession planning to target individuals across all key positions (either internal or external to our organization) who can fulfill the role and responsibilities. Succession planning will also help us develop future leaders. Having a strong pipeline of talent will allow us to fill critical leadership positions with individuals who have the necessary skills to take our company into the future. We will develop well-defined succession plans with our Human Resources staff to make sure Key Personnel are replaced seamlessly and in accordance with the Department's and Contract requirements. This includes proposing any replacement personnel to the Department for approval.

We will work to find and hire replacements before the departing employee leaves to provide as much opportunity for job-shadowing and knowledge sharing as possible. If this is not possible, we will minimize transition issues by making sure departing key employees share detailed information with their supervisor or interim replacement.

CCHA *Plus* Will Meet All Section 5.2 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 5, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.2 that are not detailed in our response.

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.

CCHA *Plus* proposes a single, fully integrated physical and behavioral health (BH) solution to Coloradans in the Accountable Care Collaborative Program (ACC Program), and ***we will complete the vast majority of work required by the Contract without the use of Subcontractors***. Our organization offers extensive expertise in Colorado as a Regional Care Collaborative Organization (RCCO) serving as a Primary Care Case Manager (PCCM) in the ACC Program. Our organization also brings many years of experience managing comprehensive, integrated behavioral and physical health for Medicaid populations. We are well positioned to meet Contract requirements with minimal help from Subcontractors.

CCHA *Plus* will not subcontract more than **40%** of the total value of this Contract. In fact, we anticipate subcontracting less than **1%** to other organizations.

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We will not subcontract services related to directly managing our physical and BH services, and except for telephonic translation services, only CCHA *Plus* staff will interact directly with our Members. Our proposed Subcontractors listed in Table 5.2-4 are limited to print and fulfillment services, interactive voice response (IVR) phone capabilities, translation services for printed materials and our website, and telephonic translation services.

CCHA *Plus will not subcontract more than 40% of the total value of this Contract.* In fact, we anticipate subcontracting less than 1% to other organizations.

In the few areas that we will work with Subcontractors, CCHA *Plus* will retain sole responsibility for fulfilling Contract requirements. We understand that we will be fully accountable for our Subcontractors' performance and will implement processes to monitor, supervise, and enforce Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to Members. Our managing partners' well-defined processes have proven successful, and we will apply the same rigorous standards to seamlessly deliver services to our ACC Program Members, Providers, and stakeholders.

Proposed Subcontractors (5.2.14)

Although we take pride in providing services that meet a majority of the Contract requirements on our own, our proposed Subcontractors are top-level, qualified organizations we have subjected to a comprehensive vetting process. Further, our managing partners have experience working with all 4 of our proposed Subcontractors to successfully administer similar contracts.

To see that Members receive timely, appropriate, and quality services from our Subcontractors, we will leverage an established, proven Subcontractor Oversight Program used and refined over the years serving Medicaid Members. This program enables us to continuously monitor Subcontractor performance via daily collaboration and formalized auditing processes.

Subcontractor personnel will not serve in any of the positions listed in OR 4 or depicted in our organizational chart under Figure 5.2-1 that are responsible for the performance of any activity related to the Contract.

Pending the Department's approval, CCHA *Plus* will partner with the 4 Subcontractors listed in Table 5.2-3.

Table 5.2-3. CCHA Plus Proposes 4 Subcontractors, Accounting for Less than 1% of the Total Value of the Contract

Proposed Subcontractor	Services Performed	Percentage of Work Completed by Subcontractor
Henry Wurst, Inc.	From its Denver Office, this organization provides print and mail fulfillment services for Member and Provider materials and mailings.	0.18%
Corybant, Inc.	This Colorado-based organization provides IVR phone capabilities for Member outreach and reminders, such as Well-Child Checks.	0.16%
Global Accent	This Colorado-based organization provides translation services for content in print materials and websites.	0.01%
CyraCom International, Inc.	As the leading provider of language interpreter services in health care, endorsed by the American Hospital Association, this organization provides telephonic translation services.	0.06%

Management of Subcontractors

The CCHA Plus Subcontractor Oversight Program is a best practice of one of our managing partners, and it will include activities and infrastructure that will enable us to closely and continuously monitor the performance and financial stability of our Subcontractors. To confirm that our Members are receiving the highest quality services, we will monitor Subcontractors to see that functions are being completed according to the terms of the delegation agreement, while maintaining compliance with federal, State, and contractual requirements, as well as accreditation standards. Our program's flexible approach is tailored to the functions and services each Subcontractor provides, and the scope and frequency of oversight activities reflects the nature of the role, responsibilities, and service nuances.

CCHA *Plus* will maintain full responsibility for the services Subcontractors deliver to the Colorado Medicaid Members we serve. Clearly defined expectations are a key component of our Subcontractor Oversight Program. CCHA *Plus* will execute written agreements with each Subcontractor that detail the specific scope of services required, performance standards, reporting responsibilities, and actions to address deficiencies, such as development of a corrective action plan (CAP), use of sanctions, and termination. Whenever performance does not meet requirements, we will take action and work with the Subcontractor.

Oversight Activities and Organizational Infrastructure

Our Subcontractor Oversight Program begins with a pre-delegation assessment to evaluate operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. Once the Subcontractors meet required criteria, approval is sought through the Delegate/Vendor Oversight and Management Committee (DVOMC), the administrative oversight and final approval authority. Our written Subcontractor agreements will clearly define expectations, all required provisions, and performance standards and metrics. Staff training will include CCHA *Plus* policies and procedures and the ACC Program; HIPAA; fraud, waste, and abuse; cultural competency; and more. Once operational, our program will include ongoing oversight activities as outlined in Table 5.2-4.

Table 5.2-4. Our Oversight Program Monitors Subcontractors throughout the Life of the Contract

Timing	Oversight Activities
Daily	• Account Managers will work with Subcontractors to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns.
Monthly	• Complete a Performance Indicator dashboard on each Subcontractor • Review performance against standards, including trends, and report submissions • Conduct Subcontractor, Account Manager, and local Oversight team meeting to review performance metrics • Conduct DVOMC meeting to discuss approval of delegation, performance monitoring, CAPs, and terminations
Quarterly	• Conduct Joint Operations Meeting with Subcontractors to discuss performance, as well as present issues, gaps, and concerns to the DVOMC • Report to one of our managing partner's National Quality Improvement Committee to discuss any quality issues with Subcontractor performance
Annually	• Perform annual audit to confirm that Subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements • Present audit findings to the DVOMC and the local Oversight team

CCHA *Plus* will assign an Account Manager to each Subcontractor for day-to-day management, as well as oversight and performance review. This approach builds trust between our organization and our Subcontractors, which in turn helps prevent compliance issues.

The Account Manager will work with our local Oversight team (led by our Compliance Officer). With deep knowledge of our Members and their needs, the team will have support from compliance, regulatory, and other departments related to the services provided.

Our monthly Performance Indicator dashboard (customized for each Subcontractor) is a key component of our Subcontractor Oversight Program. Each month, the Account Manager and Regulatory Compliance team will meet with the Subcontractor to review its performance against standards. The meetings will provide a forum to discuss issues and brainstorm potential solutions. Our experience shows that transparency and open, constructive dialogue among the Subcontractor, CCHA *Plus*, and others responsible for oversight is critical to maintaining a collaborative partnership and seamless service delivery to Members.

Reports Required from each Subcontractor

CCHA *Plus* will require Subcontractors to submit 2 primary types of reports: data we need to fulfill the Department's regulatory reporting requirements, and operational information to monitor their performance against standards. Account Managers will maintain a schedule of due dates for both types of reports to proactively monitor and address any deficiencies.

During implementation, we will review the Department's reporting requirements and identify Subcontractor data we need (including format and due date) to present a complete picture of our ACC Program activities. For all reports, we will identify an internal due date prior to the Department's deadline to provide time for a thorough quality review.

Subcontractors will provide information for each monthly Performance Indicator report so that we can monitor and manage their performances against a defined set of metrics.

Addressing Deficiencies or Contract Variances

Our approach to identifying and addressing deficiencies centers on establishing and maintaining a partnership with each Subcontractor and regular, consistent monitoring. The Account Manager will work daily to identify and discuss resolution of performance issues early – before they become a problem. We

will supplement our proactive account management structure with robust monitoring, including monthly performance reporting, quarterly reviews, and annual audits.

If a deficiency is identified, the Account Manager, Enterprise Delegation Oversight and Management team, and appropriate operational areas will work with the Subcontractor to identify the root cause, initiate corrective actions, and develop a monitoring plan. The monitoring plan will include a timeline for correcting the deficiency, dashboards to review ongoing metrics, and regularly scheduled meetings with the Subcontractor to review progress. The corrective action monitoring process ends when the Subcontractor demonstrates ongoing compliance, typically within 90 days.

Notification to the Department and Approval

Pending the Department's approval per the terms detailed in OR 6, CCHA *Plus* will partner with the 4 Subcontractors listed in Table 5.2-4. We will not enter into any subcontract under this Contract's obligations without providing notice to the Department.

CCHA *Plus* will comply with Contract terms and provide written notification to the Department for approval of new Subcontractors at least 30 days prior to the effective date. Additionally, we will provide written notification at least 60 days prior to the general termination of a Subcontractor agreement or 2 days prior to a termination resulting from quality or performance issues.

CCHA *Plus* Will Meet All Section 5.2 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 6, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.2 that are not detailed in our response.

Section 5.3

COLORADO COMMUNITY HEALTH ALLIANCE

Regional Accountable Entity

5.3 REGIONAL ACCOUNTABLE ENTITY

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

We commend the Department for its efforts to eliminate the silos between physical health (PH) and behavioral health (BH). Over the past several years as a RCCO, CCHA has been the State's partner on evolutionary projects like the Accountable Care Collaborative Program (ACC Program), State Innovation Model (SIM), the Colorado Opportunity Project, the Comprehensive Primary Care Initiative, and Comprehensive Primary Care Plus (CPC+), through which the Department has laid the foundation for a fully integrated *system* of care. Together, in the next iteration of the ACC Program, CCHA *Plus* will deliver the integrated delivery system needed to address Members' complex and unique health needs across all life stages and functional statuses. As a RAE, CCHA *Plus* will offer the single administrative entity that you can hold accountable for improving Member experience and treating the whole person.

We believe Colorado's transition to a RAE structure presents an exciting opportunity to unify the administration of PH and BH services to provide whole-person care, improve health outcomes, and drive value. As a RAE, CCHA *Plus* will leverage the experience of managing partners CCHA and Anthem to deliver a truly integrated program that provides seamless administration of Members' complete physical and BH needs.

As a RCCO, CCHA is a trusted steward of Colorado resources, delivering outcome-based, cost-effective health care services and achieving better and measurable outcomes. Combined with Anthem's experience delivering integrated BH services in 18 states, CCHA *Plus* will administer the Primary Care Case Management Entity (PCCM Entity) and Prepaid Inpatient Health Plan (PIHP) as one program, improving the Member experience, identifying Members' underlying BH needs through whole-person care, increasing transparency across all stakeholders, and decreasing costs by administering the ACC Program effectively and efficiently. ***Together as CCHA Plus, we will bring a unique combination of proven local and national approaches to the ACC Program under one, truly accountable entity dedicated to caring for Colorado Medicaid Members.***

Defining Integration

We believe it is important to define the term "integration," as it can mean different things to different organizations and can be defined differently when talking about different levels of the health system. The World Health Organization (WHO) defines integrated service delivery as ***"the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money."*** CCHA *Plus* has adopted this definition as we have worked together to develop our RAE.

Additionally, the WHO acknowledges that integration is best seen as a continuum, rather than as two extremes of integrated or not integrated. The aim is to provide services that are not disjointed for the user and that the user can easily navigate. Managing change in the way services are delivered may require a mix of political, technical, and administrative action. It may require action at several levels, including sustained commitment from the top of the organization. ***CCHA Plus presents the Department with a commitment from the top of our organization, down, to cultivate integration throughout the ACC Program delivery system.*** We will use the strategies laid out in this response to accelerate our march together down the path of integration.

Integrated care can look different at different service levels. As a RAE, CCHA *Plus* will offer the following types of integration opportunities:

- Integrated administration of the PCCM and PIHP, including **local staff working together in the same office** and **out in the community**
- A **population health plan** that **integrates the Health Neighborhood and Community** in the planning and delivery of interventions for all stages of life and levels of health
- **Multidisciplinary Care Coordination teams** that integrate physical health (PH), behavioral health (BH), LTSS, public health, and social services systems
- An integrated **Provider Support program** that supports both PH and BH **bi-directional integration** opportunities — both the integration of BH into primary care and primary care into BH settings
- A Health Neighborhood where Providers coordinate and collaborate with one another to reduce duplication and fragmentation, **reducing waste,** and **creating a more seamless experience for Members**
- A Community that works together in a team-based approach to offer integrated services to Members and families **breaking down the silos of Medicaid, public health, and social services**
- A sophisticated technological platform that leverages the power of integrated PH and BH data and innovative tools to drive all RAE efforts

We will provide the Department with customizable innovations, including best and promising practices that effectively integrate care through enhanced access, quality of care, and efficiency of care.

Administering the PCCM Entity and PIHP as One Program

CCHA *Plus* will serve as the single RAE in Region 6 and perform all Contract functions in compliance with State and federal statutes, regulations, and rules. As an HMO, we will administer the ACC Program per the requirements for both a PCCM and PIHP as defined in 42 C.F.R. §438.2 to fully integrate clinical care, operations, management, and data systems. ***We will bring proven local and national approaches to integrated care under one, truly accountable entity dedicated to caring for Members.***

Our single governing body will oversee all operations. Composed of one board of managers that includes community Network Providers, BH experts, senior hospital executives, and CCHA *Plus* executives, we will augment our governing body with a structure of committees to provide a balanced perspective from Health Neighborhood and Community partners. The CCHA *Plus* governance structure will drive our mission and purpose while confirming we meet Contract goals through ongoing monitoring and oversight.

The governing body will also see to it that we:

- Strengthen the coordination of services by advancing Team-based Care, thereby improving the Member and Network Provider experience

- Identify underlying BH needs in Members through whole-person care that promotes Member choice and engages Members in self-directed care in their community
- Identify and intervene for Members at risk for comorbid conditions and decrease costs by treating Members effectively and holistically
- Increase transparency and promote greater accountability through collaboration between Network Providers, Health Neighborhoods, Community organizations, the Department, State agencies, stakeholders, and CCHA *Plus*
- Deliver solutions that achieve the Quadruple Aim (improving quality of care, reducing per-capita cost of care, improving patient and family experience of care, and improving Network Providers' experience of delivering care)

We will consult with our Health Neighborhood Advisory Committee who will provide recommendations on integrated care efforts and decide how we invest our incentive payments in the community. We will select the members of our Health Neighborhood Advisory Committee with the explicit purpose of convening a diverse, multidisciplinary system of health care providers, community organizations, and other service providers that support ACC Program Members in the region.

In the remainder of our response to OR 7, we describe how we will administer the PCCM Entity and PIHP as one program that integrates clinical care, operations, management, and data systems.

Clinical Care Integration

CCHA *Plus* will work with the State to develop statewide stratification that segments the population according to Appendix I. This clinical integration model will stratify the level of interventions needed for Members based on their PH and BH risk status:

- Low physical health risk or complexity and low behavioral health risk or complexity
- High behavioral health risk or complexity and low physical health risk or complexity
- Low behavioral health risk or complexity and high physical health risk or complexity
- High physical health risk or complexity and high behavioral health risk or complexity

We will supplement the Department's stratification system with our proprietary predictive modeling program to determine what interventions and resources we should provide to reduce risk and improve health for our Members in each of the 4 quadrants.

For all risk stratification categories, ***our care coordination model will address Members' PH and BH needs through a team-based approached of supports located in the Member's community.*** Building on CCHA's past care coordination experience and success, CCHA *Plus* will expand the Care Coordination team to include local BH Care Coordinators to support Members through the full care spectrum. Our care coordination model is one that integrates Care Coordinators into the community they serve. Each representative of a Member's care team will be well-versed in collaborating as equal partners of an integrated PH and BH team to expedite getting Members care, thereby streamlining the process to get Members care quickly.

Member Testimonial

Our Care Coordinator has helped me with coordinating care around my son's physical and behavioral health needs. I appreciate all the work that Claire has done to help with my family, and she has provided a tremendous amount of support. She is always making sure that we know about resources/ support, and on top of it, to assure our needs are being met.
Emma

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Using this team-based approach, when a Member requires specialized care — for example, support for substance use disorder (SUD) or Serious and Persistent Mental Illness (SPMI), we will augment the Member's care team with a specialized Care Coordinator (in other words, trained to support Members with special conditions). As a RAE, we will have direct access to BH providers and can streamline intake processes. As a result, our care

coordination model will be able to deliver care for a multitude of issues and address Members' total health care needs quickly, reducing the time between diagnosis and treatment — a direct benefit to the Member, as well as the Network Providers. Members will receive individualized care from a team of people who both understand the unique needs of the Member and the resources available within the Member's community in which they live — all without the delays caused by fragmented care delivered by disparate programs and companies.

We provide additional detail on these programs and others in our responses to OR 13-16 and 18-20.

Operations Integration

As a RAE, we will provide a seamless operational experience to Members and Network Providers, meaning Members will have simplified access to Member services and increased Member choice, and Network Providers will have easy access to Provider services, as examples.

Local Staff Integrated in the Community. Both Members and Network Providers will receive support from a team of CCHA *Plus* employees trained to address questions and provide direction for Members or Network Providers regardless of the reason for their outreach. Because our team will be local and integrated in the community, both Care Coordinators and Practice Coaches will spend 90% of their time in the community.

Composed of local, specialized teams that include all level of operations (both Member- or Provider-facing and those who do not interact with Members or Network Providers), our employees will understand needs and resources available at both the region and community or population health level for both PH and BH needs. This approach delivers support to Members and Network Providers in a specialized manner that upholds the unique nature of each community and its Members' inherent social determinants of health.

Practice Transformation and Value-Based Purchasing. As a RAE, we will collaborate with the Department and stakeholders to design and implement a new ***single, value-based payment incentive program to support the provision of Medical Home quality of care and to incentivize improved PH and BH outcomes*.** We will leverage both CCHA's local Colorado-specific experience and current methods and Anthem's national experience and methods supporting Network Provider practices to transform their operations and implement value-based payment arrangements essential for true integration of quality-focused care. Building on the experience of both CCHA and Anthem in supporting PCMPs and Health Neighborhoods to advance their performance, improve member outcomes, and engage in Team-based Care, CCHA *Plus* will collaborate with the Department to accelerate integration, improve quality, reduce costs, and pay Network Providers for the increased value of whole-person care they deliver.

We are experts and strong believers in the use of value-based purchasing and incentive programs to drive improvements in quality, access, and evidence-based clinical performance. Our Practice Transformation Coaches will work with practices to align the ACC Program's efforts with CPC+, SIM, and other practice transformation projects. Our Provider Support team will be comprised of Practice Transformation Coaches, including BH specialists, to help align the Program's efforts across the full continuum of care. Our Practice Transformation Coaches and co-located Care Coordinators will collaborate with Network Provider staff, reviewing their Population Health Management Plan monthly.

Provider Testimonial

Over the years, RMYC has grown to trust and rely on the CCHA team of experts to help us with practice transformation initiatives. We regularly meet to share best practices related to care coordination services, and over time, we have seen our Care Coordinators become essential and integrated members of the clinical teams and more impactful in their ability to help patients and families.
Jessica Dunbar, Executive Director, Rocky Mountain Youth Clinics

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Health Neighborhoods. The cornerstone of our integrated program initiatives will be the expansion of current medical neighborhoods, including BH Providers to decrease fragmentation and improve care coordination with increased communication and data exchange between and across health care Providers and community organizations. As a RAE, CCHA *Plus* will expand the scope of CCHA's current Health Neighborhood and Community Engagement program to promote Members' BH well-being, in addition to Members' PH well-being, by creating a Health Neighborhood and Community consisting of a diverse network of health care Providers and community organizations that provide social and other health needs within the region.

Community. CCHA *Plus* recognizes that to truly improve Member health and well-being as well as optimize resources in the Community, we need to integrate with our Communities. We need to know, understand, and implement initiatives that build local Communities. This is particularly true for those Members with complex needs that require services from a variety of agencies. Through CCHA's efforts on the **Colorado Opportunity Project** and collaborations with key community organizations, including **schools, local public health agencies** and **human services departments, jails** and **prisons,** and **housing agencies,** they have seen significant success pulling our community together to address social determinants and reduce health disparities and inequities for Members. The Colorado Opportunity Project opened the door to coordination of non-medical services, and CCHA *Plus* seeks to leapfrog the project into a new era of health integration where Members interact with a single Care Coordinator who works as part of a team to deliver the package of services right for the Member and their family at their stage of life and level of health.

As a RAE, we want to leapfrog the Colorado Opportunity Project into the next era of integrated community health delivery systems. We will engage in disruptive innovation efforts that will pilot new approaches to enrollment in and delivery of services. We will work with community partners, especially County Public Health and Human Services Departments, to explore new ways of doing things. For example, we would like to see one lead Care Coordinator assigned to an entire family to connect them with the medical and non-medical services each family member needs based on their life stage and level of health. A combination of the Colorado Opportunity Project and 2Gen models that, if done right, will reduce duplication and remove roadblocks, so that ACC Members can achieve success throughout their lives. As a RAE, we will bring our success in Jefferson County and our penchant for innovation to the Department, so that together we can catapult this program to the next level of health and well-being.

Innovative & Collaborative

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As a RAE, CCHA *Plus* Community Liaisons will work to support local Communities, leverage community resources and establish new partnerships and then connect CCHA Care Coordinators and Network Providers to them. Additionally, we will seek to co-locate CCHA *Plus* Care Coordinators at Community organizations like The Action Center, the Marian House, and Family Tree where Members and families go to receive services.

We provide additional detail on these programs and others in our responses to OR 14-15.

Management Integration

A single, local CCHA *Plus* management team will oversee our organizational, operational, and governance structures, representing our belief that integrated health care is best delivered locally and in a highly coordinated manner through a multidisciplinary team approach (all employees filling the key positions listed in the RFP will be located in Colorado). Therefore, our role in the delivery system for Colorado Medicaid Members includes collaboration with Members, family members, caregivers, Network Providers, Care Coordinators, and community-based supports — to support a highly integrated PH and BH structure. Our locally focused, collaborative structure allows us to effectively serve Members while improving quality of care and health outcomes, and decreasing health care costs through the reduction of unnecessary, inappropriate, or duplicative services.

Our locally based, multidisciplinary BH and PH leadership, supported by our structure of committees, will provide oversight of the staff that performs the day-to-day execution of Contract requirements. They will make certain of timely communication among all functions throughout our organization and will monitor trends in both the delivery of care and health outcomes to identify areas of opportunity and evolve our delivery methods to serve Members holistically.

We provide more information about our management structure and governance in OR 8.

Data Systems Integration

Our innovative technology platform enables fully integrated care using advanced data analytic capabilities that drive operational improvements and population health strategies and enable effective data sharing among the Care Coordinators, Network Providers, and Health Neighborhoods, as well as internal committees. Data and information for both PH and BH will be integrated in our unified system to support operational processes, analytics, reporting, and data exchanges (for example, to and from the Colorado interChange) to promote data quality, control, and consistency across all covered benefits. This will allow our multidisciplinary care team to work together from one system and provide a new opportunity for Network Providers to be part of the care team and coordinate with other Providers.

Because our cohesive technology system supports access to comprehensive Member health data, advanced data analytics (including predictive modeling), as well as operational, management, and regulatory information, CCHA *Plus* will use the power of our systems to merge the PH and BH data to identify and support Members proactively. This combined set of data will support integrated care through increased transparency and access to Members' holistic care needs. Our multidisciplinary teams, Network Provider partners, Care Coordinators and other participants of Members' care teams will use sophisticated care coordination software, including an electronic care coordination tool and population health functionalities to support whole-person integrated care. Our use of technology will fortify our multifaceted, bi-directional care coordination to drive improved communication, care efficiency, and outcomes, as well as a seamless member experience across the delivery system.

Our integrated technology will allow us to, for example, identify a Member who is receiving medications for depression who is also pregnant. We will be able to proactively confirm all the Member's PH and BH needs are being met by linking that Member to all available resources, identifying community supports that may be helpful, and eliminating any barriers quickly. It will also allow for:

- Provider dashboards that give a fuller picture of the Member with combined PH and BH data
- Integrated data sets that shine light on BH access concerns
- Sophisticated tools, like predictive modeling, that leverage the integrated data and assist in the development of the population health plan
- Data sharing across the Health Neighborhood to identify duplication in services and coordinate efforts among providers
- Data sharing in our communities to understand Member needs and gaps in care to help us work towards a seamless, integrated system of care for all services (for example, Medicaid, public health, and social services)

Similarly, using this comprehensive data, our predictive modeling program will help identify Members with potential comorbid and co-occurring conditions and engage them in care coordination to decrease fragmentation of care and improve outcomes.

We provide additional detail on our systems in our responses to OR 21-23.

Integration Experience

Both CCHA and Anthem have deep experience in delivering integrated care. As a current RCCO, CCHA coordinates with Community Mental Health Centers and substance use providers to get Members the care they need — in other words, CCHA does not stop at the Member's PH issues. They have partnered with community BH Providers to integrate BH care into PCMP offices. ***In fact, CCHA has partnered with 11 practices that have an integrated BH Provider and 30 practices that have a co-located BH therapist.***

To support integrated, value-based care in the community, CCHA:

- Works with multiple local Health Alliances to work on issues like high-service users and specialty care access
- Coordinates with hospitals on transitions of care and unnecessary emergency room (ER) use
- Participates in no wrong door efforts with LTSS providers
- Shares data with multiple Health Neighborhoods and Community partners
- Works with community partners, like schools and housing providers, to remove roadblocks to Member health and well-being
- Hires Practice Transformation Coaches to support PCMPs with quality improvement

In addition to CCHA's experience, Anthem brings a wealth of experience managing integrated PH and BH Medicaid benefits, including mental health and substance use disorder (MH/SUD), in 18 states. For example, in Florida, Anthem's local health plan uses regional multidisciplinary teams to address Members' PH, MH/SUD, and social support needs. Their model relies on strong partnerships between employees, the State, and Providers who meet regularly to identify best practices and lessons learned. They share performance data — including readmission rates, length of stay, and utilization data of various BH codes — to show Providers how their performance compares to their peers. The performance feedback helps to incentivize better Provider practice and improved care.

In Kansas, Anthem's local health plan delivers fully integrated PH, MH/SUD, LTSS, and pharmacy benefits led by a Managed Care Organization (MCO) clinical leadership team comprised of a psychiatrist, internist, and other clinical professionals who oversee integration and coordination of Members' care, as well as linkages to social support services. They engage Members telephonically and in the community depending on their needs and work closely with Providers and other stakeholders to help identify gaps in care as well as strengths. In addition, Anthem supports a pay-for-performance model for both PH and MH/SUD to incentivize Providers to improve member outcomes and lower costs. Because of these efforts, Anthem's Kansas program has begun to see a decrease in hospitalizations and ER use and higher rates of outpatient care, allowing the right treatment at the least restrictive level of care.

The new RAE structure presents an exciting opportunity to unify the administration of PH and BH services to provide whole-person care, improve health outcomes, and drive value. CCHA *Plus* will streamline Network Provider support and care coordination services to create administrative efficiencies, reduce Network Provider confusion, and improve the Member experience. We will offer the Department and Members the systems, tools, and experience to deliver an integrated system of care that improves outcomes and increases transparency.

CCHA *Plus* Will Meet All Section 5.3 Requirements

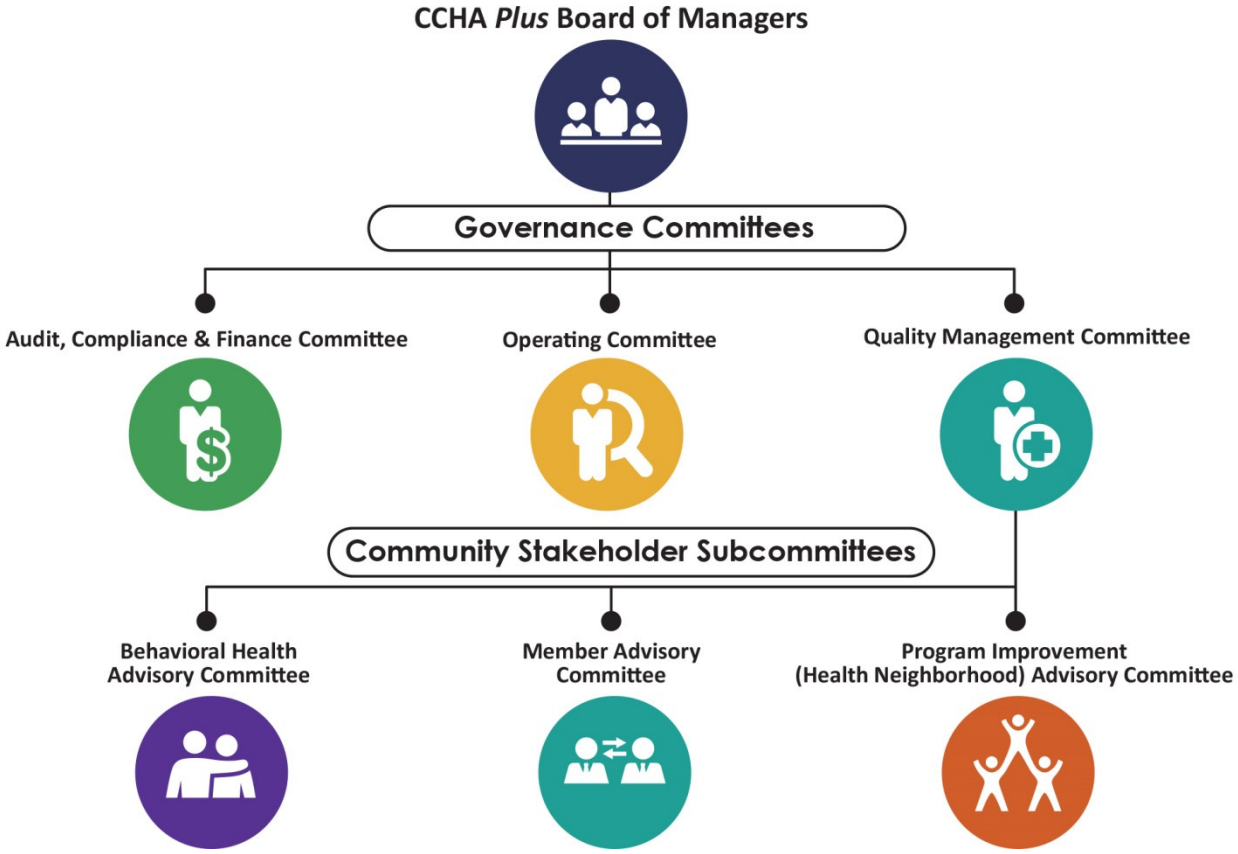
In addition to detailing how CCHA *Plus* will meet the requirements that address OR 7, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.3 that are not detailed in our response.

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.

The CCHA *Plus* governing body includes a board of managers (the board) augmented by a committee structure that promotes clear accountability while fostering inclusive participation from Members, Providers, and the Community to help guide and inform the RAE model. As we continue to serve Coloradans and expand as a RAE, our new governing body includes several board members who have experience with the growth of the ACC program, plus new board members who bring extensive behavioral health (BH) background and expertise.

Figure 5.3-1. CCHA Plus Board of Managers



The CCHA *Plus* Board of Managers (5.3.5-5.3.6)

The CCHA *Plus* board of managers comprises members from the 4 diverse managing partner entities who jointly oversee the activity and performance of CCHA *Plus*. The 7-member board is selected based on their clinical, operations, management, and data experience as well as minimal opportunities for conflicts of interest. ***This board will be augmented by region specific representation, which may include Health Neighborhood and community partners.*** The CCHA *Plus* board of managers will be responsible for the following:

- Driving the mission and purpose of CCHA *Plus*
- Monitoring and overseeing CCHA *Plus* and the Colorado Medicaid Contract to meet ACC goals

- Efficiently managing the CCHA *Plus* financial operations in compliance with ACC Program requirements
- Making sure CCHA *Plus* adheres to legal and ethical standards
- Reviewing data to drive value, experience, and outcomes for the Medicaid program
- Administering the Medicaid program in compliance with the requirements for both a Primary Care Case Management Entity (PCCM Entity) and a Prepaid Inpatient Health Plan (PIHP)

The board members include senior hospital executives, BH experts, Medicaid program executives, and health management services organization experts. Their combined experience serving the physical and behavioral health needs of the Medicaid population is extensive and imperative to the success of the RAE. While we will actively seek Provider insight and feedback on our operations through various subcommittees, we believe it is important to separate the operations of CCHA *Plus* from the direct delivery of service to Members to avoid conflicts of interest. Therefore, we will not include large Medicaid Providers, such as Federally Qualified Health Center (FQHC) and Community Mental Health Center (CMHC) representatives, on our board of managers. We will list the names and credentials of the board members on the CCHA *Plus* website, CCHAcares.com, as follows:

Catherine I. Kelaghan
Catherine I. Kelaghan is interim Chief Human Resources Officer of Anthem, Inc. In this role, Ms. Kelaghan is responsible for succession planning and talent management, compensation and benefits, workforce development, diversity management, associate engagement, and corporate security.

Ms. Kelaghan also serves as Vice President and Counsel for Anthem, Inc. As a member of the legal department's senior management team, Ms. Kelaghan oversees the company's employment and employee benefits litigation and provides legal support to human resources, information technology, health care analytics, strategic sourcing, marketing, and two Anthem subsidiaries, TAI Software and HealthCore. She and her team also provide legal advice on all HIPAA privacy and security matters as well as intellectual property matters.

Ms. Kelaghan has been with Anthem for more than 20 years, beginning her career in the company's legal department and later spending three and a half years working in human resources, first as Director of Benefits & Workplace Best Practices and later as Director of Benefits, Stock & Executive Programs. Prior to joining Anthem, Ms. Kelaghan spent two years with Towers Watson in Cincinnati as a consultant.

She is admitted to practice law in Indiana and Ohio, and earned a Bachelor of Science in Accounting from the University of Dayton and a Juris Doctorate from the University of Cincinnati College of Law.

Eric Lloyd
Eric Lloyd is Chief Executive Officer of Amerigroup Nevada, one of two contractors administering the Nevada Medicaid program. In this position, Mr. Lloyd is responsible for all aspects of the Company's health plan operations in the State of Nevada. Joining Amerigroup in 2008, Mr. Lloyd served as Vice President of Government Markets and Transition Officer before he became Chief Operating Officer in Nevada. In 2009, he helped launch Amerigroup Nevada.

With more than 20 years of experience in the health care field, Mr. Lloyd also held leadership positions with Inter Valley Health Plan in California and national plans Humana and PacifiCare Health Systems, which is now UnitedHealthcare. His expertise includes business development, sales, new program start-up, operations, and network development.

He is a member of the Finance and Sustainability Advisory Committee of the Nevada Silver State Health Insurance Exchange. Mr. Lloyd also serves on the Health Care Steering Committee of HealthInsight, the

community-based, federally sponsored quality improvement organization. He is a board member for the Nevada Health Information Exchange. His community service includes serving on the board of the United Way of Southern Nevada and as chair of the United Way Access to Health Care Committee. He also serves on the board of the After-School All-Stars. Mr. Lloyd holds a Bachelor's degree in Kinesiology from the University of Colorado Boulder and a Master's degree in Health Administration from Loma Linda University School of Public Health.

Kenneth Nielsen
Mr. Nielsen is the President and Chief Executive Officer of Physician Health Partners (PHP). He has been with PHP since 2004 and previously served as Vice President of Finance and Shared Services. In this role, and to the credit of those that work with him, PHP has established new business segments and consistent growth while continuing to enhance the company's financial stability. Mr. Nielsen has more than 18 years of financial experience in a leadership role in the health care industry. He served at Colorado Healthcare Purchasing Alliance (The Alliance) as the Controller, working with many of Colorado's largest self-funded employers who purchased health care benefits for their employees. In 1997, Mr. Nielsen joined Colorado Access, which provided health care to more than 100,000 Medicaid patients, serving in multiple financial and operational roles, including Director of Financial Planning and Decision Support.

Manuel A. Arisso, JD, LHRM
Manuel Arisso is a proven leader and executive in the areas of health care, policy with an emphasis in government sponsored programs, public health, health strategy, BH, and health care integration. Mr. Arisso also has a proven record in business management from startup, implementation, and ongoing operations realizing significant growth and sustainability.

Mr. Arisso began his tenure with Anthem in the fall of 2015 with responsibilities over specialty BH and foster care across the business life cycle from ideation to ongoing operations across Anthem's current and future Medicaid markets.

Prior to joining Anthem, he held key roles within Magellan Health Services government affairs, business strategy, and behavioral health operations.

Mr. Arisso introduced the first Medicaid specialty plan for individuals living with serious mental illness, bringing forward a holistic, integrated program serving members of the plan in an innovative fashion while exceeding growth expectations.

As the CEO for the Medicaid specialty plan in Florida he was accountable for all plan operations and integration activities. Most recently, Mr. Arisso is accountable for the growth and management of specialty BH and foster care programs for Anthem. Inc.

Mr. Arisso received a Juris Doctorate from Florida State College of Law where he served as an Executive Editor of the FSU Business Review. Prior to earning his law degree, he earned a Bachelor of Arts from Florida International University in Political Science with a minor in Economics and Criminal Justice. Additionally, he obtained a certificate from the Institute of Public Utility Research at Michigan State University on rate setting and a certificate in Health Risk Management from the University of South Florida is a licensed health risk manager.

Pam Nicholson
Pam Nicholson is the Chief Strategy Officer at Centura Health. She leads the strategic planning, clinically integrated network, employer strategies, service line planning, advocacy, marketing, and communications for the $3.4 billion multi-state health system. Focused on bringing innovation to the

delivery of care and patient experience, Ms. Nicholson is aligning and integrating the system's products, services, systems of care, and capabilities to optimize health value across Colorado and western Kansas.

With close to 30 years of health care experience, Ms. Nicholson has developed business models, regional pilots, and long-term relationships with Providers, hospitals, strategic partners, employers, and payers. Her expertise in physician alignment, network development and integration, managed care, community partnerships, and consumer product development helped the system to embrace consumerism and develop innovative strategies and partnerships to transform health care and meet consumers' needs.

Carter A. Beck
Carter is Senior Vice President and Counsel with Anthem and has held that position since late 2010. He joined the company in 1996. He currently has responsibility for legal activities for major business segments, including enterprise clinical initiatives, enterprise provider contracting, enterprise pharmacy, and enterprise program integrity. Mr. Beck has held many roles prior to his current role, including responsibility for the enterprise legal teams supporting Commercial Business and legal teams in the East and legacy Midwest. He has worked in Anthem's offices in Mason, OH, Denver, CO, Manchester, NH and Atlanta, GA.

Prior to joining Anthem, Mr. Beck was in private practice in Cincinnati, OH, focusing on defense litigation, medical malpractice defense, and insurance coverage actions.

He is a graduate of the University of Cincinnati – College Conservatory of Music, earning a Bachelor of Music, summa cum laude. He received his law degree from the University of Cincinnati – College of Law. He is licensed to practice law in OH, KY, NH and GA.

Tom Cain, MD
Dr. Cain is the board chairperson for PHP. He is an internal medicine and geriatrics physician who has practiced at the Senior Health Centers at St. Anthony since 1997. Dr. Cain received his undergraduate degree from Indiana University, Bloomington in 1985 and his Medical Doctorate from the Northwestern University Medical School in Chicago in 1990. He served his internal medicine residency at Boston City Hospitals, his residency in internal medicine at Rush-Presbyterian-St. Luke's Medical Center in Chicago, and his geriatric fellowship at the Northwestern University Medical School. Dr. Cain is board certified in internal medicine and geriatrics and is a member of the American Geriatric Society.

Governance Committees

The board will have three committees: the Audit, Compliance, and Finance Committee; the Operating Committee; and the Quality Management Committee. The three committees will report into the board to provide reports and recommendations to hold CCHA *Plus* accountable for all the requirements needed to perform as a RAE in the ACC Program.

Audit, Compliance, and Finance Committee

The Audit, Compliance, and Finance Committee will focus on contractual requirements, financial solvency, risk management, and financial audit. The committee will report back to the overall board with recommendations and reports. This committee will verify the proper licensures, such as our Health Maintenance Organization Certificate of Authority, are kept in good standing and that we continuously comply with all pertinent state and federal statutes, rules, and regulations, including the Department's 1915(b) waiver for the ACC Program. The committee will regularly review reports from management on financial and compliance policies and practices, oversee the external financial audit, and have the

authority to convene subcommittees. Subcommittees will be developed and meet as needed to facilitate efficient operations and provide timely reports and recommendations back to the committee.

Operating Committee

The Operating Committee will be responsible for ensuring operational integration of behavioral and physical health functions of the RAE. This committee is integral to bringing together the 4 functional areas of expertise of our managing partners. The committee will provide a communication channel between the Board and CCHA *Plus* Key Personnel and Operations teams. Additionally, the Committee will ensure the RAE maintains compliance with the RAE Contract, including oversight of all contract deliverables as defined by Appendix II of the RFP. The CCHA *Plus* mission and values as well as RAE operations and management will be driven by this committee. Based on the needs of the RAE program, this committee can be expanded to include Provider and community stakeholder organizations such as FQHCs and CMHCs.

Quality Management Committee

The Quality Management Committee (QMC) will provide program direction and oversight to make sure CCHA *Plus* operates as one combined entity that integrates clinical care, operations, management, and data systems. This committee will drive RAE and practice performance measures, RAE Contract compliance related to quality improvement and performance, utilization management (UM), credentialing, and medical direction. To improve Network performance, the QMC will monitor practice and RAE performance while developing, recommending, and overseeing clinical education, policies, and procedures that help deliver high-value health care. The committee will oversee and report to the board the following activities:

- Establish a long term, strategic vision for clinical performance and quality management programs
- Oversee UM activities at the RAE, Provider, and Member levels
- Maintain and monitor qualifications and credentials of Network Providers
- Monitor clinical and financial performance at a Provider and practice level and provide leadership, guidance, education, and strategies for improvement
- Review nationally endorsed, evidence-based clinical guidelines and recommend tools and resources for adoption of guidelines at the point of care
- Receive recommendations from the Program Improvement (Health Neighborhood) Advisory Committee to develop value-based payment approaches that drive value and support integrated care
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical and service quality improvement studies
- Review HEDIS® and CAHPS® data and create action plans for improvement

Additionally, this committee will have 3 community stakeholder subcommittees that encourage Member, Provider, and Community insight and guidance into our program development and delivery. The QMC will funnel information from these subcommittees back to the overall board for oversight and to the operational teams of CCHA *Plus* for implementation.

We designed our quality and utilization systems and processes to facilitate the delivery of person-centered, culturally and linguistically responsive, high-quality services to Members. These systems and processes also enhance consistency in service delivery by providing a framework for clinical decision-making. We will create additional subcommittees of the QMC as needed to respond to specific program needs, such as credentialing.

Community Stakeholder Subcommittees

CCHA *Plus* will also have 3 stakeholder committees: the Behavioral Health Advisory Committee, the Member Advisory Committee, and the Program Improvement (Health Neighborhood) Advisory Committee. These committees will allow Members, Providers and key Community stakeholder partners to guide, educate, advocate, and otherwise provide critical feedback and ideas that create change.

Behavioral Health Advisory Committee

The Behavioral Health Advisory Committee (BHAC) will provide a platform for BH Providers, Members and advocates to communicate recommendations, questions, and concerns directly with CCHA *Plus* staff. The group will convene Providers from CMHCs and independent BH Providers, including substance use providers, as well representatives from emergency rooms, the Colorado Crisis System, primary care providers, dental providers, Members with a BH diagnosis, advocates and other organizations serving the needs of Members. This committee will help shape our BH programs and services as well as drive integration that creates a more seamless system for Members. The BHAC will:

- Identify areas of opportunity and coordination between CCHA *Plus* staff, community-based Providers, and consumer advocacy organizations
- Provide input on BH issues impacting our Members and their families
- Consult on quality measurement data and performance improvement projects related to BH
- Review Member experience data specific to BH, including ECHO survey results, complaints/grievances, appeals, and select quality of care issues
- Recommend to the Operating Committee and QMC effective strategies to improve integration of services and overall Member health
- Provide insight on integrated care efforts in PCMP and BH settings

In Region 6, we will continue to engage in CCHA's relationships with Arapahoe House, Colorado Crisis Services, Mental Health Partners, and Jefferson Center for Mental Health. Additionally, we will reach out to organizations such as National Alliance on Mental Illness (NAMI) Boulder, Soft Voices Drop in Center, Chinook Clubhouse, Recovery Trust, Colorado Mental Wellness Network, and Federation for Families for Children's Mental Health to give guidance to our BH program and participate in the BHAC. We will also include independent BH providers, large and small PCMPs, and Dental Aid to engage in delivery system integration efforts.

Member Advisory Committee

The Member Advisory Committee will be open to any Member enrolled in the ACC Program in our region. This committee represents the Medicaid Community and will help drive our entire program model. We will post meeting information and minutes to our website, CCHAcares.com. Our Care Coordination team will help contact Members to participate in the committee and will follow up on topics throughout the year outside of the scheduled meetings. We will survey attendees after each meeting to find out what is important to them and how we can improve the Colorado Medicaid Program and the meetings. We will solicit feedback and ideas from them on these topics:

- Member education materials to see if they are understandable and needed in the community
- Pilot program ideas and implementation
- Engagement efforts and ideas
- Access issues with specialty Providers, including mental health and substance use
- Care Coordination programs and screening tools
- Website functionality
- Communication methods such as video, tele-town halls, and posters
- Evaluation of the RAE's integration efforts

As a RCCO, CCHA has used this committee structure to build an engaged and vocal Member Advisory Committee that has provided valuable input in creating and implementing projects. There are 8 to 15 Members present at each meeting who represent a broad and diverse population including Medicare-Medicaid Program enrollees, families, adults without children, pregnant moms-to-be, individuals who are blind or deaf, and children and youth in foster care. Their input on programs is invaluable and they have helped CCHA improve many initiatives such as phone outreach scripts, CCHA Map to Medicaid educational brochure, and pilot program goals with DispatchHealth. OR 9 provides examples on how the member feedback has been used to improve RCCO operations.

Program Improvement (Health Neighborhood) Advisory Committee

The Program Improvement (Health Neighborhood) Advisory Committee will be open to any Providers, Community partners, Members, advocates, and other stakeholders serving the CCHA *Plus* population. To avoid conflicts of interest, we do not include large Medicaid Providers on our board of managers. However, we value the input of Providers and other partners as active subcommittee participants that inform our operations, innovations, and investments in the community. As a RCCO, CCHA has used this committee structure and established the Health Neighborhood Advisory Committee to make sure these partners have a strong voice in the direction of programs. The CCHA Health Neighborhood Advisory Committee makes recommendations on how CCHA should reinvest KPI payments it receives from the State. Recently, the Committee decided to fund the Boulder County GENESIS and GENSISTER programs. The CCHA *Plus* Program Improvement (Health Neighborhood) Advisory Committee will continue to have the important task of determining how to invest in the Community. We will continue to post the dates, locations, and meeting minutes to CCHAcares.com.

This Committee will have standing representatives from the region's Health Neighborhood and Community, such as FQHCs, CMHCs, dental, Long-term Services and Supports (LTSS), hospitals, specialty Providers, primary care, county agencies and public health departments, community alliances, and community resource partners. It will also be open to Members and Member advocates, and the information will be public. This group will play a vital role in program development and help CCHA *Plus* in the following ways:

- ***Review requests and decide how to reinvest funds received from the Department back into the Community to best serve Colorado Medicaid Members and achieve Key Performance Indicators***
- Encourage partners to participate in the region's Health Neighborhood and Community and provide new opportunities for collaboration
- Formulate pilot and value based purchasing programs, such as our Practice Incentive Program
- Provide guidance on how to help Network Providers adopt and leverage the Primary Care Alternative Payment Model
- Review program key performance indicators (KPIs) and other metrics and progress, and provide ideas to further enhance our efforts
- Create an avenue to share best practices for serving the Colorado Medicaid population and how we can collectively improve the care delivery system
- Discuss program policy changes and provide feedback for improvement
- Review the Quality Improvement programs and related evaluation data
- Provide a representative for the statewide Program Improvement Advisory Committee

We will rely on the Program Improvement (Health Neighborhood) Advisory Committee to help drive the program to better serve our Members. We believe working collaboratively is in the best interest of our Members, and we act as the liaison within the community whenever possible.

In Region 6, we will continue to work with the following entities, as well as additional organizations needed to help guide our RAE:

- CMHCs Jefferson Center for Mental Health and Mental Health Partners
- FQHCs Clinica Family Health, Metro Community Provider Network, and Salud Family Health Centers
- Independent PCMPs and BH Providers contracted with CCHA *Plus*
- Alliances like the Jefferson County Hotspotting Alliance, the Colorado Prevention Alliance, and the Mile High Alliance
- Hospital partners from St. Anthony, Lutheran Medical Center, Longmont United, Boulder Community, Good Samaritan, Children's Hospital Colorado, and Avista Adventist
- Substance abuse Providers like Arapahoe House
- LTSS, Community Centered Boards (CCB), and Single Entry Points (SEP) including Adult Care Management, Imagine!, and Developmental Disabilities Resource Center
- County and public health agencies, school districts, and jails/corrections facilities in Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties
- Community partners like The Action Center, Seniors' Resource Center, Area Agency on Aging, and Dominican Home Health
- Dental Providers and organizations like Dental Aid
- Specialty Providers from areas such as cardiology and oncology

Conflicts of Interest (5.3.7- 5.3.9.2)

The members of the CCHA *Plus* board do not have any perceived conflicts of interest based on the description in 5.3.7.1.1 or 5.3.7.1.2. CCHA *Plus* will submit the Conflict of Interest Plan and any Updated Conflict of Interest Plans to the Department in accordance with the timeframes outlined, and we will also post our Conflict of Interest Plan on our website.

As part of our Conflict of Interest Plan, we will mitigate real or perceived conflicts of interest through our governing board as well as through the governing committees and stakeholder committees. Our multi-layer governing and advising structure fosters accountability throughout the organization.

The CCHA *Plus* board will adhere to our written Conflict of Interest policy. The policy will be presented to the Department and upon approval adopted to minimize and manage conflicts of interest; disclose ethical, legal, financial, and other conflicts; and remove themselves from decision-making if it is a conflict involving themselves, their family members, or entities to which they or their family members are closely associated. Under this policy, board members are required to disclose actual or potential conflicts of interest, as well as certain relationships and transactions, and to enable the CCHA *Plus* board to take steps it considers necessary or advisable to address conflicts of interest.

The board of managers and the Audit, Compliance, and Finance Committee will have primary responsibility for implementing this policy and reviewing it annually. This policy will be disseminated to board members upon joining the board and annually thereafter. The board may delegate the responsibility of disseminating this policy and collecting signed disclosure statements to a board committee or board chairperson who will oversee the process, but may be assisted by staff. Any potential conflicts will be reviewed and the board will provide disclosure statements and make recommendations if action is required or advisable. If any conflicts of interest arise or if we revise the Conflict of Interest Policy, CCHA *Plus* will notify the Department and update the policy on CCHAcares.com.

Process for Identifying and Resolving Conflict of Interests

CCHA *Plus* will uphold a strict Code of Business Conduct and Ethics, which obligates us to comply with all applicable laws, rules, and regulations related to operations. To uphold our Code, we will act in an honest manner at all times; report any suspected or observed misconduct, including violations of law, policy, or procedure; make a full and timely disclosure of any situation that may result in a conflict of interest or the appearance of a conflict; conduct ourselves in a manner that avoids actual or apparent conflict of interests to protect our business reputation and integrity of the program; and not accept gifts, payments, fees, services, discounts, valuable privileges, or other favors that may appear to improperly influence performance of our duties. We will also mandate that our vendors, Contractors, and Subcontractors comply with the Code.

We will maintain a conflict of interest policy and procedure to make sure that all employees act in the best interest of our organization and to avoid conflicts. We will require all CCHA *Plus* employees to complete the conflict of interest attestation to certify there are no potential conflicts. If any employees have a change in status, they must complete the attestation again within 30 days of the change. Management-level staff and board members must also complete the attestation once a year. Our commitment to compliance spans our entire organization. As soon as we learn of any potential conflict of interest or deficiency — whether identified by us, the Department, Providers, or other party — we will investigate the root cause and take action to mitigate the conflict and prevent recurrence. Our Ethics and Compliance team will research and investigate potential occurrences to determine if a conflict exists and take appropriate steps to resolve them. We will immediately report any identified conflicts to the Department. We embrace transparency, open communication, and continued dialogue across our organization and with the Department so we can continue to meet the expectations of the Department, Providers, and the Members we serve.

CCHA *Plus* Will Meet All Section 5.3 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 8, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.3 that are not detailed in our response.

Section 5.4

COLORADO COMMUNITY HEALTH ALLIANCE

Member Enrollment and Attribution

5.4 MEMBER ENROLLMENT AND ATTRIBUTION

CCHA *Plus* Will Meet All Section 5.4 Requirements

CCHA *Plus* acknowledges that there are no Offeror Response questions associated with the requirements set forth in Section 5.4. We affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.4, specifically noting our obligations to the Department in:

- 5.4.1 Member enrollment, attribution, and assignment processes
- 5.4.2 Medicaid eligibility verification and enrollment
- 5.4.3 Acknowledgment that the Department will enroll Members into the ACC on the same day that a Member's Medicaid eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS)
- 5.4.4 Acknowledgment that the Department will assign Members to the Contractor based on the location of the PCMP Practice Site to which the Member is attributed
- 5.4.5 Acknowledgment that the Department will automatically re-enroll Members with the PCMP and RAE that was in effect at the time of their loss of Medicaid eligibility if there is a loss of Medicaid eligibility of two (2) months or less
- 5.4.6 Non-discrimination against individuals eligible to enroll in the Accountable Care Collaborative
- 5.4.7 Acceptance of all eligible Members that the Department assigns to the Contractor in the order in which they are assigned without restriction
- 5.4.8 Understanding that Members may select a different PCMP through the Enrollment Broker
- 5.4.9 Receipt and processing an attribution and assignment list from the Department
- 5.4.10 Development of policies that more effectively support Member accountability for utilization of health services over an extended period of time
- 5.4.11 RAE Reassignment Process

Section 5.5

COLORADO COMMUNITY HEALTH ALLIANCE

Member Engagement

5.5 MEMBER ENGAGEMENT

OFFEROR'S RESPONSE 9

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

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA,** a peak performing RCCO with deep local roots including local primary care doctors, specialists and the largest hospital system in Colorado. To CCHA, we add **Anthem,** an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

State Auditor Testimonial

CCHA defines "member engagement" as "person- and family-centered interactions which invite the member to participate in his/her healthcare." CCHA understands that engagement is not one-way communication; the member must "participate" in order to be considered engaged.
Health Services Advisory Group Auditor for the Department

CO_RAE_HlthSrvAdvGroupAuditor01a_44_COB_TST_1.1

CCHA *Plus* strongly believes that Member engagement is effective only when Members are invited to participate in their own care and well-being in an active, person- and family-centered way. The managing partners of our organization have extensive experience involving Members in their care and influencing positive behaviors through a variety of initiatives, locally in Colorado, and on the national level. During its 6 years of experience as a RCCO, CCHA has been working with, listening to, and serving Coloradans every day in their communities. CCHA has had the opportunity to work with Members with varied, unique needs, through each life stage, and from many diverse cultures. They have learned that engaging Medicaid beneficiaries can be a challenge: Members are often hard to find; face health-related, socioeconomic, or geographical barriers to care; and are unaware of the benefits available to them. To overcome this challenge, CCHA has implemented many innovative approaches to Member engagement that have allowed them to learn and refine the existing Member Engagement program.

Leveraging our Colorado experience, and informed by Anthem's national expertise and resources, the CCHA *Plus* strategy for Member engagement features the following components:

- Established roots in local communities: our Care Coordinators will live and work in the communities they serve, bringing an intimate understanding of the challenges our Members face
- Our company-wide "no wrong door" policy means that Members can connect with our program through any avenue, including referrals from a Network Provider, family member, or Community Partner
- An evidence-based person- and family- centered model designed to engage and support Medicaid beneficiaries; we will meet our Members where they are, taking the time to build a relationship of trust and mutual respect
- An out-of-the-box approach to engaging Members, including using smart phones; attending local community events; and visiting churches, YMCAs, and other places in the Community that our Members trust
- Culturally, linguistically, and disability appropriate and responsive materials and communications that account for the unique needs of each individual
- A comprehensive, prevention-focused health literacy program that supports Members' efforts to navigate the health care system and encourages self-care
- Alignment with Colorado's 10 Winnable Battles
- Alignment with The State of Health: Colorado's Commitment to Become the Healthiest State

Targeted Health Education Methodology

Our targeted health education methodology will be informed by facts and adjusted as needed to promote the safety, health, and well-being of our Members. CCHA *Plus* will use information from the State's Health Needs Survey, claims data, information from our predictive modeling system, input from our Care Coordinators, Network Provider reports, Member feedback, Department and Community partner input, and other sources to determine which health conditions to target for Member education and engagement.

We will design our education and engagement programs and activities to communicate effectively with all Members. At the general population level, these programs will include information on wellness promotions, health tips, access to the Health First Colorado Nurse Advice Line and Colorado Crisis Services, our online Health Topics Library, and other general information on accessing benefits and services. We will also develop initiatives and campaigns to target health risks for the general population (for example; obesity, the flu, and smoking) to educate Members on how to improve their health.

At the individual level, we will provide education and engagement designed to assist Members with complex or chronic conditions to manage their conditions. We will engage Members as active participants in their health care decisions and address their biopsychosocial strengths and needs through quality services and supports, care coordination and management, a recovery focus, and health promotion. We will help Members with complex conditions achieve optimal outcomes, and we will explore various engagement avenues such as targeted mailings, email messages, and phone calls.

Building Blocks to Member Engagement: Meeting Members Where They Are

As a RCCO, CCHA has seen first-hand that Medicaid Members in Colorado face a variety of challenges that — if not proactively addressed — may present a barrier to accessing care. For example, some Members lack stable housing or are homeless; others have unreliable access to transportation or have a disability that impedes their ability to access care; others face psychosocial barriers such as abuse, neglect, or alcohol dependency. Some Members have low literacy levels, face language and cultural barriers, or are not aware of the Medicaid benefits available to them. ***CCHA has a long history of meeting Members where they are,*** and within their communities; key to this effort is appointing Care Coordinators to each community they serve.

Care Coordinators have helped Members navigate the health system, connect to non-medical supports and services, and serve as a trusted advocate when needed. They represent the ethnicities and cultures of the CCHA membership. Often, they are native to the communities they serve. For example, CCHA Care Coordinators are not just telephonically based as many other companies are; ***they spend 90% of their time in the community conducting home visits or working in practices and other facilities or community centers where Members are most comfortable.***

Care Coordinators are highly skilled and receive regular training around cultural responsiveness, including Culturally and Linguistically Appropriate Services (CLAS), motivational interviewing, and trauma-informed care. CCHA *Plus* will deploy a multi-disciplinary team of Care Coordinators, including social workers, nurses, BH specialists, and community resource specialists to function within the community to meet Members where they are.

CCHA *Plus* will prioritize finding and connecting with Members in a timely and effective manner. If a Member who enrolled has incorrect or missing contact information, we will employ various strategies to connect with and engage that Member. This includes accessing Member information through local

hospital partners' databases. We are also able to access contact information and connect with Members through our established relationships with Network Providers, specialists, BH providers, and Health Neighborhood partners, including Long-Term Services and Supports providers, Community Centered Boards, Single Entry Point, home health agencies, and skilled nursing facilities.

Once we connect with Members, we will start the process of ***building trust*.** We will meet them where they are and take the time to listen. We will seek out and engage Members in homeless shelters, coffee shops, churches, and through partnerships with charitable organizations such as The Action Center or the Marian House. We will also have staff stationed in primary care offices, emergency rooms (ERs), and other medical facilities to help our Members access the right level of care, at the right time, in the right setting.

Community visits are a great time to learn about Members, their cultures and backgrounds, their living conditions, and to understand the role of the family in supporting their care. Frequently, family members share their health challenges as well. This gives us an opportunity to employ a family-centered approach to assisting each individual in the household by connecting family members with the services they need.

CO_RAE_CommunityVisits_44_COB_1.1

Our highly qualified team of multidisciplinary health professionals will work across the entire continuum of care to support our Members' physical, behavioral, and social needs. We are a resource, connector to supports and services, advocate, and many times, the first person that makes them truly feel heard. Often, the Member's family or caregiver is present and joins in the conversation.

Using Member Feedback to Enhance Our Program

At CCHA *Plus*, we believe Members should drive our work. To be Member- and family-centered, we must hear directly from our Members about how to engage them, through:

- The Member Advisory Committee
- Member surveys
- Member focus groups
- Data: Provider Call Center reports, claims data, complaints and grievances, and Ombudsmen reports. We look forward to using CAHPS® survey results to evaluate and enhance our performance.

We consider Members to be active participants and at the core of the health care system. As such, Members are empowered to provide feedback about our services. We care about what we are doing well, what might be improved, and whether we are successful in our service delivery. ***We will rely on Member feedback to drive operational change and program and policy decisions. When we consider our Members' perspectives and understand how our delivery affects them, we are more relevant and helpful to them and more committed to our work.*** CCHA *Plus* will ask Members to participate in their health care, provide feedback on our services, and influence our delivery system. Member feedback will augment our quality monitoring program and help provide direct feedback to our call center.

As a RCCO, CCHA regularly solicits feedback during Member interactions, such as asking individuals to complete their Satisfaction Survey. Results from CCHA's most recent Member survey were overwhelmingly positive:

- 97% responded that representatives were "very respectful and courteous"
- 95% responded that they would recommend CCHA to a friend or relative
- 96% responded that CCHA helped them with their needs

CCHA *Plus* looks forward to taking what CCHA has learned about using Member feedback to enhance their program and build on it for the RAE. We will incorporate Member feedback into the fabric of our daily operations. This includes tracking, reviewing, and evaluating Member feedback received through our call center, in Primary Care Medical Provider (PCMP) offices, and during home visits.

To identify opportunities to enhance our education and engagement, we will also collect, examine, and evaluate data from numerous sources, such as Provider Call Center reports, claims data, complaints and grievances, Ombudsmen reports, and Member emails and surveys. We will use this information to implement processes and procedures to improve education and engagement. Our Quality Management Committee will regularly review this information as part of our Continuous Quality Improvement process. The committee will include representatives from key departments, including Health Promotions, Community Relations, Marketing, Health Plan Operations, Provider Relations, and Quality Management. Our Quality Management Committee will develop and oversee implementation of system-wide changes that enhance contact with and services to Members.

Our management team and Board will review Member feedback from all sources, identifying issues and developing initiatives to enhance our services and provide Members with the information and tools they need to manage their care effectively.

Member Advisory Committee

CCHA *Plus* understands that we cannot deliver person-centered services if we do not understand Members, their lives, and what they need. We recognize the value of the work being done by the Department's Member Experience Advisory Council and will use the recommendations to improve our program. Additionally, CCHA *Plus* will maintain a Member Advisory Committee (MAC), a forum for gathering input on the quality of the program and enhancing Member satisfaction. CCHA *Plus* will include a MAC and build on CCHA's learnings to make the MAC a productive and influential part of RAE operations. The committee will meet quarterly to provide advice regarding health education and engagement program development. The MAC will identify education needs and cultural values, assisting in the review, development, implementation, and evaluation of Member health education information and tools. We will solicit Member feedback about every aspect of the work we do so we can confirm that the interventions we offer apply to the real lives of Members. As part of our commitment to promoting Member engagement in our activities, the MAC will reflect the diversity of the region, including its Members, their families, and other caregivers. The MAC will provide guidance about Member needs and values, including education, cultural and engagement activities, care coordination approaches, provider experiences and preferences, grievance resolution, and Member materials. The MAC will also feedback on our efforts to address Colorado's 10 Winnable Battles, Member engagement efforts, Interactive Voice Messaging (IVM/engagement scripting), and the language and method of the Health Risk Assessment. MAC feedback will better equip us to understand how our messaging impacts our Members. Consequently, this will help us reduce the potential for confusion, mistake, or misunderstanding while increasing chances for successful Member engagement opportunities. By understanding our Members' perspectives, we will be able to develop better policies and more person- and family-centered program decisions.

The MAC will serve as the voice of our Members, sharing feedback for CCHA *Plus* review and analysis to address Member concerns, opportunities for improvement, and barriers to accessing care. Additionally, we will refer MAC concerns to executive staff in the appropriate functional areas to improve programs, processes, and educational materials. And we will hold ourselves accountable for using the feedback our MAC provides. We will regularly provide updates to the MAC on changes we make based on feedback received.

The MAC will review Member materials and our website to make sure they are culturally appropriate. These materials and our website will:

- Comprise easy-to-understand language and comply with all applicable requirements of 42 C.F.R. § 438.10
- Be available in English and Spanish, as well as other languages as determined by demographic assessment and need
- Use culturally sensitive and demographically appropriate images that illustrate the topic and colors adapted for color-blindness to promote easier readability and gray-scale equivalents
- Be available, upon request, in various formats for Members with limited vision
- Include a Provider Directory listing languages spoken by PCMPs and OB/GYNs
- Include information on accessing the variety of linguistic services available to Members

State Auditor Testimonial

CCHA has designed appealing member-facing materials on a variety of topics—general CCHA information, maternity program, well-child visits, where to go for care (emergency department [ED] alternatives), social support resources, care coordination—which provide information on how members can interact with the Department, with community resources, with their doctor, and with care coordinators. All outreach communications are carefully designed to stimulate members to respond and engage in the healthcare system.
Health Services Advisory Group Auditor for the Department

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Person- and Family-Centered Approach (5.5.1)

Our person- and family-centered approach promotes the health and well-being of the entire population and recognizes that Members are at the center of their care. Our population health management plan provides health promotion interventions based on the unique needs of the Member and their family. For Members requiring care coordination, we meet them where they are in recovery and recognize Members as primary contributors in their care. Engaging Members in their health and well-being, using a person- and family-centered approach, increases positive health outcomes: Engaged Members and their families are more likely to:[1]

- Complete needs assessments
- Participate in person-centered care planning
- Actively work with their Health Team to meet goals (such as keeping medical appointments, filling and taking prescriptions as directed, and following other clinical and service provider advice)

Aligned with the Department's person- and family-centered approach and central to CCHA's model, we will honor each individual's preferences, strengths, and contributions. We embrace the Department's direction to shift "the relationship between health care professionals, and Members, and families from the traditional focus of 'doing to and for' them… [by] embrace[ing] the approach of partnering 'with' clients and families… [and] acknowledge[ing] that they are essential allies for quality and safety within any health care setting." ***Through our person-centered approach, we engage Members where they are and recognize them as primary contributors to their care.*** Our Members will interact with Care Coordinators on their own terms.

[1] Center for Health Care Strategies, Inc., *Building a Culture of Engagement for Medicare-Medicaid Enrollees: Health Plan Approaches,* Sarah Barth and Brianna Ensslin, Center for Health Care Strategies; http://www.chcs.org/media/PRIDE-Culture-of-Engagement-FINAL.pdf

Our program will use best practices, such as screening in health care settings and schools and motivational interviewing, to supplement traditional clinician engagement. We will proactively educate Members on using their Medicaid benefits and health services. We will coordinate care and services across the System of Care to support Members' wellness by focusing on their interests, abilities, strengths, motivations, and personal goals. Through the lens of self-determination and a focus on community inclusion, we will facilitate their active participation in choosing Network Providers and accessing community resources. Because a strong support system is the foundation of resiliency, we will work with Members' natural supports to identify and meet their needs and goals.

As we engage Members in care coordination, we will utilize the Patient Activation Measure to identify their readiness to change, encourage them to identify strengths and needs from their perspective, and guide their care. This evidence-based and person-centered engagement methodology increases the probability that Members will develop self-directed care plans with achievable goals. We will work with them to address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and other needs that improve health and well-being. This planning helps Members use their Medicaid benefits effectively and access other parts of the health care system.

We will address social determinants, such as resources needed to meet individual needs, proactive strategies to mitigate or manage crisess, and day-to-day flexibility to respond to ever-changing needs. We will use a trauma-informed engagement approach and embrace strategies such as motivational interviewing. We will team with Network Providers, local governmental resources, community resources, and faith-based partners to wrap supports around Members. Currently in Region 6, these supports are often delivered face-to-face by caring and qualified CCHA Care Coordinators building real relationships with Members, grounded in the community.

We will align our work with our Members to the Colorado's 10 Winnable Battles and Colorado's State of Health to help define our priorities.

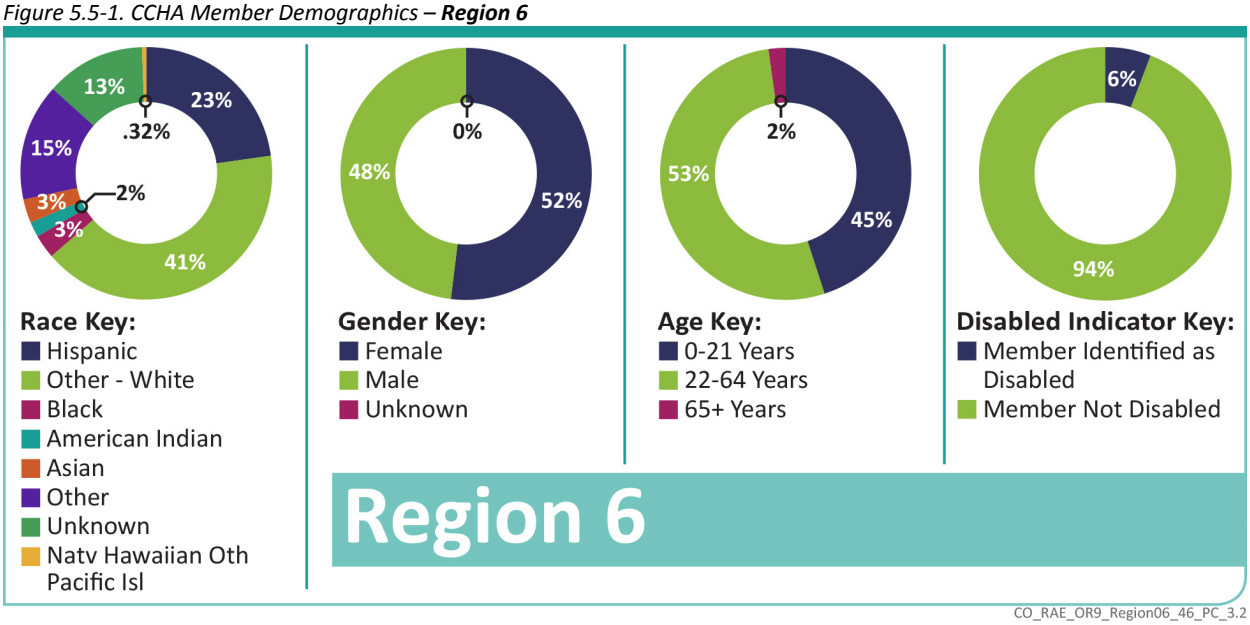
Cultural Responsiveness (5.5.2)

We believe that Members are most effectively engaged in their health care when systems, services, and Network Providers are culturally competent for all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds; disabilities; and regardless of gender, sexual orientation, or gender identity. Our Member engagement approach meets all National Culturally and Linguistically Services in Health Care (CLAS) requirements defined by the State and complies with Title VI and the National CLAS standards for Behavioral Health (BH) benefits. We have adopted all 15 CLAS standards to promote the equitable and effective treatment of all Members entering the health care system. Through our partnership with Anthem, CCHA *Plus* will maintain a Cultural Competency Plan that outlines our participation in the Department's efforts to promote National CLAS standards. For example, we will:

- Incorporate the CLAS standards into our policies, procedures, and practices; Anthem recently received the NCQA Multicultural Health Care Distinction, which is a symbol of quality in organizational efforts to address the diverse needs of Members.
- Provide all employees cultural competency training upon hire and annually. Employees have access to a toolbox with a comprehensive, searchable cultural competency database.
- Use trained professional interpreters and translators, and actively discourage use of untrained friends or family to interpret.
- Work with the MAC to identify and develop strategies for addressing health disparities. The Quality Management program will monitor the quality, appropriateness, and accessibility of care to achieve desired health outcomes.

We will tailor our approach to our Membership demographics; central to this approach is understanding the cultural and racial background of our Members, as detailed in Figure 5.5-1. For example, recognizing that a significant percentage of Members are Spanish-speaking, we will provide all Member materials in Spanish and strive to hire Spanish-speaking staff.

*Figure 5.5-1. CCHA Member Demographics – **Region 6***



Our cultural competency effectiveness will result from full incorporation of the CLAS standards into our systems and services. Our key activities in achieving cultural competency will include the following:

- Providing a high-performing organizational culture of social awareness and cultural sensitivity
- Recruiting and retaining a culturally diverse, competent workforce that reflects the cultural, racial, and ethnic backgrounds of the Members we serve
- Assessing the cultural, ethnic, racial, and linguistic characteristics and needs of our Members annually and adjusting clinical and service programs to best meet them
- Developing a comprehensive cultural competency training curriculum and making certain all CCHA staff receive annual culturally and linguistically appropriate education and training
- Making sure materials are easily understood and available in a Member's preferred language, when possible, through actively seeking our Members' review and approval of member-facing communications
- Making certain clinical assessments and care plans reflect relevant cultural issues through activities including monthly reviews of Care Coordination assessments, which encompass analysis of cultural, ethnic, racial and linguistic characteristics
- At no cost to the Member or Network Provider, offering language assistance services at all points of contact to Members and families with limited English proficiency; or who are deaf or hard of hearing; or who have limited eyesight or are blind
- Developing collaborative relationships with local partners, including organizations that serve minorities, communities of faith, and advocates for individuals with disabilities
- Providing Care Coordinators with Person-Centered Thinking and Trauma-Informed Care training

Delivery of Culturally Competent Services

We will identify and seek to recruit providers with the characteristics and experience to offer care compatible with our Members' cultural health beliefs and in Members' preferred languages whenever possible. We will monitor Network Providers' racial and ethnic population mix in an effort to confirm the network meets the needs of our Members.

Our provider directory and web-based provider locator will include languages spoken by each Network Provider. Members can request assistance from Care Coordinators to find a Network Provider who speaks a specific language. Our Provider Relations, Quality, Care, and Utilization Management departments will collaboratively review aggregate data from various sources, including HEDIS® reports, U.S. Census reports, cultural needs and assessment reports, and Colorado Medicaid program data, to see that our network reflects our region's cultural diversity. CCHA *Plus* will update enrollment data daily; our language line usage report monthly; and provider language and ethnicity as needed. We will incorporate Member survey information and Member complaint data into our programs to ensure the programs and services we offer are culturally responsive.

Cultural and Disability Competency Training for Staff and Network Providers

Cultural competency is an integral part of our Medicaid Training Academy (Academy) for staff. We will make Academy training available to Network Providers for continuing education. This training is evidence-based and modeled after the U.S. Department of Health and Human Services Office of Minority Health. The goal is to raise awareness about culture and language sensitivity to advance health equity and increase the quality of services provided to all people to reduce health disparity and achieve health equity.

Our entire staff will be required to take cultural competency training during new hire orientation and annually thereafter. Innovative CLAS-related practices include courses available through an internal, online, tool. Some examples of courses it includes are Assessing Cultural Adaptability, Communicating Across Cultures, End-of-Life Cultural Aspects, and Focusing on Abilities.

Through our Medicaid Training Academy, we offer multi-modality training venues for all Network Providers, including in-person, online, tailored webinars, and written materials aligned with population-specific needs and requirements. We will also conduct CLAS training for Network Providers as part of our new Network Provider orientation program, as well as on-demand through the CCHA *Plus* provider portal, along with our Cultural Competency Toolkit. We will also include articles and notices related to cultural competency in our provider newsletters.

Angela's Story: Eliminating Barriers to Communication

Angela is a seven-year-old Member with a hearing impairment. Her PCMP contacted our Care Coordinator for assistance after experiencing difficulties securing a face-to-face translator for Angela's appointments. Communication was particularly challenging as her mother is Spanish-speaking and does not know sign language.

We arranged for interpreter services to meet both Angela's and her mother's needs during provider appointments. We also located free sign language and English as a Second Language classes in the community for Angela and her mother. As a result, Angela received the care she needed, her mother participated in her treatment, and communication significantly improved with the PCMP and between Angela and her mother.

Anthem **Member Centered**

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Language Assistance Services

We will provide access to appropriate linguistic services for all Members. This is not only a regulatory and contractual requirement; it is a core element of our approach as a RAE. We will recruit, hire, and retain a culturally diverse workforce. We will annually review demographic files to verify that we are able to meet the linguistic and cultural needs of our Members. For example, the prevalent non-English language in Region 6 is Spanish. Therefore, we will strive to recruit employees who speak Spanish.

We will train all our employees to identify the need for interpretation services and to initiate them. Through our language services vendor, we will serve our Members in more than 200 languages other than English. When a Member who does not speak either English or Spanish calls us, we will place him or her on a brief hold to bring in the language services vendor and then will be connected in a three-way conversation with an interpreter and the Member. For the hearing impaired, TDD services will be provided through various resources.

To further assist Members in understanding the ACC Program and their available benefits and services, CCHA *Plus* will provide a guide for Members that explains how to request information and options to call for different languages.

Empowering Members through Health Literacy

CCHA *Plus* supports the Department's focus on health literacy to improve Member engagement and outcomes. We know that health literacy is affected by belief systems, communication styles, and understanding of and response to health information. Health literacy is an early step in engaging our Members. When working with our Members, we will listen to their needs, build on their strengths, and collaborate with them to develop culturally responsive care plans that help them make better-informed health care decisions. ***CCHA Plus seeks to empower our Members through education and learning on how to navigate the system.***

We know very well that Members cannot engage in their own health care if they are not aware of the benefits and services available to them. Additionally, Members with complex medical and social support needs may not know they are eligible for assistance through other publicly funded programs besides Medicare and Medicaid, or may have difficulty maintaining their enrollment in these programs. To help our Members improve their health and well-being, we will educate them on the medical and non-medical services available to them. Individually, ***our Care Coordinators will work to empower Members to engage in and self-direct their care by informing Members of their choices and helping them develop their own health and wellness goals.***

State Auditor Testimonial

CCHA has designed appealing member-facing materials on a variety of topics—general CCHA information, maternity program, well-child visits, where to go for care (emergency department [ED] alternatives), social support resources, care coordination—which provide information on how members can interact with the Department, with community resources, with their doctor, and with care coordinators. All outreach communications are carefully designed to stimulate members to respond and engage in the healthcare system.
Health Services Advisory Group Auditor for the Department

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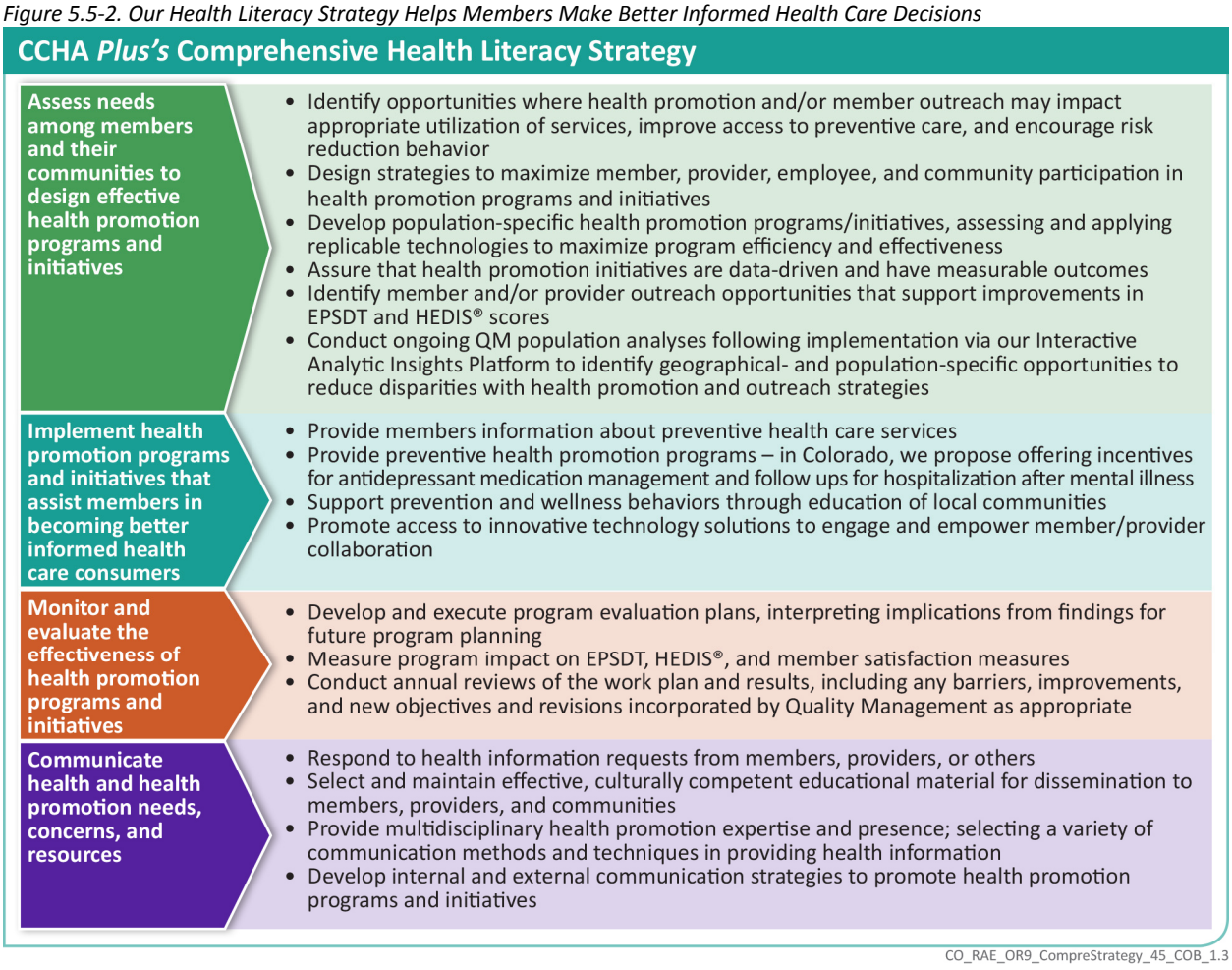
CCHA Plus will go beyond explaining benefits or referring Members to Medicaid Customer Service: We will provide other education aimed at engaging Members as active participants in their health care, empowering them to navigate these systems on their own, and confirming that they understand how to receive support from CCHA Plus as necessary. As a RAE, CCHA *Plus* will bring extensive expertise in applying a comprehensive health literacy strategy (Figure 5.5-2) to support Members and their families in managing and making decisions about their health care. We will help educate Members so they can make informed choices, by assuring their access to comprehensive health information, ongoing support, and innovative tools and resources. ***Our programs***

will engage Members in healthy behaviors and preventive services to reduce illness, help them become better-informed health care consumers, and improve their quality of life. We will have a dedicated resource who will oversee our health literacy and education program.

Figure 5.5-2. Our Health Literacy Strategy Helps Members Make Better Informed Health Care Decisions



In addition to our internal health literacy strategy, CCHA *Plus* will continue to participate with The Colorado Health Foundation, the Department, Connect for Health Colorado, Colorado Division of Insurance, and the Colorado Consumer Health Initiative in the statewide health literacy campaign for all Coloradans: **The Health Information Literacy initiative.** Through this effort, CCHA participated in the development of messaging and a toolkit database for health care organizations to use. CCHA *Plus* will continue to distribute this information through social media campaigns, office or practice materials, scripting, and other resources to guide the conversation around health literacy. We will also continue CCHA's current participation in the Provider Resources and Messaging subgroup.

Commitment to Disability Competent Care

Approximately 50% of CCHA's Network Providers are accessible to Members with disabilities. CCHA *Plus* will continuously work to expand this network to increase accessibility for our Members. Our Care Coordinators will support Network Providers in caring for Members with special needs, specifically focusing on complex care coordination, transitions of care, maternity care, high ER use, Medicare-Medicaid enrollees, and general care coordination. In several primary care and hospital locations, CCHA *Plus* will use Care Coordinators to confirm that disability competent care is delivered.

CCHA has collaborated with the Department and Colorado disability advocacy groups to implement the Disability Competent Care (DCC) Project in Region 6. The project assesses willing PCMPs to determine their proficiencies in providing disability competent care, including access and communication standards that comply with the Americans with Disabilities Act (ADA) of 1990. CCHA participated in a Department workgroup to develop the DCC assessment tool. Once Network Providers are assessed, they work with Department staff to provide a practice report that includes suggestions for improvement and potential resources they may access to make those improvements. CCHA *Plus* looks forward to continuing a partnership with the Department and the disability advocacy community to allay any concerns regarding competent care, and expanding the project to additional PCMPs.

Member Communication (5.5.3)

CCHA *Plus* is committed to communicating with Members in ways that are easy to understand, culturally and linguistically sensitive, and effective. Our Member materials will focus on delivering clear, consistent messages that attract our Members' attention and reinforce their knowledge about and engagement in a health care system that supports their individual safety, permanency, and well-being. Multiple communication channels offer opportunities to improve Members' overall understanding of their health care options and how to use their benefits wisely. We will ensure that all our Member communications adhere to Colorado Medicaid's brand standards.

Provider Testimonial

The free materials provided by CCHA have been invaluable to Jefferson County OLTC Care Coordinators when meeting with new and existing Members. The materials help in educating Members about not only their Medicaid benefit, but also services and resources available to them. These materials are great reference for areas such as diabetes care, mental health topics and heart health.
Karin Stewart, Jefferson County Options for Long Term Care

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We will have policies and procedures in place so that Members receive the information they need to make informed health care choices at the right time. Our Member communication approach will be multi-layered. We will deliver our message where our Members live, reaching out to them in multiple ways.

We will strive to write our Member materials and health information at a sixth-grade reading level to the extent possible and distribute through a variety of channels such as:

- Face-to-face interaction at Network Providers' offices, Members' homes, and other community locations
- Member material mailings
- Member website in English and Spanish
- One-to-one contact through telephone calls
- Emails
- Facebook/social media
- Community outreach (for example, bus shelter ads)
- Wellness Centers in the community
- School-based health programs and initiatives
- Community events, including health fairs, breakfasts, farmer's markets, and health screenings

All materials will be available in English and Spanish. If additional prevalent non-English languages are identified, we will make materials available in those languages.

Our approach will combine high-tech and high-touch communication initiatives***. While we will employ multiple communication methods, our primary strategy for promoting awareness of benefits and services will focus on direct engagement — in person and through telephone calls. This high-touch engagement enables Members to obtain immediate answers to their questions and maximizes our opportunity to inform them of benefits and services, as well as the availability of community-based resources.***

INNOVATION Additionally, as a value added benefit, Members can sign up for the Lifeline program and receive a free smart phone, free monthly minutes, a minimum of 500 MB of data, and text messaging. This value-added benefit will help support Member independence by providing an important tool for individual success. It will also help make certain Members always have a way to contact us, which is especially important for those experiencing a crisis. Participants will receive health-related text messages and reminders and can call our Member Services department without reducing their cell phone minutes.

Toll-Free Call Line

CCHA *Plus* will use our community resource experts to help Members with a myriad of issues, including connecting to a PCMP, understanding their health benefits, and connecting with other medical and non-medical services. We take this opportunity very seriously and will work hard to plant the seeds for a relationship that will engage Members in their care. Our Member Services Representatives will be trained in motivational interviewing, CLAS, and trauma-informed care to listen and understand each Member's unique needs.

We understand that good customer service drives overall satisfaction. We will continually evaluate and adjust staffing levels to adapt to evolving call trends and assure adequate staffing during peak call periods.

For the RAE, the Member Services toll-free line will operate 24/7. Callers to our toll-free line will be able to select assistance from a menu that directs them to the resource best able to address their needs and preferences: Member Services (24/7 Call Center) Representative, Care Coordinator, or self-service options. Our Member Services Representatives will offer:

- A single point of contact to assist Members in accessing services across BH and PH needs
- Assistance for any Member, including those outside our region who need help contacting their PCMPs or RAEs
- Round-the-clock automated self-service for enrollment status, requesting an ID card, finding or changing a PCMP, or requesting a provider directory.
- Advanced technology that enables us to flow calls to multiple call centers, as needed, to respond to spikes in call volume or business disruptions resulting from outages or natural disasters
- Clinical assistance 24/7 through the Health First Colorado Nurse Advice Line and the Colorado Crisis Line
- Telephone menus in English and Spanish

State Auditor Testimonial

CCHA reinvested in personnel and mechanisms to build a robust and increasingly sophisticated member engagement program through the call center. CCHA has used continuous learning experiences to reinvent and improve mechanisms for engaging with members, has and will continue to increasingly engage members through collaborations with community partners, and foresees increasing use of technology applications in future endeavors. In addition, IVR calls and messages targeted specific member populations; call center activities were supported through data systems; and staff were trained in effective communication and engagement techniques. Most recently, select call center staff have been trained as subject-matter experts in specific program areas, and cross-training of staff is being pursued to expand the base of expertise.
Health Services Advisory Group Auditor for the Department

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We know we cannot just wait for our Members to call. Many Members will not know we exist if we do not engage in proactive efforts to communicate with them. As a RCCO, CCHA has engaged in innovative approaches to transform the call center into an enterprising outreach tool. Their Member Service Representatives participate in multiple ***telephonic engagement campaigns*****,** using a combination of live outreach and computer-generated calls to connect with Members.

Currently, CCHA's Interactive Voice Messaging (IVR) allows them to call Members directly, multiple times if necessary, to connect with them about whatever their health needs may be. In our role as RAE, CCHA *Plus* will use this population-health based approach to focus in on populations needing to interact with the health care system; for example, pregnant moms, pediatric Members in need of a well-child check, or Members receiving Medicare and Medicaid services. Upon answering the phone, Members will hear a custom-tailored recorded message, sometimes from a physician, asking them to work with us on a defined health care need. Members who do not answer the call can also receive a voicemail with instructions on how to follow up. IVR saves human resources and dramatically expands Member outreach capabilities.

IVR campaigns will leverage data we receive from State partners, including raw claims and eligibility files, the monthly pregnancy list, and roster data, as well as the hospital admission, discharge, and transfer data feed from Colorado Health Information Exchange (HIE).

As a RCCO, CCHA transformed their call center into an innovative Member outreach tool. Member Service Representatives participate in multiple telephonic engagement campaigns, using a combination of live outreach and computer-generated calls to connect with CCHA Members. Since starting IVR outreach in 2013 in Region 6, CCHA has received almost **100,000 inbound calls**. They estimate that nearly **95%** of them have been generated by the IVR — either the Member accepted the IVR call or returned a voicemail it generated.

Innovative & Collaborative

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Using this approach, CCHA has experienced a significant increase in connection rate with Members. Since starting IVR outreach in 2013 in Region 6, CCHA estimates that nearly 95% of inbound calls have been generated by the IVR — either the Member accepted our IVR call, or returned a voicemail it generated. Despite the dramatic increase in inbound calls from the addition of IVR technology, ***CCHA's call center has still managed to maintain performance that consistently surpasses CMS and NCQA standards.*** As the CCHA call center data in Table 5.5-1 demonstrates, they continue to far surpass national standards for call center responsiveness.

Table 5.5-1. CCHA's Community Resource Center Consistently Surpasses CMS and NCQA Standards

Element/Standard	CMS standard	NCQA standard	CCHA actual 2016	CCHA actual 2017
Call Abandonment Rate	≤ 5%	≤ 5%	4%	5%
Service Level	≥ 80%	≥ 70%	98%	94%
Average Speed of Answer	≤ 60 seconds	≤ 30 seconds	13 seconds	17 seconds

As a RAE, CCHA *Plus* will continue to leverage this IVR technology to outreach Members for our population health programs or to connect with Members who need Care Coordination services.

Communication Strategies

CCHA *Plus* will proactively engage members using multiple communication strategies, including:

- **Well-child Outreach:** We will call parents around their child's birthday to remind them to schedule a well-child check and connect them with a PCMP if they do not have one.
- **PCMP Appointment Assistance:** We will attempt to connect a Member to their PCMP directly by calling the PCMP office while we have the Member on the line to set up an appointment.
- **High-Risk Medicare-Medicaid Member Outreach:** We will attempt to conduct an assessment, known as the Service Coordination Plan, and connect the Member with a Care Coordinator.
- **Maternity Outreach:** We will call Members who are newly pregnant in order to conduct a maternity assessment, connect Members with maternity resources and, if necessary and appropriate, enroll Members in our maternity Care Coordination programs
- **Behavioral Health Services:** Members will be able to access BH services by calling our single, toll-free Member Services Call Center. Representatives will be available 24/7 to address Member inquiries

about BH services. Qualified BH professionals will also be available for immediate crisis interventions and to link Members to the Colorado Crisis Support Line, where appropriate.

- **Dispatch Health:** Depending on the success of CCHA's current pilot program with DispatchHealth to reduce unnecessary ER visits, CCHA *Plus* will continue to conduct next day outreach to Members who have used DispatchHealth and will attempt to schedule a follow-up appointment directly with the PCMP office. We will also conduct a brief assessment of needs to determine whether the Member would benefit from care coordination support.
- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Outreach:** CCHA *Plus* will place outreach calls to Members or their caregivers for those whose services are 90 days past due. When necessary, Outreach Specialists will help Members or their caregivers schedule appointments and arrange for transportation. If we are unable to reach the Member directly, the Outreach Specialist may contact the PCMP or patient-centered Medical Home to attempt to locate the individual. Care Coordinators will integrate provision of primary and preventive services, including lead screenings, directly into the Member's Health Care Plan. This coordination includes arranging transportation when necessary. Additionally, we will explore options for outreach mailings to include information such as annual preventive health reminders, EPSDT overdue service reminder postcards, and EPSDT information for new mothers.
- **Nurse Advice Line:** CCHA *Plus* Care Coordinators will call calls Members after they have used the Health First Colorado Nurse Advice Line to ensure they have a PCMP and to assist with scheduling a follow up appointment and, when necessary, arrange for transportation to the PCMP appointment.

Electronic and Written Communication with Members

CCHA *Plus* brings experience working in Colorado with PCMPs to develop written materials to prompt proactive communication with Members. When CCHA began its work as RCCO, they developed a comprehensive set of written materials that, with the Department's input, that are regularly updated, supplemented, and refined. CCHA *Plus* will build upon this experience to design Member materials that expand and strengthen Members' sense of responsibility and engagement in their own health care and reinforce health literacy.

CCHA *Plus* will adhere to all material review and distribution requirements detailed in the RFP. Our Member Advisory Committee will guide development and the Department will review and approve all Member-facing communications before distribution. We will also confirm adherence to CMS and Department guidelines.

As a RCCO, CCHA has also adapted quickly to changes from the Department. For example, ***when the Department changed the program name from Medicaid to Health First Colorado, CCHA was the first RCCO to make the change across their website and materials.***

CCHA regularly receives feedback from Members and Network Providers that their materials are easy to understand and useful. Additionally, CCHA's materials have been recognized by the Department's staff and independent auditors, who noted that CCHA's Member-facing materials are appealing; these materials are often specifically requested by providers and community partners.

CCHA *Plus* recognizes that many Network Providers and community partners cannot afford to create and print Member-centered educational materials. Our materials will be available on our website, CCHAcares.com, for CCHA Network Providers, county agencies, and community partners to view and order at no cost.

Member materials will meet all RFP requirements and cover a comprehensive range of topics, including those examples detailed in Table 5.5-2. Requests for paper copies of electronic communications will be honored within 5 days of the request.

Table 5.5-2. Examples of Current CCHA Comprehensive Member Educational Materials

Document Title	Description
General Member Materials	
Map to Medicaid – Your CCHA Member Guide to First Health Colorado (Colorado's Medicaid Program)	Provides an overview of Colorado's Medicaid Program and how to get connected to a Care Coordinator, as well as contact information for medical and non-medical services in the community, including transportation, housing, and food assistance
ACC Program Member Enrollment Card	Helps Members remember their PCMP contact information. Provides links to information about the ACC Program, CCHA, care coordination available to the Member, and Colorado's Medicaid Program enrollment information.
Personal Health Record	Provides Members with a booklet to fill out their personal health information that concisely represents their current health status, concerns, and goals
Colorado's Medicaid Program Buy-in Program for Children with Disabilities	Provides an overview of the program cost, service options, eligibility, benefits, and application instructions for all Members who have a child with a disability
Supplemental Materials	Offers information about advance directives, grievance and appeals process, EPSDT, CCHA website, and more
Avoidable ER Visit Materials	
Did You Know That Many Trips to the ER Could Be Avoided?	Demonstrates the importance of avoiding the ER and offers a reference grid detailing which health care facility (PCMP, Urgent Care Center, or ER) should be used for a variety of medical conditions
Do You Know Where to Go for Medical Care?	Provides an overview of the benefits associated with using a PCMP or Urgent Care Center rather than an ER
Do You Know Where to Go for Medical Care? – Urgent Care Facilities Near You	Provides up-to-date contact information for all regional Urgent Care Centers
Condition-Specific Materials	
Depression Can Affect Anyone	Provides an overview of depression, including symptoms, helpful techniques, crisis hotlines, and treatment options
Diabetes Foot Care Guidelines	Provides an overview of the major health promotion strategies a Member can use to manage their diabetes
Recovery Journey	Provides information on the recovery process for Members with a mental health or additional condition
Maternity and Well-Child Educational Materials	
Maternity and Postpartum Brochure	Provides a broad step-by-step guide for the entire pregnancy process, including initial appointment through well-baby checkups and postpartum depression treatment (all applicable contact information is included)
Maternity Postpartum and First Well-Baby Check Card	Provides information, as well as contact information and appointment reminder, for the six-week postpartum appointment on one side and the new baby's pediatrician and first appointment on the flip side; this card is used with new mothers at their final prenatal appointment or at hospital discharge
Well-Child Visits – Protect Your Child's Health and Well-Being	Provides an overview of the importance of the well-child visit, the difference between a physical or sports physical and a well-child visit, as well as instructions for scheduling the visit
Important Milestones and Tips to Help Promote Health and Wellness	Provides a detailed explanation of how to care for all ages of children in reference to development milestones, positive parenting tips, safety tips, and nutrition tips

In addition to producing custom materials, CCHA *Plus* will collaborate with groups such as Colorado Crisis Services and the SBIRT program to print and distribute their materials to our Members, practices, and community partners. CCHA *Plus* will continue CCHA's collaboration with local public health agencies (LPHAs) and Centura Health to distribute the new statewide ***Let's Talk Campaign*** or ***Hablamos Colorado*.** This was developed by a coalition of LPHAs that received a grant to create a Mental Health Stigma campaign as part of the Statewide Innovation Model project.

As a RCCO, CCHA has been collaborating with the following organizations to develop Member materials, and CCHA *Plus* will continue to work with groups like this:

- Susan G. Komen — breast cancer
- Colorado Crisis Services — behavioral health
- Local Public Health Agencies — public health
- American Diabetes Association — diabetes
- Centers for Disease Control and Prevention — influenza
- American Heart Association — overall health
- Imagine! Autism Spectrum Disorders Program — autism
- Aging with Dignity, Colorado Advance Directives Consortium, Colorado Hospital Association for Advance Directives — aging and advance directives
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) — substance abuse
- Colorado Department of Public Health and Environment — fall risk prevention

Respecting Member Rights and Privacy

CCHA *Plus* will continue to post and distribute Member Rights and Privacy Practices to individuals, including Members, families, Network Providers, caseworkers, and stakeholders.

Further, as part of our internal training program, our staff will receive instruction on Member rights. This comprehensive training module is designed to help them understand a Member's right to:

- Receive information pursuant to 42 CFR 438.10
- Be treated with respect and due consideration for their dignity and privacy
- Have all records and medical and personal information remain confidential
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Freely exercise their rights with CCHA *Plus* or its Network Providers to prevent or remedy adverse treatment
- Request and receive a copy of their medical records and request that they be amended or corrected

Member Handbook

We appreciate the Department's effort to reduce confusion among Members regarding the duplicate mailings they receive upon enrollment in the ACC, and will collaborate with the Department to create a Member Handbook for distribution to newly enrolled and existing Members. We are happy to walk through the information included in the handbook. As a RCCO, CCHA reviewed the most recent version of the handbook and provided edits and suggestions to the Department. CCHA *Plus* looks forward to continued contributions to, and collaboration with, the Department to develop one statewide Member handbook. Additionally, we are happy to test the Department's Member Handbook with our Member Advisory Committee, Program Improvement (Health Neighborhood) Advisory Committee, Behavioral Health Committee, or with our Network Providers.

Website

CCHA *Plus* managing partner Anthem recently surveyed consumers to determine what drives the Member experience. The research has shown access to health care is the top factor. This is true for both Medicaid beneficiaries and for consumers overall. ***Access to health care includes having a choice of high-quality Network Providers and being able to get medical care-related information in the way that works best for the Member.***

Delivering information on medical care, coverage, and service according to the individual's preference is crucial — whether the Member prefers printed materials, online access, a mobile app, or speaking with a Member Services Representative on the telephone. The Member section of our website, CCHAcares.com, will include the elements outlined in RFP Section 5.5.3.8 and enable Members to find facts about their benefits, information or guidance on how to become a better self-advocate, and resources to increase their general health and health care knowledge. Our information will be culturally appropriate and geared toward the health needs of Members. All information on the website will be available in English and Spanish and offer additional language options. Further, our website will offer full accessibility and comply with many of the ADA and Section 508c requirements supporting assistive technology tools to eliminate barriers for people with disabilities. For example:

- Content will be written to a sixth-grade reading level, to the extent possible
- We will use colors that are adapted for color-blindness to promote easier readability and gray-scale equivalents
- The website will contain multiple navigation options, including plain text, drop-down and image navigation in various text sizes for easy readability
- The website will include access to information in a printer-friendly format, to the extent possible

Additionally, we will include a Network Provider search tool that enables users to find providers by location and specialty. Through responsive design, those with smartphones or tablets will be able to access the website, and content will be reformatted to suit the device being used.

The current CCHA website has been an effective tool for Members and has gone through several iterations of content and functionality based on feedback from the Member Advisory Committee. It averages more than 1,000 unique visitors per month. Its "Find a Doctor" page is the most frequently visited page, comprising around 20% of all views. Leveraging the learnings from CCHA as a RCCO, features of the CCHA *Plus* website will include:

- **Find a Doctor:** Members can search this directory of CCHA-contracted pediatric, family medicine, internal medicine, geriatric, and OB/GYN practices that are accepting new Medicaid Members. Information will include location, language spoken, gender, and area of specialty. As a RAE, this functionality will expand to include BH and substance use providers.
- **Health Topics Library:** Featuring the Xplain software platform, Members are able to search thousands of health topics and find easy-to-understand educational information and video tutorials to help them manage their conditions. Topics are searchable by body location or system, disorders or conditions, diagnostic tests, therapies, demographic groups, health and wellness, or alphabetically. This tool can be used during meetings with Members to offer additional resources for their conditions and empower them to further their health care education and literacy.
- **Community Resources:** The community resource page will list our toll-free 24/7 Call Center telephone number and provide information such as educational videos; information regarding Colorado Crisis Services and the Health First Colorado Nurse Advice Line; and links to existing searchable community resource directories such as the 2-1-1 Colorado Database, Aging and Disability Resource Center, and LinkingCare.org. We will offer the Community Resource Link as a value-added

benefit, which is an online resource that locates and displays all available local community-based programs, benefits, and services. It will provide a reliable source of information about the wide range of programs and services available to Colorado Medicaid Members. This easy-to-use online tool will display all locally available supplemental supports and services, such as addiction and recovery services, mental health services, and local support networks.

- **Health Resources:** Provides quick links and phone numbers for resources frequently needed by Members, including BH, dental, disease management, preventive care, and wellness.
- **Connecting to Care Coordinators:** Houses important information about our Care Coordination program, what to expect from Care Coordinators, and how to connect with a Care Coordinator.
- **Colorado Medicaid Program:** Contains information and links to the program website, ACC Program information, Member Handbook, and the Department's ACC Program and benefits videos.
- **Medicare-Medicaid Program:** Provides information about the Medicare-Medicaid Program benefits, as well as links to the Department's site for more information.
- **Contact Us:** Members can use this page to connect with us at their convenience and request information. Care Coordinators or other staff, as appropriate, will respond to these requests via telephone or email, depending upon Member preference.

Online Well-Being Program. We understand that focusing on mental health is important and the CCHA *Plus* Online Well-Being program, offered as a value-added benefit, will include web and mobile resources to help strengthen mind, body, and spirit. Our Online Well-Being benefit will provide a safe, secure environment that offers personalized resources to help Members take an active part in improving their health and well-being.

Advisory Committees. Information about our Member Advisory Committee and Program Improvement (Health Neighborhood) Advisory Committee meetings will be provided on our website, and past minutes will be posted publically on the website.

As a RAE, we anticipate enhancing the CCHA website to include a broader range of information and resources for Members.

Notification of Termination of Network Provider Contracts

Our primary concern is always the well-being of Members. Assuring seamless transitions and continuity of care is an integral part of assisting Members when a Provider disenrolls from the network. We will manage our care coordination services and processes so that each Member receives uninterrupted care.

As a current RCCO, CCHA established policies and procedures to accommodate Members when a Network Provider becomes unavailable through disenrollment, and they have experience helping them transition to a new Network Provider. CCHA *Plus* will maintain these policies, and our first priority will be to enable Members to continue receiving the best care possible with no disruption to their course of treatment. Detailed policies and procedures will guide our steps to:

- **Identify Affected Members.** We will run a report to identify all Members who are assigned to a disenrolling PCMP. For provider terminations, we will run a report that will identify all Members with 4 or more claims from the Network Provider within the last 12 months. In addition, our Network Relations Representatives will work with the Care Coordination team to make sure we identify any recent BH authorization requests or referrals to the terminating provider.
- **Notify Affected Members.** We will provide written notification to all identified Members within 15 days of receipt or issuance of the termination notice. We will mail a letter that explains the Provider's termination and gives instructions for selection of a new Network Provider. If the Member is receiving care coordination services, the letter will also include the Care Coordinator's name and telephone number for follow up.

Marketing (5.5.4)

CCHA *Plus* will comply with all the requirements listed in Section 5.5.4 that are not detailed in our response.

Health Needs Survey (5.5.5)

CCHA *Plus* supports the Department's move to assess all Members upon enrollment in the ACC. As a RCCO, CCHA has extensive experience conducting and using information from health needs surveys to drive population health and care coordination efforts for Members. CCHA currently conducts a brief health needs survey with all Members upon initial engagement with care coordination services. The survey enables Care Coordinators to capture important information about each Member's unique health care, social, and cultural needs. CCHA currently uses this information determine the level of care coordination the Member may require: community resource expert, social worker, or nurse, as well as the type of needed care coordination program.

In fact, CCHA is currently using the Department's Health Needs Survey included in the draft RFP and referenced in Section 5.5.5 of the final RFP to prepare Care Coordinators for taking action on the survey data we will receive as a RAE. ***As a result, as a RAE, CCHA Plus will bring experience in using the data from the Department Health Needs Survey to immediately act upon the data feed we receive from the Department to inform engagement and care coordination activities.***

CCHA *Plus* will leverage current capabilities to process daily transfers to the Department of data containing responses from the Member Health Needs Surveys. Currently, CCHA processes several daily feeds from the Department and other partners, including the 834 Eligibility file and the ADT feed from CORHIO. As discussed in OR 15 and 21, CCHA *Plus* brings sophisticated analysis capabilities and we are able to combine the feed with other data sources to enrich the information we receive and make it even more actionable, such as physician EHR data or Medicaid claims data. Additionally, ***we are able to feed the health needs survey into our electronic care coordination tool so our Care Coordinators will have individual survey responses available at their first contact with the Member and be able to refer Members for BH services, if needed.***

Member Education on Medicaid Benefits (5.5.6)

CCHA *Plus* seeks to help Members not only with their health, but with their well-being. Care Coordinators often find Members are struggling with social issues such a keeping a roof over their heads or feeding their families. We know that these issues often need to be addressed before Members can focus on their health. Our program-based Care Coordination model will enable our Care Coordinators and our Health Neighborhood and Community Engagement team to become experts on specific types of social assistance most needed by the population we are serving. For example, with the current ACC Program, ***CCHA Care Coordinators working on Medicare-Medicaid have become experts in filling out waiver program paperwork to help Members get the services they are eligible for and need to improve their health. The Care Coordinators who work on the CCHA Maternity program have direct contacts at the county family services divisions, enabling them to connect Members with Nurse Family Partnership, Prenatal Care, WIC, and other resources.***

Internal training for CCHA *Plus* Care Coordinators and close collaboration with the Department will enable them to help Members understand their Medicaid benefits, including what is covered by Medicaid and where to go for care that will be covered by Medicaid. ***Care Coordinators will also be able to identify gaps in coverage and benefits where Members may not even be aware of additional support available to them or how to access it.*** Care Coordinators will collaborate with other agencies in the Health Neighborhood and Community if a Member has unique and complex benefits barriers (for

example, working with local DHS, SEPs, CCBs, and Ombudsmen; and reaching out to the Department, when appropriate), exhausting all efforts to provide answers and proper navigation for Members who may be uncertain of next steps. We value comprehensive follow up with Members to make certain they do indeed connect with benefits and services following navigation.

Healthy Communities

Through the CCHA *Plus* managing partners, we bring experience establishing relationships with Healthy Communities program and staff. CCHA *Plus* looks forward to collaborating with Healthy Communities programs to engage in various collaborative projects and also work to define roles and avoid duplication of services. Over the years, CCHA as a RCCO has trained the staff of Healthy Communities programs regarding the ACC Program and the services the RCCO offers Members. As a RAE, CCHA *Plus* understands the value Healthy Communities bring to our child Members and their families, whom we will refer to Healthy Communities for assistance with EPSDT, community resources, and navigating child and family services. In their work as a RCCO, CCHA has found opportunities to partner with Healthy Communities programs where RCCO and Healthy Community roles may overlap. For example, CCHA is currently collaborating with Boulder County Healthy Communities to conduct outreach to Members to complete well-child visits. CCHA currently has formal agreements with Healthy Communities programs in Region 6. These agreements enable them to share data so they may enhance collaboration. CCHA *Plus* will leverage existing relationships the RCCO brings with Healthy Communities programs and staff and expand formal agreements to Healthy Community programs in the region to collaborate on shared Members and improve Member and family experience.

The Healthy Communities programs are well suited to performing onboarding services for Colorado Medicaid children and their parents, and we are excited to expand our collaborations with them. This expansion will enable us to focus additional resources on Members who require complex care coordination support. In response to the recent Healthy Communities program evaluation report recommendation, which states that “making clear distinctions (between RCCOs and Healthy Community functions) will help avoid duplication of effort and require coordination between the programs to refer clients back and forth depending on the clients’ level of need,” we look forward to participation in the onboarding and engagement activities of the Department and Healthy Communities programs. This collaborative partnership will comply with all requirements detailed in RFP Section 5.5.6.2 and 5.5.6.2.3.

Promotion of Member Health and Wellness (5.5.7)

CCHA *Plus* will work with Members to educate them on how to use benefits, services, and local resources to improve their health and well-being. We will receive Health Needs Survey data from the Department combined with data from other sources and sophisticated tools like our predictive modeling system, so that we may engage Members with some existing knowledge about their health needs and risks. We will outreach Members using our population health plan described in OR 15 and based on their immediate health needs and risks. Members will receive health literacy information to understand the benefits and services available to them as well the assistance CCHA *Plus* can provide. Our Provider Support team will help Network Provider offices educate Members about their benefits and services. Targeted information about managing specific chronic conditions, such as diabetes and asthma, will be available to Members and Care Coordinators will be able to provide this information directly to Members. CCHA *Plus* will adapt the program as changes in benefits arise. We will use a foundation of evidence-based practices, innovative proven programs, and strategies to assist in managing and coordinating the provision of care for our Members in collaboration with them and Network Providers.

Our Health Neighborhood and Community teams will focus on education and engagement in densely populated areas to reach the maximum number of Members. We will focus our efforts and initiatives in

less urban areas where Members may have challenges obtaining health care. As CCHA does now, and as a RAE, we will continuously review claims data, Member feedback, Network Provider input, the immediate and long-term goals of the Department and its sister agencies, and stakeholder objectives to refine and refocus our education and engagement program to meet Members' evolving health and wellness needs.

Our education and engagement efforts will focus on selected topics, geographical areas, and unique Member populations that require special attention. ***Our goal is to provide Members with the information and tools they need to manage their own health care wisely*****.** Through our efforts on general and targeted education and engagement, we will strive to:

- Improve clinical outcomes
- Enhance Member satisfaction
- Reduce unnecessary costs
- Empower Members to use benefits and services efficiently
- Advance Members' knowledge of and comfort level with navigating the health care system

We will focus on making health care and healthy living part of our Members' everyday lives rather than a foreign environment that they experience only when they are ill or have an emergency. By integrating healthy living and proactive management of chronic conditions into the work that we do, we help build a better and healthier future for Members. By employing multiple communication avenues and multi-media innovations to deliver our message, we can reach Members in familiar settings, open up a dialogue about health care, and invite their active participation.

We will work with local public health agencies to align our health promotion work with Community Health Needs assessments and collaborate with the counties to deliver public health services that encourage health and wellness and align with the 10 Winnable Battles and the State of Health.

As described in OR 15, our population health approach will include numerous health promotion interventions, such as:

- Integrated complex care coordination
- Wellness website
- Crisis Center follow-up
- Outreach trigger follow-up
- Tobacco cessation (adults)
- Wellness mailings
- Tele-town hall
- Influenza vaccination campaign
- Gaps in care
- Community nutrition, exercise, and obesity initiatives
- Well-child check appointment reminders during a child's birthday month (pediatrics)
- Post residential discharge follow-up for Child Mental Health Treatment Act children (pediatrics)

One of Anthem's most successful initiatives has been ***Clinic Days*** held at key provider offices. We will work with high-volume PCMPs to hold open appointments for CCHA *Plus* Members within a block of time over the course of several days (sometimes extending evening or weekend hours, or holding sessions during school vacations, to maximize parent or guardian availability). We will contact Member families or guardians with due or overdue screenings to schedule appointments during these time slots. We will confirm attendance with the Members' families or guardians the evening before and offer small incentives (such as movie gift cards) to complete the appointment.

Innovations in Outreach: Technology and Social Media

We recognize the power of new technologies to engage our Members, particularly youth, in an educational dialogue about their health care. We know that Members are increasingly using the Internet, smart phones, and social media daily. As a RAE, CCHA *Plus* will explore the use of email, texts, the Internet, and social media to provide Members with a convenient and enjoyable way to focus on their health. Our goal is to make health care information easy to access, simple to understand, and fun to share with other family members. We designed our engagement program to establish a long-term relationship with Members and give them the tools to improve their wellness and manage their own health care.

We will also employ social media to keep in touch with Members and connect them with the latest news about their benefits and services. Our education and engagement program will employ technology, direct messaging, and personal approaches to continuously promote our Members' health and wellness. As technology evolves, we will introduce new initiatives to keep our Members engaged, making it convenient for them to stay in touch with us and manage their own health. We will provide all information in a HIPAA-compliant, secure environment.

Program components include:

Figure 5.5-3. DispatchHealth Mobile App

- **DispatchHealth:** This innovative program implemented by CCHA as a RCCO, allows Members to use their smart phones to connect with a multidisciplinary team of providers in place of visiting the ER (see Figure 5.5-3). Members can request care using the DispatchHealth mobile app, website, or by calling directly. The DispatchHealth medical team follows up with a telephone call to understand the Member's needs and get them the right care.
- **Interactive Website:** We will provide Members with the needed information, education materials, and support tools to make fully informed decisions about their care and service options, facilitating their participation in self-care and care planning actively, and consequently increasing their potential for wellness. We designed our website to help Members find information and guidance on becoming a better self-advocate for their care and resources for those who desire to increase their general health and health care knowledge. Member selections may change over time as other helpful resources become available. Our website will inform Members of community-based, free care initiatives and support groups through the use of Community Resource Link. This valued-added benefit shows all available community organizations and associations that Members can contact or work with to further enhance their health care goals and improve their wellness. The information is delineated by region and offers links to organizations such as the Salvation Army, Boys & Girls Clubs, WIC, YMCAs, state offices, Habitat for Humanity, United Way, and health coalitions.
- **Email:** When Member emails are available, we will send general and targeted emails to Members to inform them of benefits and services, announce Clinic Days and other unique events within their communities, and remind them about scheduling PCMP appointments. Members can also email us through the website with questions or help requests. We respond to requests within 2 business days. We use email to efficiently increase engagement with our Members while providing important health and plan information.

- **Interactive Text Messaging Program:** Anthem brings an Interactive Text Messaging Program that offers two-way communication to Members. We will use this interactive communications technology with Colorado Medicaid Members in coordination with the LifeLine cell phone program. Its innovative, outbound, two-way phone interaction technology will extend the reach of our Care Coordination services. It will also facilitate our connection to Members with Lifeline phones and improve outcomes while decreasing costs. Members can ask questions via text messages and receive prompt responses.

Community Partnerships and Collaboration

CCHA has established partnerships with community organizations to find Members *where they are* in their communities. CCHA *Plus* will build upon these relationships and continue to offer community events that are designed to be fun and informative. They may include screenings for blood pressure, body mass index, diabetes or glucose, dental checkups, hearing tests, healthy eating curriculum, and child immunization and flu vaccine programs — all providing valuable health checks to both Members and the broader community. Our events will also include grassroots sponsorships and other efforts to enhance our outreach to less urban areas. We will coordinate these events with faith-based, senior, and school programs; community health fairs; and other educational, community, advocacy, governmental, and professional organizations.

During these events, CCHA *Plus* will take the opportunity to meet individually with Members to answer specific questions they have and let them know about programs and services that apply to their specific needs. We will provide a variety of resources, including our Member guide; PCMP, dental, and urgent care lists; and other resources applicable to the specific event and attendees. For example, CCHA recently participated in a resource fair at Eaton Senior Community and engaged with Members on general education about the ACC Program benefits, as well as finding PCMPs and dentists that accept Medicaid, and transportation resources. In addition to providing resources to meet current needs, CCHA confirmed that the Members they spoke with knew how to reach CCHA if their needs change in the future.

Examples of other events over the past couple of years that CCHA has participated in include:

- Imagine! Provider Fair
- VIVAGE Resident Holiday Party
- Joint Resource Committee
- Emerald Elementary School Registration Event
- VIVAGE Lake Loop Event
- DDRC Resource Fair
- Eaton Senior Community Resource Fair
- Highlands West Resource Fair
- Emerald Elementary School Spring Dance
- MCPN/JCMH Community Partner Fair
- Healthy Jeffco Summit
- Jefferson County Public Health Tobacco Cessation Forum
- VISTA Volunteer Presentation
- Maternity Summit
- Jefferson County Head Start Health and Safety Fair

CCHA *Plus* will continue to work with the counties and Colorado Department of Public Health and Environment to understand community's unique needs and resources through the Community Needs Assessments (CHNA) and CHAPs data. This data will help us understand how we can support our communities' efforts to improve the health of our population. They will also help us to understand the resources available to our Members.

Member Engagement Report (5.5.8)

Throughout the term of its existing Contract with Colorado, CCHA has submitted a bi-annual report to the Department describing how it was engaging Member and community stakeholders in the region. CCHA *Plus* will continue to comply with this requirement. CCHA has received positive feedback from the Department on the transparency of their report, as well as the breadth of their efforts in the community and innovative approaches they have piloted to connect with Members. As a RAE, CCHA *Plus* will submit the Member Engagement Report to the Department bi-annually. The Report provides an excellent opportunity to learn from the Department about new ways to engage with Members and to collaborate with the Department and new partners they identify (such as DispatchHealth) on Member engagement efforts in our communities.

CCHA *Plus* Will Meet All Section 5.5 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 9, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.5 that are not detailed in our response.

Section 5.6

COLORADO COMMUNITY HEALTH ALLIANCE

Grievances and Appeals

5.6 GRIEVANCES AND APPEALS

OFFEROR'S RESPONSE 10

Describe how the Offeror will handle grievances and appeals.

CCHA Plus is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is CCHA, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add Anthem, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make CCHA Plus: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.

Strong grievances and appeals processes are critical to protecting Members' rights and health and to improving our program operations and oversight. We respect Members' and Network Providers' rights to make inquiries, file grievances, and appeal decisions — and CCHA *Plus* will provide assistance throughout the process. Clearly delineated policies and procedures and a robust, state-of-the-art information system (that provides automated routing, tracking, and reporting capabilities) will support our grievance and appeals process. Our system will provide alerts to facilitate grievance and appeal reviews within the timely review resolution and Member notification requirements. We will capture all actions related to receipt, review, decision determinations, and notifications in the application.

As a current RCCO, CCHA has maintained a grievance policy that gives Members, Network Providers, and Health Neighborhood and Community stakeholders an avenue to voice grievances without fear of retribution or withholding of services regarding the treatment and care that were furnished or failed to be furnished by CCHA, the Department, or Colorado Medicaid Providers. CCHA tracks grievances and pinpoints trends for quality improvement activities. They have established a close working relationship with the Colorado Medicaid Ombudsman and the Medicare-Medicaid Program Ombudsman, collaborating to resolve many Member concerns.

We share grievance, appeal, and State Fair Hearing information with members, providers, and subcontractors that includes the following mix of required and other topics.

Member Rights
- To express and expect resolution of grievances and appeals
- To file a State Fair Hearing Request
- To get help and information about grievances, appeals, and State Fair Hearings

Grievances
- What a grievance is
- Multiple methods for filing a grievance, including verbally through our Member Services toll-free phone number
- What information to include in filing a grievance
- Grievance timelines
- Member notices

Appeals
- What an appeal is
- Multiple methods for filing an appeal, including verbally through our member Services toll-free phone number
- Information to include in filing an appeal
- Appeal timelines
- The appeal resolution process
- Member and provider notices
- Expedited appeals
- Types of appeals, including medical appeals and provider payment appeals
- Continuation of benefits during an appeal

State Fair Hearings
- What a State Fair Hearing is
- How to request a State Fair Hearing
- Continuation of benefits during a State Fair Hearing

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Anthem brings more than 26 years of experience resolving all types of Medicaid inquiries, grievances, appeals, and State Fair Hearings for Members, their representatives, and Network Providers in compliance with State and federal Medicaid requirements. As a RAE, leveraging our managing partners' experience, CCHA *Plus* will be well positioned to address the new influx of behavioral health (BH) grievances and appeals. The comprehensive, Member-centered, and holistic CCHA *Plus* Grievance, Appeal, and State Fair Hearing system complements and incorporates the Department's procedures for handling appeals of physical health (PH) adverse benefit determinations and complies with federal, State, and NCQA requirements.

We will offer a "no wrong door" approach to filing grievances and appeals. No matter how Members choose to reach us, they can be confident that a skilled, knowledgeable Representative will assist them. We will also accept grievances and appeals routed to us from Network Providers, Health Neighborhood and Community partners, the Department, other state agencies, legislators, the ombudsmen, and others to make sure all receive a prompt response to their concerns. We will train all employees on properly receiving and managing grievances and appeals; this cross-departmental training contributes to a consistent, structured process.

Members will be notified of our process through multiple channels, including our website, Care Coordinators, and educational materials. Our goal is first call resolution; historically, Anthem has ***resolved more than 90% of general Member inquiries during the initial call*****.** If the issue cannot be resolved, the Representative will link the caller to the appropriate individual for resolution via a warm transfer or referral and follow-up.

Grievances and Appeals (5.6)

CCHA *Plus* will provide training for our employees and Network Providers to recognize grievances and appeals quickly, to understand grievance and appeal procedures completely, and provide courteous and professional responses throughout each process. We will provide clear and comprehensive information to Members, Network Providers, and Subcontractors about our processes. We will not discriminate or take punitive action against Members or Network Providers for filing a grievance or appeal.

We will employ multiple strategies to inform Network Providers about and assist Members with all information required in RFP Sections 5.6.3 and 5.6.4 regarding their rights to file a grievance, appeal, or State Fair Hearing, and how to take these actions, as shown in Table 5.6-1. Network Providers will be able to file grievances and appeals on their own or on behalf of a Member if they have the Member's permission. We will notify Network Providers about the Member grievances and appeals process and make sure they understand the corresponding Network Provider grievance and appeal process through the strategies listed in the following table.

We will also provide materials to help Members and other parties distinguish between those grievances and appeals directed to us (Behavioral Health) and those directed to the Department (non-Behavioral Health related issues) for resolution.

Table 5.6-1. We Will Employ Multiple Strategies to Assist Network Providers and Members with Grievances, Appeals, and State Fair Hearings

Information Strategy	Approach
Network Provider Manual and Training	We will furnish Network Providers with a provider manual at the time of contracting; it will also be available on our website. It will include information on grievances, appeals, and State Fair Hearings topics, such as rights, required time frames, and specific processes. Our Provider Support team will educate Network Providers on grievances and appeals through initial and recurring training and the provider manual, which we will incorporate by reference into the Network Provider agreement.
Member Educational Materials	We will provide Members educational materials about grievances, appeals, and State Fair Hearings, such as a Quick Reference Guide that uses clear and direct language to advise Members to call Member Services for assistance with questions, concerns, or grievances. We will also work with the Department to include this information in the RAE regional information section of the Member Handbook.
CCHA *Plus* Employees	We will educate all our employees, including Provider Support Team, 24/7 Call Center (Member Services) Representatives, Care Coordinators, and Utilization Management employees, to identify grievance and appeal situations quickly, notify Members of their rights, offer support with problem solving, and assist them throughout the process. Network Providers will be able to call our 24/7 Call Center to ask questions about a BH service denial, reduction, or approval in an amount or duration less than requested; to learn about or get help filing grievances, appeals, and State Fair Hearings requests; and to understand next steps throughout each process.
Website	Our website will offer Members and Network Providers a variety of resources. In addition to the provider manual, Network Providers will be able to use our website to access information about grievances, appeals, and State Fair Hearings. Our website will also include a link to an electronic copy of the Department's Member Handbook that is accessible without logging on.
Network Provider Newsletter	We will utilize our Network Providers newsletter as an avenue to share news and updates from the Department about grievances, appeals, and State Fair Hearings.
Notice of Action Letters	For each BH service request that we deny, reduce or approve in an amount or duration less than requested, we will mail the Network Provider or Member a Notice of Adverse Benefit Determination letter that includes an appeal request form, an explanation of Member appeal rights, and directions for requesting an appeal.
Grievance and Appeals Forms	Our grievance and appeal forms will include instructions on form completion and submission, time frames for submissions and determinations, and obtaining assistance completing or filing the form. When applicable, these forms will also describe a Member's right to request a State Fair Hearing and the process and time frames for making this request.

We will share information using clearly written, readily available materials that are easy to understand and compliant with State and federal Medicaid requirements. We will train 24/7 Call Center (Member Services) Representatives, Care Coordinators, and Utilization Management employees to share this information verbally during any contact with a Member or Member representative that involves an expression of dissatisfaction with any aspect of the Member's experience.

Grievances (5.6.5)

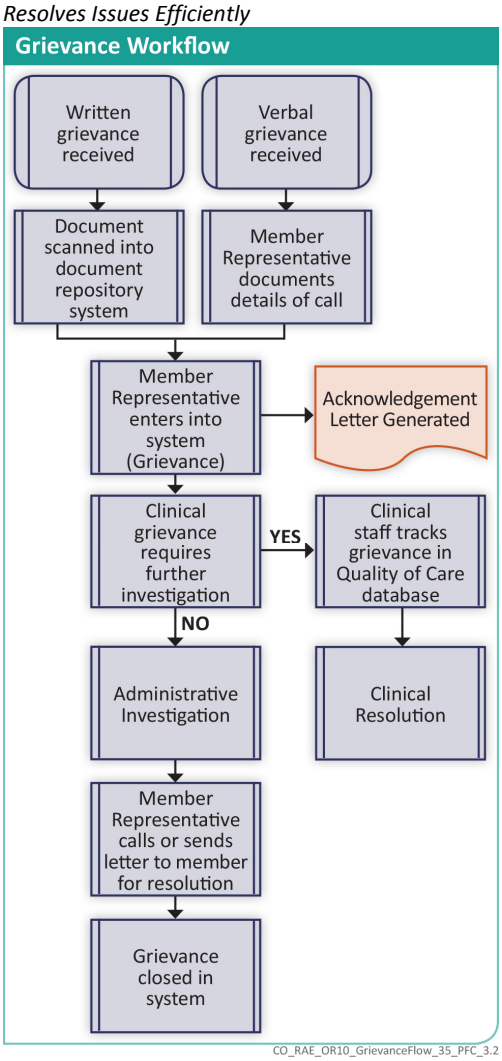
A grievance is an expression of dissatisfaction, regardless of whether identified by the Member as a "grievance" or received by any of our employees orally or in writing. If we are unable to resolve an issue during the initial call (or within 1 calendar day), we will help the Member access the State's grievance system for a PH appeal or begin a BH appeal, where applicable. Within 5 calendar days, we will confirm receipt of a grievance and provide an expected date of resolution. We will resolve the grievance within 15 business days of receipt or more expeditiously if the Member's health condition requires.

The CCHA *Plus* Member grievance response process, illustrated in Figure 5.6-1, will help Members resolve issues and pursue grievances in a courteous, professional, culturally and linguistically appropriate, and timely manner. Seven of Anthem's Medicaid programs have maintained a ***100% compliance rate*** for grievance resolution turnaround time for the 2 most recent quarters, and all plans sustain average resolution timeliness above 95%.

CCHA *Plus* will uphold RFP requirement 5.6.5.6; we understand that Members have the right to bring unresolved grievances to the Department and that the Department's decision is final.

Further, we will document problems submitted by our Network Providers, as well as the solutions we offer. We understand that the Department may review any of the documented solutions and we will comply with these requests. We will honor the Department's determination of whether the solution is insufficient or otherwise unacceptable, and collaborate to find a different solution or follow a specific course of action.

Figure 5.6-1. Our Member Grievance Process Resolves Issues Efficiently



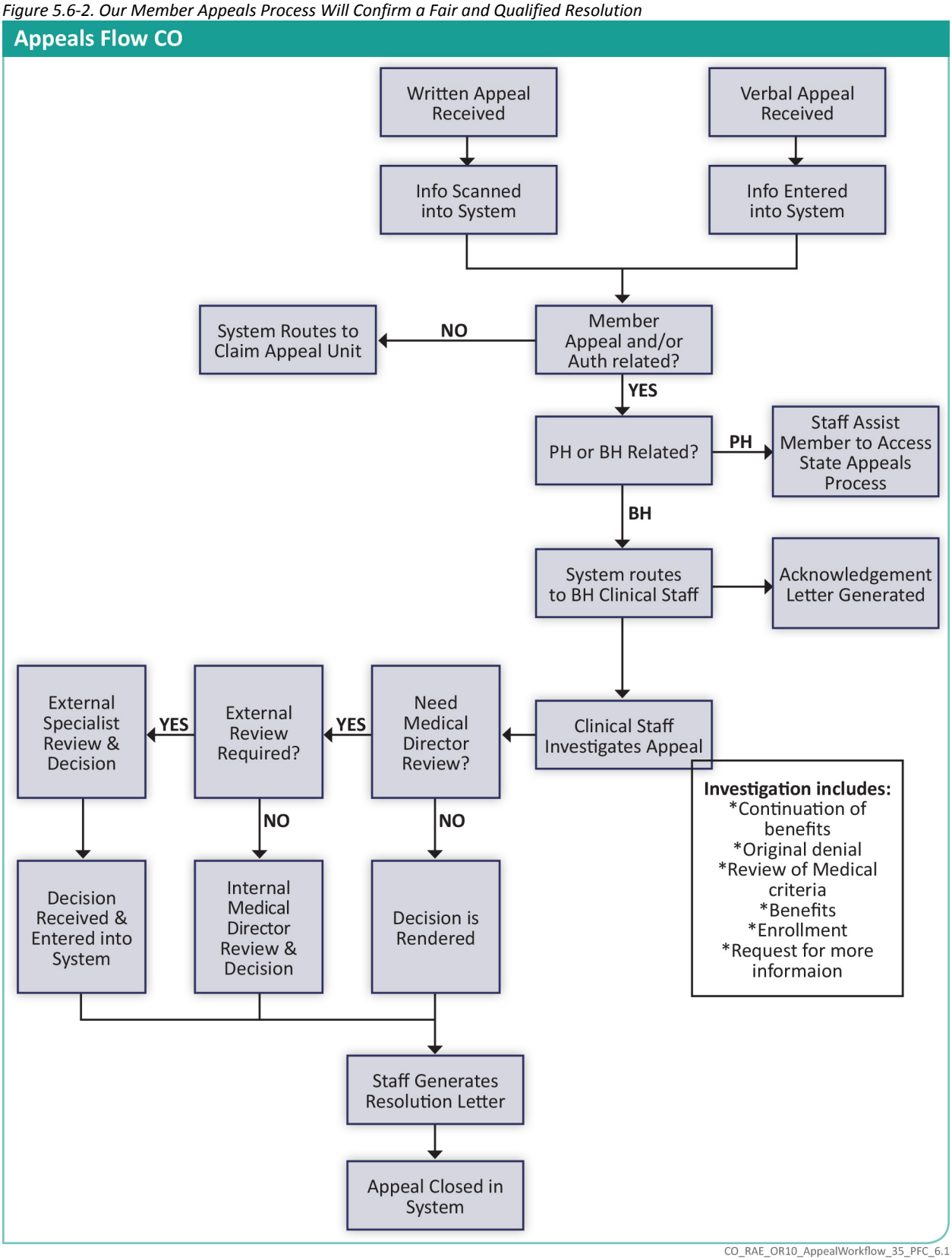
Notice of Adverse Benefit Determination (5.6.6)

When a BH service request is denied, reduced, or approved in an amount or duration less than requested, we will provide a Notice of Adverse Benefit Determination ("Notice of Action") letter that explains the steps to appeal the decision. Our Notices of Action will include the information specified in RFP Section 5.6.6 and be sent per the schedule detailed in Section 5.6.6.2. The Notice of Action will confirm that a Member; authorized representative; Network Provider who has the Member's written consent; or estate representative of a deceased Member may file a grievance or appeal and be parties.

Out-of-Network Providers that render services to Members will have this information at the earliest opportunity — either within 10 calendar days of approval for a service or immediately upon receipt of a claim.

Members, or their authorized representatives, may communicate dissatisfaction with any adverse determination through our appeals process, detailed in Figure 5.6-2. We will handle all BH-related inquiries. We will also help Members access the State's existing system for PH appeals.

Figure 5.6-2. Our Member Appeals Process Will Confirm a Fair and Qualified Resolution



Handling Appeals for the Capitated Behavioral Health Benefit (5.6.7)

Our appeals process — including for the Capitated Behavioral Health Benefit — will comply with the requirements detailed in RFP Section 5.6.7 and 42 C.F.R. § 438.400. Members may file an appeal, in writing or orally. They may call our Member Services Helpline, where a Member Representative will describe the appeal process and help the Member file an oral appeal request. Members may opt to file an appeal in writing by either mailing or faxing a letter. We will record the date we receive the initial appeal request. If a Member files an oral appeal on a matter with a standard resolution time frame (10 days), we will send the Member an acknowledgment letter and include the appeal form, requesting completion and return with any additional information. We will use the date of receipt of the oral appeal to calculate the final date for resolution.

When we receive a mailed, faxed, or oral appeal, we will record the appeal in our Core Operating System (COS). This system documents all data elements needed to investigate, track, trend, and record appeals. Additionally, the electronic COS initiates the mailing of a written acknowledgment to the Member regarding his or her appeal request within 3 business days of its receipt. The letter notifies the Member of the right to present evidence and allegations of fact or law in person, as well as in writing. It also notifies the Member of his or her right to examine the case files including any medical records or other documents and records both before and during the appeals process. If the Member requests an expedited appeal resolution, the letter details the limited time available to present evidence and allegations of fact or law.

After receipt of a request for an appeal, a grievance and appeals BH clinician will review the case and obtain any additional relevant information, including clinical detail and medical records as necessary. The clinician will summarize the case and any subsequent actions taken within the electronic medical management system. The grievance and appeals clinician will then route the case to an appropriately licensed psychiatrist or physician in the same or similar specialty as the Network Provider on record. The Medical Director or reviewing physician will not participate in the review if they have been involved in the initial determination or are subordinate to any person involved in the initial determination. The Medical Director or physician reviewer will contact the Network Provider as necessary to discuss possible appropriate alternatives. He or she will render a decision and document it in the COS.

Our national BH specialists will perform appeals duties related to BH services consistent with processes for other types of services, State requirements, and NCQA guidelines. Our specialists will apply their BH expertise to resolve Network Provider service authorization and claims issues for all levels of mental health and substance use disorder treatment in a timely, accurate manner. We will integrate all data related to BH appeals processing and related activities and include it in all appeals reports to the State.

Continuation of Benefits and Services during an Appeal (5.6.7.11)

We will see that Members continue to receive previously authorized services throughout the appeal and State Fair Hearing processes as required in RFP Section 5.6.7.11. We will encourage Members or their authorized representatives to contact Member Services for help understanding when they can ask for an extension of benefits and for help completing the request.

If the final resolution upholds our original adverse decision, we will document the determination and close the appeal. We understand that, in this situation, we will have the right to recoup the costs of providing services during the appeal process by deducting payments to the Network Provider. We will advise Network Providers of adverse decisions by copying them on Member communications.

Resolution and Notification of Appeals (5.6.7.12)

We will resolve appeals and provide notice as expeditiously as the Member's health condition requires, not to exceed the time frames detailed in RFP Section 5.6.7.12. As an example of our ability to meet this requirement, ***more than 3/4 of Anthem plans have achieved a BH appeal turnaround time compliance greater than 90% and 3 are currently maintaining 100% compliance to date in 2017.*** For appeal decisions not wholly in the Member's favor, notice to the Member will include the following:

- The Member's right to request a State Fair Hearing
- Instructions on requesting a State Fair Hearing
- The Member's right to receive benefits pending a hearing
- Notification of the Member's possible liability for the cost of any continued benefits if the adverse benefit determination is upheld

Expedited Resolution of Appeals

We will closely monitor compliance with requirements for timely resolution of grievances and appeals. We will review all requests for expedited appeals to see if they meet the criteria for expedited resolution, and if so, we will follow the expedited appeal process. If the request does not meet the criteria for expedited resolution, we will treat it as a standard appeal, follow those time frames, and inform the Member that we have transferred the appeal to the standard resolution time frame. We understand that this time frame can be extended up to 14 days at the Member's request or when the extension is in the Member's best interest.

State Fair Hearing Process (5.6.7.13)

Upon exhaustion of the appeal processes, Members dissatisfied with our appeal resolution may request a State Fair Hearing. Appeal resolution letters will inform the Member of his or her State Fair Hearing rights and how to request a hearing. We will cooperate fully with State Fair Hearing processes and decisions. We will inform the Member, authorized representative, or a Network Provider authorized by the Member that they may request a State Fair Hearing 120 calendar days from the date of a an adverse appeal resolution notice. We will document Fair Hearing requests in our COS and produce a position statement, which will be forwarded to the State. A representative from our Quality department may attend the hearing and present testimony, arguments, and all related documentation such as physician adviser case notes, Utilization Management case notes, medical records, and contract benefits.

Expedited State Fair Hearing (5.6.7.14)

We understand that when an appeal is heard first through our process, the Department's Office of Appeals will issue a final agency decision for an expedited State Fair Hearing decision as expeditiously as the Member's health condition requires, and under the time frame and requirements detailed in RFP Section 5.6.7.14.

Ombudsman for Medicaid Managed Care (5.6.8)

We know our work does not stop when a grievance has been filed with either the Medicaid Managed Care Ombudsman or the Medicare-Medicaid Program Ombudsman. We consider the Ombudsmen as another partner to problem-solve and help our Members get what they need. Just as CCHA does now, CCHA *Plus* will continue to refer Members to the Ombudsmen to help with problem-solving, grievance resolution, in-plan and administrative hearing-level appeals, and referrals to community resources, as appropriate. Upon request from an Ombudsman — and without requiring a signed release of information or permission from the Member — we agree to share PHI with the Ombudsman with the following exceptions. We will not share psychotherapy notes or substance use disorder-related information, nor will we share PHI if we have previously obtained the Member's written and explicit

instructions not to share information with the Ombudsman. We will have a policy outlining these requirements distributed to Network Providers, Subcontractors, advocates, families, and Members. Our Member and Provider Services Representatives will be trained to keep Members and Network Providers informed of these requirements.

MMP Ombudsman facilitates Member's increased mobility and independence

The MMP Ombudsman referred Antonio to Care Coordinator Naomi after he received a denial to get a power wheelchair. She listened to Antonio explain that one of his goals was to return to work, and so the manual wheelchair would not suffice. Naomi coordinated an additional mobility evaluation; the wheelchair was approved and delivered to Antonio; and he was able to move from his assisted living facility into independent housing with her help.

CCHA Member Centered

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Similarly, when the Ombudsman contacts CCHA *Plus*, we will work to problem solve and resolve grievances expeditiously. In CCHA's experience, Member grievances primarily relate to benefits or experience of care. Currently, both ombudsmen have a direct contact at CCHA; they contact CCHA often to help resolve issues with Network Providers or benefits. In fact, they have found CCHA so helpful that they occasionally contact CCHA for help troubleshooting in other ACC Program regions. In this next phase, if the Ombudsman reaches out to CCHA *Plus* to help resolve a dispute with a Member attributed to a large Network Provider, such as a federally qualified health center, we will facilitate the coordination with the health center. Some examples of the types of complaints our Care Coordinators will help to resolve include issues regarding durable medical equipment, billing concerns, and navigating/coordinating resources.

CCHA has received feedback from both ombudsmen that they are responsive and quick to resolve issues. Please see letters for support from the Health First Colorado and Medicare-Medicaid Program Ombudsman, attached as Attachment 4.2-1: Letters of Support. CCHA *Plus* intends to build on those outstanding relationships in the ACC Program.

Grievance and Appeals Reviews and Reports (5.6.9)

As required by the current RCCO Contract, CCHA submits grievances and appeals reports. In our role as RAE, CCHA *Plus* will continue to comply with this requirement. We will document all activities of the grievance and appeal process in our COS. The system supports generation of reports for Department review. Summaries of grievance and appeal data are routinely included in the Quality Management Evaluation that CCHA submits to the Department each year, including analysis of opportunities for improvement.

Our Quality Management Committee will periodically review Member grievance and appeal reports from our COS. These reports will categorize grievances and appeals by topic to enable a detailed understanding and we will analyze the specifics to identify opportunities for quality improvement. We will also share our grievance reports with our Member Advisory Committee and Program Improvement (Health Neighborhood) Advisory Committee to receive feedback from Members, Network Providers, and Health Neighborhood partners on how we can make quality improvements to our ACC Program.

As RAE, CCHA *Plus* will submit a quarterly Grievance and Appeals Report to the Department, containing the information (required per RFP Section 5.6.9) 45 days after the end of each reporting quarter.

CCHA *Plus* Will Meet All Section 5.6 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address Offeror's Response 10, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.6 that are not detailed in our response.

Section 5.7

COLORADO COMMUNITY HEALTH ALLIANCE

Network Development and Access Standards

5.7 NETWORK DEVELOPMENT AND ACCESS STANDARDS

OFFEROR'S RESPONSE 11

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

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

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA *Plus* will bring extensive experience in building and supporting physical health (PH) and behavioral health (BH) provider networks. We will deliver a comprehensive Provider Network so that Members have access to the full range of PH and BH care they need. We will continue to be a leader in practice transformation, supporting providers locally to improve their performance and Member outcomes. Our **Provider Network Development strategy** for the ACC Program is built on the following:

- **Local, on-the ground experience** of CCHA serving as the RCCO in Region 6 (for example, expected utilization of services, number and types of providers required to furnish the covered benefits)
- **Strong relationships** built over the years with providers, community leaders, and advocacy groups in Region 6 and **understanding of the challenges** they face
- Continuous attention to and **participation in communities,** so we can listen and **learn from Members and their families** what challenges they face in accessing the health care system (transportation, social determinants of health impacting access to care)

As a RCCO, CCHA has experience building an urban-based Provider Network in Jefferson County and parts of Boulder and Broomfield Counties. CCHA also supported the participation of smaller practices in two sparsely populated mountain communities, where they have successfully facilitated access to primary care and helped those practices apply Lean workflows to increase service capacity.

Federally qualified health centers (FQHC) will continue to be a critical part of the health care safety net delivery network. Their importance in filling the gaps is balanced by recognizing that they are not positioned to provide sufficient access to the changing Medicaid population. It is important to note that FQHCs only have the capacity to serve one-third of Members statewide. In Region 6, they serve approximately 20% of the Members. ***It is imperative that the RAE bring the ability to build a robust network of independent Medicaid providers to serve the entire Medicaid population, ensuring access to care and Member choice.*** CCHA successfully contracted with nearly 1,100 independent providers and more than 260 practice sites in Region 6.

With the addition of Anthem to the CCHA Plus partnership, we will bring extensive experience in developing comprehensive BH networks and be fully equipped to address current Member access issues by including independent mental health and substance use disorder (MH/SUD) providers in the Network.

Anthem has comprehensive BH networks in place in 18 states today, with more than 6,000 BH providers in the Medicaid and Medicare networks alone. In those states, Anthem manages integrated PH and MH/SUD benefits, which includes services ranging from crisis services and outpatient therapy for families and children, to intensive psychiatric rehabilitation, to peer support services through their local health plan delivery model. Anthem is a national leader in building robust, efficient, cost-effective provider networks, and successfully building 13 unique state Medicaid networks within the last 48 months.

Throughout this section, we outline our network development approach to maximize Member choice and make sure we have ample capacity to address the unique needs of the Members we serve.

a. Allow for Adequate Member Freedom of Choice Amongst Providers

CCHA *Plus* will develop a broad panel of Network Providers to assure Member choice. We will offer contracts to all FQHCs, CMHCs, Rural Health Clinics (RHCs), and Indian Health Care providers within the region. We will build a comprehensive network of PH and BH providers to allow Members choice in accessing the full range of services and supports they need.

Region 6 is estimated to have **148,263 ACC eligible Members** when the RAE contract begins. As the incumbent RCCO, CCHA knows the Region 6 population well. CCHA has built a robust provider network that includes providers with specialized training and expertise across all life stages, levels of health and ability, gender identities, and cultural identities.

CCHA has achieved significant success in contracting and retaining providers in Colorado, having current contracts with more than 75% of all Colorado Medicaid providers in Region 6 and nearly all of the large provider practices with more than 350 attributed Members therein. CCHA has supported Member choice, including when Members occasionally seek care outside of their communities. **CCHA currently contracts with 68 PCMP practices outside the Region 6 geographic boundaries,** serving nearly 6,000 CCHA Members and more than 38,000 ACC Members.

CCHA *Plus* is experienced and ready to assist PCMPs and BH providers in navigating the Colorado Medicaid program. We are confident in our ability to retain PCMPs and BH providers to protect Member access and choice. Our Network Relations Representatives will work diligently and creatively to continuously expand our network capacity. We will use established strategies to contract with providers, including partnering with the Department, sharing testimonials from other Network Providers, and sending our Chief Clinical Officer out to providers' offices. We will work to identify barriers and understand issues that may be preventing providers from contracting, and will work collaboratively to build relationships with these providers and bring them into our Network.

Additionally, we will offer our **Provider Support program** to Network Providers. Our program encompasses an array of tools, payment methodologies, and information to support providers, enhance access, guide evidence-based decision making, improve quality, and decrease fragmentation. CCHA *Plus* will use these resources and expertise to support CMHCs, as well as independent MH/SUD providers, to broaden the array of Network Providers accessible to Members. ***The CCHA Plus provider support approach is unmatched in its in breadth and depth in the State. For more information, see OR 17.***

b. Meet the Unique Needs of the Populations in its Region

To assess the needs of our Members and assure the adequacy of our provider network, we will take the following approach:

- We will analyze the Region's population's unique characteristics and the services they need to identify available providers by type and specialty that we will target for participation in our network.

Our anticipated enrollment determines the composition and capacity of our provider network, including PCMPs, specialists, hospitals, BH, and ancillary providers.

- We will capture the physical location of each provider to map access for members and expand our network as needed.
- To account for expected utilization of services, we will establish target ratios of members to providers by provider type. We will use conservative member-to-provider ratios, assuring appropriate access for services.
- We will target all available providers within the travel distance requirements established in the RFP, including providers in contiguous counties that also fulfill the travel and distance requirements. We will use GeoAccess software to measure both the average distance of Members to a provider and the percentage of Members who have access to a provider of each type within the defined travel distance standard.
- To determine capacity, we will multiply the provider counts for each provider type by the applicable capacity ratio to determine network capacity. We test the capacity result of the network adequacy model against our anticipated enrollment.
- We will identify population centers and high-volume Medicaid providers. Our goal is to maximize continuity of services for Members so we can focus on providers who currently provide the most services to the covered population. Conversely, our analysis will also identify where both Members and availability of providers are sparse. This will help us develop our strategies for contracting with providers in population centers and in underserved areas.
- We will couple geographic adequacy with the capacity standards in GeoAccess software to evaluate the capacity and adequacy of our network.

We understand the critical role that culture and ethnicity play in the health of Members, and we believe that Members are most likely to access care and complete treatment when systems, services, and practitioners are culturally competent. CCHA *Plus* will combine local experience with best practices shared by Anthem programs in serving state-sponsored health programs nationwide. We will recruit providers with cultural background and experience to offer care that is compatible with Members' cultural health beliefs and in their preferred language whenever possible. We will monitor the racial and ethnic population mix in the region to ensure the network is reflective of and able to meet the needs of our Members. As part of the credentialing application process, we will require providers to tell us languages spoken by practitioners and office personnel. This helps us identify providers who can communicate in a language the member prefers. Our network will include providers who speak a wide variety of languages and reflect the many ethnicities of our Members. Cultural competence, multi-lingual support, accessibility to the provider's premises, and any special communication abilities are an integral part of our provider network development efforts. These requirements are detailed in the provider contracts, as well as ongoing communications with network providers.

c. Ensure Sufficient Capacity to Serve the Diverse Members with Complex and Special Needs

As a RAE, CCHA *Plus* will hold many advantages in developing a PCMP and BH network that will meet the unique and diverse needs of Members and ensure sufficient capacity to serve Members with complex and specialized needs. For the past 6 years, CCHA has maintained a robust provider network of PCMPs in Region 6 and the surrounding areas. ***As CCHA membership grew from 10,000 Members in the first year of the program to more than 130,000 in year 6, they expanded their Network to continue to deliver Member- and family-driven care.*** In addition, Anthem brings extensive experience contracting and supporting BH providers.

We pride ourselves on working with providers across all ages, levels of ability, gender identities, and cultural identities. Our network will include:

- Public and Private providers, including independent practitioners
- Federally Qualified Health Centers (FQHC)
- School-Based Health Centers (SBHC)
- Rural Health Clinics (RHC)
- Indian Health Care providers
- Community Mental Health Centers (CMHC)
- Substance Use Disorder Clinics
- Essential Community Providers (ECP)
- Providers capable of billing both Medicare and Medicaid

We will continuously work so that Members who live in rural mountainous areas or foothill locations can have the same access to quality care, including access to Indian Health Care providers. Our strategies and tools include network enhancement, transportation solutions, and more.

As a RAE, ***we will recruit additional BH providers*** to expand the capacity to serve Members in addition to the BH services provided by the Community Mental Health Centers (CMHCs). ***To address significant access to care issues in Region 6, CCHA Plus will contract with the local CMHCs as well as independent mental health and substance use providers to serve the BH needs of Members.*** See more information in OR 12 and 17 regarding our strategy to increase access to BH care.

The needs of our Members will drive our **Network Development Strategy.** Our strategy will involve the following:

- Review expected membership and its relation to the overall population distribution of the State
- Determine the number of providers, by type and location, needed to properly support the program based on access standards and travel distances
- Engage with providers who are currently serving Colorado Members through a combination of reviewing the current Medicaid network and outreach to providers in the community to understand their referral and use patterns
- Proactively communicate with potential providers on our strengths and experience in all aspects of Medicaid, including our hands-on approach to Provider Services and our focused support of providers who work extensively with diverse populations
- Develop Contract terms and conditions that clearly define expectations for performance and hold all parties accountable to the success of the program
- Continuous monitoring and adjusting of our recruitment focus to confirm that the needs of all Members and provider types are part of Colorado network
- Conduct ongoing gap assessment and strategic planning to address any gaps
- Offer training and technical assistance, coding and claims support, and practice transformation services to support network development and retention
- Consider single-case agreements with providers offering specialty care services

We will recruit and retain a broad provider Network that is culturally responsive and represents racial and ethnic communities, the deaf and hard of hearing community, the disability community, and other culturally diverse communities who may be served. This helps promote choice so that Members can select from an array of Network Providers (and change when needed) based on their cultural preferences, linguistic requirements, and unique health care needs.

We understand that people with disabilities and other complex needs require strong systems of care, and we will ensure that our network includes providers who meet the Americans with Disabilities Act (ADA) access to care standards and communication standards. We will offer alternative locations that meet these standards if we are unable to contract with a provider that meets ADA requirements. ***As a RCCO, CCHA has contracted with several providers who specialize in services to Members with***

disabilities and other complex needs, and they have partnered with the Department and disability advocacy groups to implement special programs to increase the number of providers meeting ADA standards, such as the Disability Competent Care (DCC) Project in Region 6. The DCC assesses willing PCMPs to determine their proficiencies in providing disability competent care, including access and communication standards developed by the ADA. CCHA also participated in a Department workgroup to develop the DCC assessment tool along with a practice report that includes suggestions for improvement and potential resources providers may access to make practice improvements (complemented by practice transformation efforts when applicable). CCHA *Plus* will bring local and national expertise in providing fully integrated care to Members with disabilities and complex PH, BH, and developmental challenges. This expertise will be a strong contribution to our ongoing partnership with the Department and the disability advocacy community to address stakeholder concerns and drive innovative solutions.

Member Testimonial

Our CCHA Care Coordinator has helped me with implementing ABA services into my home, applying for waiver services through the CCB, has coordinated with my PCMP regarding my child's needs and has connected my family with community resources. This has made a huge impact on my family.
Amanda

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In addition to Network Provider capacity, we understand that care coordination is important for Members with complex needs. Our Care Coordinators will work to support providers in caring for Members with complex or special needs. Our Care Coordination programs are based on the unique circumstances of the Members including complex care coordination, transitions of care, maternity care, corrections, high ER utilization, Medicare-Medicaid enrollees, and general care coordination. Care Coordinators will work in the community and will often be co-located at the point of care in the PCMP offices and local hospitals, so both the provider and Member can get the support and services they need where the majority of their care is taking place. ***These services are particularly helpful for smaller practices that may not have the staff to track down community resources that may benefit the Member. Our care coordination services are important for all Members, especially those supported by smaller practices or in rural areas that may benefit from our expertise and resources in identifying holistic community resources to support Members and their families.***

PCMP Network

Our provider Contracts will require the following of providers:

- Enrolled as a Colorado Medicaid provider
- Licensed and able to practice in the State of Colorado
- Practitioner holds an MD, DO, or NP provider license
- Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics (for PCMPs only)

We will contract with all primary care practices sites that meet the criteria for being a PCMP, and we consider each Practice Site within a health organization, group, or system a separate Practice Site. We understand that Members with disabilities and complex care needs can benefit from PCMPs from a broad array of provider types, and we will carefully consider multiple characteristics relating to expertise and accessibility when working with existing and potential PCMPs. We will allow all of the following provider types to be contracted PCMPs:

- Physician
- Osteopath
- Federally Qualified Health Center
- Rural Health Clinic
- School Health Clinic
- Family/Pediatric Nurse Practitioner
- Clinic-Practitioner Group
- Indian Health Care providers
- Non-physician Practitioner Group

Other factors we consider when contracting PCMPs include:

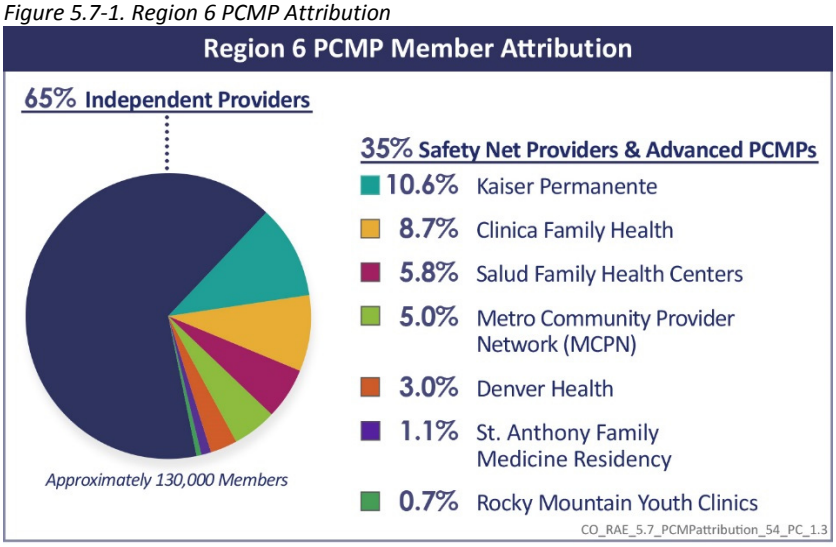
- Provides care coordination
- Provides 24/7 phone coverage with access to a clinician who can assess the Member's health need
- Has adopted and regularly uses universal screening tools including BH screenings, uniform protocols, and guidelines/decision trees/algorithms to support Members in accessing necessary treatments
- Tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information
- Has weekly availability of appointments on a weekend or a weekday outside of typical work hours (Monday-Friday, 7:30 am-5:30 pm) or school hours for School Health Clinics
- Uses available data (Department claims data, clinical information) to identify special populations who may require extra services and support for health or social reasons; must also have procedures to proactively address the identified health needs
- Collaborates with Member, family, or caregiver to develop an individual care plan for Members with complex needs
- Uses an electronic health record (EHR) or is working with CCHA to share data with the Department

Supporting CMHCs and HIV/Infectious Disease Practitioners as a PCMP

CCHA *Plus* is a strong advocate of Members receiving primary care in the place they consider their Medical Home. We know that Members with a Serious and Persistent Mental Illness (SPMI) or Serious Emotional Disturbance (SED) diagnosis may prefer to receive primary care from their Community Mental Health Centers (CMHC). As a RCCO, CCHA supported efforts by local CMHCs, Jefferson Center for Mental Health (JCMH) and Mental Health Partners (MHP), to deliver integrated PH and BH care. CCHA worked with the Department to help JCMH become the first CMHC in the State to have a clinic contracted as a PCMP. JCMH is receiving extensive CCHA Provider Support program services, from assistance with attribution to care coordination, organization and workflows, and practice transformation services. CCHA *Plus* strongly supports CMHCs as a Medical Home for Members and is equipped to dedicate significant resources to help JCMH and other providers succeed as PCMPs.

We are also well equipped to support efforts to work with specialty providers to meet PCMP standards as needed by our Member with complex needs, such as those with HIV. We recognize that individuals with HIV or other serious infectious diseases may receive their primary care from HIV/infectious disease practitioners. As a RAE, CCHA *Plus* will bring experience in working with HIV clinics to serve as a Medical Home. We welcome the opportunity to work with these providers locally to reach PCMP standards, so they may be included in our Network.

Figure 5.7-1. Region 6 PCMP Attribution



Support for the Safety Net Providers and Advanced PCMPs

As a RCCO, CCHA has offered expanded PCMP contracts to all FQHCs and Advanced PCMPs to help support their efforts in coordinating care and delivering high-quality, integrated care to Members. These providers have Safety Net or Advanced PCMP Provider agreements with CCHA to provide comprehensive care coordination to attributed ACC Members and connect them with community-based resources. CCHA passes on the majority of the attributed PMPM payment from the Department to the providers. CCHA retains the remaining PMPM for Members attributed to these providers so that CCHA can oversee, support, and assist these providers to make certain Members are receiving the best possible care and services.

While all 7 Providers combined serve approximately 35% of ACC Members in Region 6, we recognize the value these providers bring to Members and the health delivery system. **Over the past 6 years, CCHA has provided over $9M to these providers to support their efforts to improve the overall health and well-being of Members.**

CCHA's Safety Net and Advanced PCMP strategy allows them to supplement the financial support these PCMPs receive from the Department for participating in the ACC Program and to focus care coordination and provider support resources on independent PCMPs that need additional assistance to reach Medical Home status.

CCHA engages in monthly oversight to ensure Members are receiving the Medical Home level of care expected by the ACC Program. Care coordination activities are reviewed through annual case audits, which include review of Member cases and chart record review. CCHA works with the providers to verify they are engaging in Member-centered care planning and collaborates with them on Member outreach and engagement. They also work collaboratively with the providers to engage in practice transformation and population health efforts. The PCMPs select specific goals that align with the ACC Program, and CCHA works with them to create action plans as necessary.

Provider Testimonial

RMYC recently decided to expand its clinical services in the Lakewood community, and CCHA provided timely support using data analytics to help us identify where there are gaps in pediatric care in the region. They also advised RMYC about approaches to target outreach efforts to connect Medicaid patients that do not have a usual source of care with our services. These are the kinds of supports practices need now and in the future through the RAEs to really move the needle on population health and streamline precious resources. CCHA has demonstrated they can play that role effectively.
Jessica Dunbar, Executive Director, Rocky Mountain Youth Clinics

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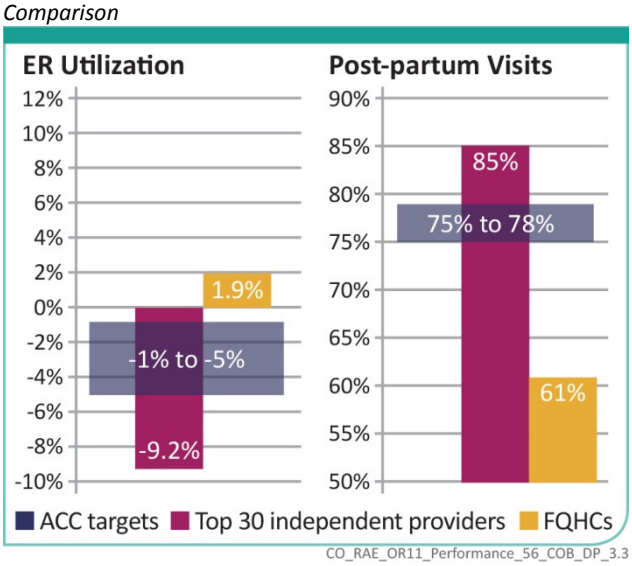
CCHA has supported PCMPs in improving their performance around specific KPIs and have substantially invested in providers on improving performance and in practice transformation. A designated member of the Provider Support team works exclusively with the Safety Net Providers and Advanced PCMPs in Region 6 and meets with them monthly to review their performance. CCHA has created a monthly dashboard for each PCMP that helps the provider track their performance on ACC KPIs and other measures and drives quality improvement activities. For more information on CCHA support for Safety Net Providers and Advanced PCMPs, please see OR 17.

KPI Comparison Table – Performance as of March 2017

As the chart in Figure 5.7-2 indicates, FQHCs in Region 6 struggle with their KPI performance, while the independent practices that CCHA coaches are peak performers in the region. As discussed above, CCHA offers support to the FQHCs to improve their performance, including performance dashboards and quality improvement activities. It is important that FQHCs improve quality performance, as they serve 20% of the population in Region 6. **In future contracts with the FQHCs, CCHA *Plus* will leverage the Department's new Primary Care Alternative Payment Methodology as well as performance-based administrative payments to achieve increased engagement from the providers on KPI performance improvement efforts.**

Figure 5.7-2. Independent Providers and FQHCs – KPI Performance Comparison



Specialty Behavioral Health Network

For developing a network of BH providers, CCHA *Plus* will focus on working with providers to promote a recovery-based, integrated collaborative approach at the practice level and beyond.

Anthem brings extensive expertise from building comprehensive Medicaid Behavioral Health Networks in 18 states, all of which it manages internally rather than through a subcontracted specialty managed care organization. These include the full array of providers, such as:

- Community Mental Health Centers
- Independent BH providers
- BH Services in the primary care setting, including Behavioral Health Home providers and co-located PH and BH Integrated Outpatient settings
- Inpatient Psychiatric Service providers
- Comprehensive Psychiatric Emergency programs
- Psychosocial Rehabilitation providers (including Clubhouse Services/Drop-in Centers)
- Therapeutic Day Treatment providers
- Mental Health Day Treatment/Partial Hospitalization providers
- Intensive In-Home Services providers
- Intensive Case Management providers
- Crisis Intervention providers, including Assertive Community Treatment (ACT) and Systematic, Therapeutic, Assessment, Resources and Treatment (START)
- Substance Abuse providers (including Inpatient, Intensive Outpatient, Substance Abuse Crisis Intervention and Targeted Case Management)
- Opioid Treatment programs
- Recovery Services providers
- Residential Services providers
- Respite providers
- Vocational providers
- School-based programs
- Peer Support providers
- Prevention/Early Intervention programs

Rather than a one-size-fits-all approach, our Provider Support program will flexibly work with providers in the way that best suits their needs and preferences. This will allow us to tailor training, incentives, and other provider support activities to meet the needs of the wide variety of BH providers needed to sustain a strong Specialty BH Network for our Members. For more information on our Provider Support program, see OR 17.

As a RAE, CCHA *Plus* will leverage CCHA's existing relationships with local BH providers and the expertise of Anthem to develop our Specialty BH Network. We look forward to contracting with any willing CMHCs, as they have been integral in enabling Member choice and promoting the continuity of care in Colorado. We will only enter into written contracts with BH providers enrolled as Colorado Medicaid providers.

To expand access to BH care in the Region, we will identify organizations, agencies, clinics, and providers delivering BH services throughout Colorado, including their programs, services, and capacity, as well as their interest and ability to expand programs and services necessary for the provision of integrated PH and BH care. We will consider the full continuum of BH services that Members of all ages, genders and cognitive abilities will need. We will analyze expected populations to identify available providers by type and specialty and will target all available providers within the travel distance requirements, including contiguous counties. We will also identify high-volume Medicaid providers to maximize continuity of services for our Members.

We bring extensive experience developing networks that allow for choice, meet the unique needs of Members, and assure sufficient capacity to serve Members with complex and specialized needs. CCHA *Plus* is poised and ready to implement a comprehensive BH provider Network that meets or exceeds access standards and includes all provider types specified in the Statement of Work. We will submit our Provider Credentialing Policies and Procedures to the Department. We will ensure that all laboratory-testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

Table 5.7-1 provides an overview of provider Network development activities and timeline.

Table 5.7-1. Network Development Activities and Time Frame

Task	Started	Applicable Time Frame
Implementation Phase		
Document key providers and stakeholders for each member population	X	Pre-RFP
Engage key stakeholders in provider community, associations, and community groups to develop trust and understanding	X	Pre-RFP
Develop competitive network database	X	Pre-RFP
Develop strategic network plan	X	Pre-award
Prioritize target providers for each population that will be served	X	Pre-award
Determine systems and operations requirements	X	Pre-award
Conduct financial analysis and develop reimbursement strategy	X	Pre-award
Develop contracting documents and recruitment packets	X	Pre-award
Obtain regulatory approval of provider contract templates		Upon award
Initiate contracting, obtain signed contracts and credentialing information		Ongoing upon award
Credential and load providers into database		Ongoing upon award
Monitor progress and compliance against target dates		Ongoing upon award
Readiness review		As specified by the Department
Achieve contracted, fully compliant provider network		Readiness review
Initiate new provider orientation and training		Within 60 days of start date of operations
Operations Phase		
Start of RAE operations		July 1, 2018
Post-implementation evaluation		Ongoing
Network management and maintenance		Ongoing

CCHA *Plus* will establish target ratios of Members-to-providers, by BH provider type, to account for expected utilization of services. While building a statewide BH network, we will also establish capacity in contiguous counties and will identify and contract with all available BH providers within a 90-mile radius of the region. However, ***our Network Development Strategy does not stop at contracting. Our Provider Support program will support the provision of integrated services through:***

- Enhancing capacity by supporting clinical integration between existing PH and BH providers
- Offering proactive provider education and outreach that addresses contract requirements
- Expanding our efforts to simplify operations and minimize administrative burden
- Expanding capacity of PCMPs and "non-traditional" BH providers in rural areas to address mental health and substance use conditions through education and reimbursement for BH screening and assessment, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Using strong reimbursement practices, and prompt and accurate claims payment

For more information on our Provider Support program, see OR 17.

d. Support the participation of smaller practices in its network, particularly in Rural and Frontier areas

CCHA *Plus* will offer our Provider Support program to assist practices of all sizes within our network, based on their level of need. While some providers are able to meet all of the Medical Home standards, many do not. Through our Provider Support program, we will assist providers with fulfilling some of the specific criteria listed above, allowing them to participate in the network as a PCMP and supporting them in their efforts to achieve Medical Home goals. The program includes a multidisciplinary support team assigned to each practice, regardless of size, to assist PCMPs and their staff in navigating the Colorado Medicaid system. Each practice team includes a single point of contact, and practices can add other Members to their provider support team, depending on their needs and goals. Provider Support team members may include:

- Network Relations Representative (serves as the single point of contact for the practice)
- Care Coordinators (nurses and social workers)
- Practice Transformation Coaches and Practice Facilitators
- Community Liaisons
- Clinical Health Information Technology Advisors
- Behavioral Health Liaisons

Additional details regarding our Provider Support program are provided in OR 17.

Support for Practices in Sparsely Populated Areas

CCHA *Plus* understands that accessing health care in rural and sparsely populated areas can be a significant challenge. When a PCMP or BH provider elects to stop providing services in a rural community, it can create a health care emergency very quickly. ***With Centura as a managing partner, CCHA Plus can leverage the Centura Health Physician Group to help solve access issues in rural areas.***

Over the years serving as a RCCO for two sparsely populated counties, CCHA brought an innovative spirit to solve some challenging health care problems in communities like Idaho Springs, Evergreen, Nederland, and the smaller towns in between. CCHA partnered with county officials to bring primary care back to those communities and then worked to integrate behavioral and social services into the clinics.

Additionally, CCHA Care Coordinators spend 90% of their time in the Community, going to Members' homes, schools, libraries, local events, coffee shops, or wherever they can reach our Members to assess their needs and connect them with services. CCHA has extensive experience working with Non-emergency Medical Transportation (NEMT) providers and finding other creative solutions to get

Members to PCMPs, BH providers, and specialty care services. Their work improves outcomes for Members and significantly reduces costs for the state, including expensive ambulance rides to town for non-emergency care.

Finally, as a RAE, CCHA *Plus* is excited to bring additional telemedicine solutions such as LiveHealth Online and Project ECHO® for improving access to care.

Below are some examples of CCHA's experiences in sparsely populated areas with connecting Members to care and the tools CCHA offers.

After the lone PCMP in ***Clear Creek County*** decided to close his practice, CCHA and Centura Health worked with county officials to bring primary care back to Idaho Springs. Centura Health partnered with Clear Creek County to find a new PCMP and worked to reopen the old clinic. The CCHA Provider Support Program stepped in to help the clinic set up its operations and implement lean workflows to expand access to care. They also collaborated with Jefferson Center for Mental Health to co-locate a BH provider in the clinic.

Community Partner Testimonial

As the incumbent RCCO serving Medicaid members in region 6, CCHA has been an invaluable partner to our county and the approximately 1,175 men, women and children who are eligible and enrolled in Medicaid programs and services. Since its inception in 2011, CCHA has helped to improve access to basic care as well as providing care coordination; a difficult feat at times for our county residents who have been without Primary Care since October of 2011.

Randall Wheelock, Timothy Mauck, Sean Wood, Clear Creek Board of County Commissioners

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However, the old clinic building is small and cannot support the needs of the population. CCHA and Centura Health joined forces again and supported Clear Creek County efforts to build a new, integrated clinic in Idaho Springs. The **Centura Health Physician Group Primary Care Clinic—Idaho Springs** opens in July 2017 and will provide a one-stop shop for Members with limited transportation options to access PH and BH as well as county social services.

Gilpin County is a rural community in Colorado's high country, neighboring the Continental Divide. Blackhawk and Central City are the only towns in the county. Due to its remote location, the community does not currently have a PCMP practicing there. Instead, Members receive care in neighboring Nederland, which sits on the border of Boulder and Gilpin Counties. Over the years, CCHA has worked closely with a Network Provider who serves more than 300 Members attributed to CCHA. The PCMP has received services from CCHA's Provider Support program tailored to the needs of the practice and the mountain community. A CCHA Practice Transformation Coach visits the practice weekly to meet with their Quality Improvement team and support their efforts around practice transformation. Additionally, a Care Coordinator is co-located in the practice to help Members with care coordination needs. Finally, CCHA partnered with JCMH to co-locate a BH provider in the office.

Similarly, Anthem has extensive experience in sparsely populated areas, **with approximately 60% of Medicaid Service Areas being located in rural counties.** CCHA *Plus* will deploy strategies from these collective experiences to support rural practices and ensure Member access to care. In addition to our Provider Support program detailed in OR 17, we bring the combined success of CCHA and Anthem with providing transportation and telemedicine support options.

CCHA partnered with Clear Creek and Gilpin counties to purchase the 'Prospector Bus.' This bus provides free rides for Members to visit their PCMP in their area or receive specialty care in the Denver/Boulder metro area.

Innovative & Collaborative

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Transportation Support

CCHA has continuously worked to find creative solutions so that Members in Gilpin and Clear Creek counties can access care. Because transportation has been one of the barriers in this mountainous area, efforts were focused there, first assisting counties in accessing Non-Emergency Medical Transportation (NEMT) services. In 2014, CCHA also partnered with Clear Creek and Gilpin counties to purchase the 'Prospector Bus.' The bus gives free rides to Members who need to access to primary care in their area or specialty care in the Denver and Boulder metro areas.

Telemedicine Support

INNOVATION As a RAE, CCHA *Plus* will offer an innovative LiveHealth Online telemedicine solution that provides Members with online access through two-way audio/video technology to Colorado-licensed, board-certified physicians and BH providers for consultations for clinically appropriate conditions (such as a cough, cold, fever, flu) or BH consultations. Members are able to access services through a video-enabled computer and secure internet connection or an app on their smartphone. LiveHealth Online providers can diagnose, make medical recommendations, and prescribe medications when necessary in accordance with State requirements. ***LiveHealth Online complements our continuum of options for Members to access health care services and expanded alternatives to the ER.***

INNOVATION To support PCMPs with helping Members with BH conditions, we can also offer an innovative Psychiatry and Addictions Case Consultation (PACC) Project ECHO®. PACC offers remote case review with clinical case management for PCMPs who care for Members experiencing addictions such as opioid addiction, chronic conditions, and other BH concerns. PACC was designed to expand the BH and addictions care capacity of providers in remote or underserved areas in Washington through weekly online clinics and in-depth clinical case consultation with University of Washington psychiatrists and addictions experts. Additionally, we will explore similar options in Colorado such as Virtual Reality (VR) therapy as an alternative for pain management. Numerous studies have shown that VR Therapy can be effective in decreasing high levels of acute pain and help support Members in their addiction recovery.

CCHA *Plus* Will Meet All Section 5.7 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 11, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.7 that are not detailed in our response.

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

Approach to Managing the Provider Network

CCHA *Plus* will maintain a provider Network that is designed to simultaneously address the primary care, care coordination, and BH needs of ACC Members, maximize Member choice, and meet the Department's expectations around access to care. We will hold our providers to the same standards of quality care for all Members we serve, regardless of Member's eligibility category.

We will leverage our experience and resources to strengthen provider practices by supporting their needs, assisting with issues as they arise, and providing the tools and resources they need to successfully serve our Members and improve outcomes. We will develop creative, collaborative provider solutions to improve Member health, access, and satisfaction. Our network maintenance strategy combines proven, comprehensive, and innovative approaches to assure network adequacy and quality including:

- Innovative value-based payment programs that reward PCMPs, BH, and Health Neighborhood providers, based on high-quality, cost-effective care
- Locally-based Provider Support teams that provide in-person, one-on-one assistance to facilitate accurate claims and encounter submission and prompt payment
- Proactive, comprehensive provider education beginning prior to contracting, as well as our multi-modality intentional trainings through our Medicaid Training Academy
- Our Provider Support program that encompasses an array of tools, payment methodologies, and information to support providers, enhance access, guide evidence-based decision making, improve quality, and decrease fragmentation

CCHA *Plus* will bring significant experience in managing comprehensive PH and BH networks that meet the ACC Program criteria. We will leverage CCHA's experience as a RCCO working locally in Colorado to monitor compliance with access to care standards, as well as Anthem's national experience managing fully integrated PH and BH services in 18 states. In addition to strong roots in the community, the national industry leadership we bring in building and managing robust, efficient, cost-effective provider Networks will drive a network that is tailored to meet the needs of our Members and the ACC Program.

Our successful strategy is anchored by the local, hands-on approach of CCHA. They meet providers where they are, and they are a trusted partner through changes in programs, policy, and benefits, demographics, cultural needs, and public health initiatives. CCHA *Plus* will continue to be a close partner to providers, helping them to meet ACC Program expectations and assure they are taking advantage of all the opportunities the program offers them. We will work to effectively improve Member outcomes with both PH and BH Network Providers through a combination of focused, face-to-face interventions and innovative technology solutions. Our network management activities will make sure that providers comply with

Provider Testimonial

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by helping our practices to improve our KPIs especially our ED utilization and Well-Child checks.
Kim Taylor, Manager, NextCare Urgent Care

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all requirements and standards. We will also work with other RAEs to establish policies and procedures to ensure continuity of care for all Members relocating to new regions. Our team will have primary responsibility for developing, managing, training, and monitoring our comprehensive PH and BH network. Through our Provider Support program, we will support providers locally in the field to advance their performance, improve Member outcomes, and improve the provider experience through education and collaboration.***Our commitment to providers is based on our understanding that collaboration and engagement between providers and our organization is essential to effectively meet the challenges of improving health care for low-income and underserved individuals.***

a. Certify Providers as meeting the Accountable Care Collaborative Criteria

In building and maintaining the existing network in Region 6, CCHA brings extensive experience certifying that PCMPs meet ACC Program criteria. To participate as an ACC PCMP in the region, each PCMP must enter into a written contract with CCHA that documents the RCCO relationship with the provider, as well as ACC Program standards and PCMP requirements. CCHA currently offers contracts to all FQHCs and CMHCs in Region 6. CCHA continuously monitors Member needs and works to recruit additional providers to meet any changes in classification or demographics. Providers excluded from participation with federal health care programs are prohibited from participating in the network.

Provider contracts are renewed annually to keep up with Department changes to the ACC Program and new initiatives available to the Network. The current Contract requires that PCMPs meet all of the criteria to qualify as a PCMP, as well as:

- Act as the PCMP for a Member and is capable of providing a majority of that Member's comprehensive primary, preventive, and urgent or sick care
- Be certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program or the PCMP practice is an FQHC, rural health clinic, or other group practice with a focus on primary care, general practice, internal medicine, pediatric, geriatrics, or obstetrics and gynecology
- Collaborate with CCHA and the Department to provide a comprehensive Medical Home for all assigned Members that facilitates partnerships between individual patients, their providers, and, where appropriate, the Member's family
- Participate in all care coordination and health improvement programs as PCMP's clinical and administrative capabilities allow
- Be in compliance with federal regulations regarding Member dismissal and only submit Member Dismissal requests that meet federal guidelines to the Department
- Be aware of and follow requirements for a clinical referral when a Member receives services from another provider
- Have access to assistance from practice transformation coaching services related to Medical Home skills, the transitions of care process, and clinical guidelines
- Have the opportunity to participate in facilitated provider education roundtables on topics of interest to the PCMPs

Maximizing their expertise and resources related to Contract requirements around ACC Program standards, CCHA has made considerable investments in providers through direct incentive payments as part of the CCHA Incentive program and through the Provider Support program's transformation activities to help move them along the continuum of Medical Home care. We know the ACC Program is iterative and constantly evolving, and CCHA *Plus* will continue to support providers, including BH providers, in moving forward with it. See OR 17 for more information about our CCHA Incentive and Provider Support programs.

In addition to CCHA's experience, CCHA *Plus* brings Anthem's experience in assessing and certifying fully integrated BH Networks in 18 states and supporting BH providers to grow capacity where needed to meet the holistic needs of Members. Anthem's commitment to evidenced-based practices for providing high-quality health care and solid credentialing processes is recognized by their NCQA Managed Behavioral Healthcare Organization accreditation. Building 13 unique state Medicaid networks in the last 48 months illustrates Anthem's strengths in evaluating the requirements of new state programs and initiatives and responding with solid provider Networks that meet required criteria. With this comprehensive local and national experience, CCHA *Plus* is well positioned to certify providers as meeting ACC Program criteria to drive a comprehensive quality provider Network for our Members.

b. Credential Providers

CCHA *Plus* is excited about the opportunity to expand access to BH care in the ACC Program and is prepared to credential providers accordingly. In addition to credentialing and offering contracts to all FQHCs, CMHCs, RHCs, and Indian Health Care providers, our provider recruitment strategy will focus on engaging independent mental health and substance use providers as well as non-traditional BH providers, such as independent peer-supporters and respite providers. CCHA *Plus* looks forward to bringing new providers into the Colorado Medicaid system to expand access to services for Members, and understands the value that solid credentialing practices bring to Members and the health care system as a whole.

We will bring Anthem's expertise in credentialing BH providers to the ACC Program. As an NCQA accredited Managed Behavioral Healthcare Organization, Anthem has proven proficiencies across the 5 NCQA standards, including credentialing and recredentialing.

CCHA *Plus* views credentialing as a critical component of the contracting process and quality management program. We will leverage standardized credentialing and application materials and automated contract intake processes to facilitate submission of applications for participation in our network. To assure a timely application process, we will use a universal application, credentialing, and contracting process. To make it easier for providers, we propose using the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource to expedite the credentialing process. Our local Network Relations Representatives will work one-on-one with providers and their office staff to answer questions and facilitate network participation.

We will continually seek ways to refine our processes and incorporate new resources and tools. Our goal is to simplify and expedite credentialing and re-credentialing, making the process as easy as possible for providers and reducing their administrative burden as much as possible, without sacrificing the integrity and completeness of our review.

Policies and Procedures. Our comprehensive credentialing policies and procedures are designed to meet both national accrediting body standards (NCQA), the Code of Federal Regulations, and Colorado-specific requirements. These policies and procedures (which are reviewed and updated regularly) describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and re-credentialing of providers. Credentialing will be conducted simultaneously with contracting to reduce administrative burdens on the providers. However, credentialing must be completed before final execution of a Contract. We will use this process to monitor that all providers we contract with are qualified to perform those Member services and deliver the best possible care. CCHA *Plus* has the systems, employees, policies, and procedures in place to accurately and timely credential and re-credential the full spectrum of providers at least every 3 years in compliance with ACC Program requirements in Section 5.7.3.4.

Quality Management Committee. Our Quality Management Committee (QMC) will engage local providers (both PH and BH) in quality management. It will provide oversight by reviewing and approving clinical practice guidelines to:

- Verify local Colorado practice context
- Approve utilization management criteria and program descriptions
- Review appeals reports, complaints, and quality of care issues

This committee will conduct peer reviews to assess levels and quality of care. The committee will also monitor practice patterns and drug utilization to verify appropriateness of care and improvement/risk prevention activities, including review of clinical studies and development and approval of action plans and recommendations regarding quality improvement studies. The committee will oversee credentialing and re-credentialing of BH Network Providers according to state, federal, and accreditation standards, and the Peer Review Committee will support assessment of levels of care and quality of care.

We will help BH providers by delivering other resources, such as our Credentialing Quick Tips, to provide clear instructions and concise information about each step of the process. To assist with accurate, complete, and timely submission of credentialing application documentation, our Credentialing Specialists can provide telephonic assistance to providers to help complete appropriate forms. Our Network Relations team is also available to make onsite visits to large group offices to review and assist in the credentialing or re-credentialing process.

c. Notify Providers regarding Selection and Retention

The CCHA *Plus* Network Relations team will meet with current and new PCMPs and BH providers to verify they are meeting ACC Program requirements as prescribed in the RFP. Newly contracted PH and BH providers will receive a welcome letter notifying them of their acceptance into our Network and will complete initial training and orientation within 30 days of becoming active. We will invite all providers to attend an initial orientation session to make sure they are informed about the ACC Program and our policies and procedures. During this orientation, the Network Relations Representative will educate the providers to make sure they are aware of the services and support that the RAE can provide to their practice and our Members.

All providers will be required to sign a new contract to include ACC Program standards prescribed by the Department. The contract will require PCMPs and BH providers to participate in the CCHA *Plus* Provider Support program and will offer opportunities to earn incentives for reaching practice transformation benchmarks through the CCHA Incentive program, Behavioral Health Quality Improvement program, or the Safety Net Provider Support program.

We will clearly communicate credentialing decisions to providers. Our policies and procedures for the selection and retention of providers will comply with 42 CFR § 438.12 and will be posted on our website. We will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. We will have a process in place to document decisions on the admission or rejection of providers in accordance with the policies and procedures and will provide documentation to the Department upon request. Where a provider credentialing application has been rejected or a provider is at risk of not being retained, we will engage the provider with our Provider Support program in an attempt to remedy the deficiencies.

As part of our Provider Support program, CCHA *Plus* will conduct ongoing training with providers to facilitate the sharing of best practices, communicate new and updated policies and procedures, and reinforce education. We will offer formal group training for all providers. To maximize participation, we offer training using various modes and venues. We will take attendance at every training session and

track individual provider participation. When a provider does not attend scheduled training sessions, our Network Relations Representatives will contact the provider to schedule training, including the option of a one-on-one or webinar session, and remind him or her that training is a requirement for earning incentives. At initial training, we distribute copies of our provider manual and member benefits collateral. Instructions will be presented on how to use the provider section of our website, which contains key information. We will also offer a question-and-answer session that fosters an environment of information sharing.

CCHA is a practice support leader, and this education and training is just one facet of the comprehensive Provider Support program that CCHA *Plus* will continue to offer and enhance for all Network Providers. We will maintain close contact with contracted providers through their participation in our Provider Support program and will review and update the contracts annually to allow providers and the RAE to evolve with the ACC Program.

d. Monitoring Network Adequacy and Ensuring Compliance with Access to Care Standards

Knowing it is important for our Members to access care when and where they need it, we will work to assure that our Network is available to serve current and anticipated enrollment in compliance with the Department's access standards listed in RFP Section 5.7.4 and the network adequacy requirements in 5.7.5 of the RFP. We will monitor our Network to confirm compliance with contractual requirements and NCQA standards for access to care and quality of services using GeoAccess, claims utilization, utilization management, cost of care, and other data, as well as availability of appointment times outside of business hours, timeliness of appointment availability, and other related Contract requirements.

Based on an analysis of current and future needs, we will develop work plans that identify specific network development activities. The work plans will be developed to comply with the Accountable Care Collaborative network access requirements, RAE policies, specific staff or department responsibilities, and anticipated timeframes for completion. Our Provider Support team leaders will review our work plans, monitor progress, and revise activities as necessary. Should any gaps occur, we will leverage our **local Network Management staff,** along with available data sources, to identify and recruit additional providers to fill any identified gaps and ensure freedom of choice.

In preparation for implementing the CCHA RCCO contract in 2011, CCHA developed an Access to Care Methodology to ensure the PCMP network would meet access to care standards. The following considerations were included in the methodology:

- Anticipated population growth over the course of the contract
- Expected utilization of services, accounting for unique needs of the population
- Numbers and types of providers needed
- Number of providers serving Medicaid
- Number of providers serving Medicaid and accepting new Members
- Geographic location of Members and providers, considering transportation availability
- Accessibility of providers for Members with disability

They also made sure all time and distance standards were met for the Member population. As a RAE, CCHA *Plus* will leverage CCHA's experience in developing a Primary Care Network for the ACC Program, including their Access to Care Methodology, and add Anthem's expertise in building a BH Network. We will have the policies, procedures, and systems in place to effectively monitor and manage our PCMP and BH Networks to meet the specific time and distance requirements in RFP sections 5.7.4.7 – 5.7.4.10.

Additionally, we will apply the following ratios:

- Adult primary care providers: one per 1,800 adult Members
- Adult mental health providers: one per 1,800 adult Members
- Mid-level adult primary care providers: one per 1,200 adult Members
- Pediatric primary care: one per 1,800 child Members
- Pediatric mental health providers: one per 1,800 child Members
- Substance use disorder providers: one per 1,800 Members

Our network development strategy will also include assuring Members have access to other important services including after-hours urgent care, adequate follow-up care after hospitalization, and preventive care services such as well-child visits and depression screenings. We will contractually require, educate, and monitor PCMP and BH providers on access to care standards and time and distance standards required by RFP section 5.7.2 and 5.7.4, including the following timeframes:

- Within 24 hours of a Member's request for urgent care, with the exception of Emergency Behavioral Health Care which requires phone contact within 15 minutes after initial contact, including TTY accessibility, and in-person contact within 1 hour of contact in Urban and Suburban areas and within 2 hours after contact in Rural and Frontier areas
- Within 7 calendar days of a Member's discharge from a hospitalization for outpatient follow-up appointments
- Within 7 calendar days of a Member's request for non-urgent, symptomatic care
- Within one month of a Member's request for a Well Care Visit, unless an appointment is required sooner to address Early Periodic Screening, Diagnostic and Treatment schedule requirements

Administrative intake appointments or group intake processes will not be considered as a treatment appointment for non-urgent symptomatic care.

In maintaining our Network as a RAE, we will consider:

- **Utilization of Services.** We will analyze our Member populations and their needed services to make sure our Network Providers meet or exceed the required Member-to-provider ratios and assure appropriate access to services.
- **Geographic Location of Providers and Members.** Each quarter, or upon any significant changes in network composition, we will evaluate GeoAccess reports for physical and geographic adequacy to identify network gaps and make sure Members have ample choice. The industry-standard tools we use will enable us to evaluate network adequacy and access and include geographic overview maps, provider and Member location maps, means of transportation, Member accessibility summaries, and detailed accessibility reports. We will monitor access for Members with disabilities by capturing physical access information for each location and use this data to map access.
- **Secret Shopper Phone Calls.** We will use these calls to collect data on appointment availability and access to care, including hours of operation and after-hours availability. We will document provider responses to confirm compliance, identify potential quality improvement opportunities, and make sure accurate information is maintained in our system.
- **Routine Appointment Waiting Times.** We will survey a statistically sound sample across our network quarterly to verify appointment standards and access to services for PCMPs and BH providers.
- **Member Services Data.** We will use this data to identify potential compliance issues. For example, if we receive repeated calls regarding inaccessibility, we will contact the provider.
- **Quality of Care and Access Concerns.** We will investigate these as part of our Continuous Quality Improvement program. We will review the outcomes of quality of care reviews, including Peer Review Committee actions.
- **Grievance and Appeals Data.** We will use this data to identify trends at the individual provider level.

- **Member Satisfaction Surveys.** Annually, we will engage a qualified organization to administer the most current version of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey querying Members on key questions, including access to care.
- **Provider Data Review.** We will analyze out-of-network authorizations, service coordination needs, Member cultural competency and language needs, provider capabilities, and providers who have not submitted claims.

Selecting a Provider

We will offer support to Members to select Network Providers based on their unique needs and preferences. In addition to building a strong network, CCHA *Plus* will deploy care coordination strategies to connect Members to Network Providers. We will maintain a **Provider Network Directory** and update it as providers are added and as we are notified of any practice closings or changes to the provider's panel size, availability, or scope of practice. The Directory will be available online and include all the requirements of the new federal managed care regulations: provider's name and any group affiliation, street address, phone numbers, website URL, specialty, whether a provider is accepting new patients, the provider's cultural and linguistic capabilities including languages spoken by the provider or skilled medical interpreter at the provider's office, and whether the provider's office is accessible to people with disabilities.

Members will also be able to search for providers via the CCHA *Plus* website on the "Find a Provider" page and via multiple search options including provider or clinic name, address, or zip code. CCHA *Plus* Members may also request a list of Network Providers based on city and zip code. This list may be provided to Members via phone, email, mail, or in person at home visits. CCHA *Plus* will audit the Provider Network Directory regularly to verify that the PCMPs are still accepting new patients and that their information is accurate. Our Care Coordination team will also be available to help Members that require extra assistance when choosing an appropriate PCMP or BH Network provider to meet their needs.

Appointment Availability for Routine and Urgent Care

In addition to contracting with a robust provider Network, CCHA *Plus* Practice Transformation Coaches will regularly assess practices to determine how quickly a Member can see a provider for different levels of care. Practice Transformation Coaches are also able to work with practices on workflows and scheduling to assure timely appointments and allow for same day add-ons in most of the clinics we work with.

Additionally, CCHA *Plus* will take actions necessary to ensure that all primary care, care coordination, and BH services covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

- Using out-of-network providers
- Using financial incentives to induce network or out-of-network providers to accept Members

To assist PCMP practices and Specialty BH Network Providers with connecting Members to the care or resources they need at the point of care, community-based CCHA Care Coordinators are already stationed at several PCMP offices across the Region 6, and may be deployed by CCHA *Plus* to other PCMP and BH provider offices as needed.

Extended Hours

Most Region 6 PCMP practices serving CCHA-attributed Members currently offer same day appointments; some have hired mid-level providers to see acute care and same day patients, and some have hired mid-level providers who have their own patient panel. While

In our current PCMP provider network, **50 out of 260** contracted provider locations are currently offering evening and weekend hours.

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the existing CCHA network ensures adequate service coverage from 8 am to 5 pm Mountain Time, Monday-Friday, we know Members need more options to access care outside of normal working hours. CCHA has also worked with many PCMPs in the network to offer **extended hours** on evenings and weekends, and CCHA *Plus* will continue this important outreach. CCHA *Plus* Practice Transformation Coaches will support providers with operational changes and workflows needed to extend office hours.

One of Anthem's most successful initiatives has been ***Clinic Days*** held at key provider offices. We will work with high-volume PCMPs to hold open appointments for CCHA *Plus* Members within a block of time over the course of several days (sometimes extending evening or weekend hours, or holding sessions during school vacations, to maximize parent or guardian availability). We will contact Member families or guardians with due or overdue screenings to schedule appointments during these time slots. We will confirm attendance with the Members' families or guardians the evening before and offer small incentives (such as movie gift cards) to complete the appointment.

Additionally, the **CCHA Incentive program** will offer incentives to Network Providers for offering extended office hours. For more information on the program, see OR 17. We will also partner with the Department on the Primary Care Alternative Payment Methodology, as well as other initiatives like Comprehensive Primary Care Plus (CPC+) and the State Innovation Model (SIM) that may be used to incentivize extended hours care. ***Of approximately 260 Network Provider locations in Region 6, more than 50 locations are offering evening and weekend hours that include access to clinical staff.***

24/7 Availability

We will also have a central, dedicated phone line that Members can call 24/7 for help connecting with the right care and services at the right time. When Members call our dedicated 24/7 support number, we will educate them about after-hours care options and the opportunity to avoid unnecessary ER utilization. CCHA *Plus* Care Coordinators in the community, at provider offices, and at hospital locations will also communicate this information to Members. Additionally, our written Member communications will provide information on their options to receive routine and urgent care outside of normal work hours. These materials will be available at no cost to our PCMPs and are regularly shared with Members during primary care visits.

We will also promote access to the 24/7 **Health First Colorado Nurse Advice Line** where Members can get free, real-time advice and answers from nurses on medical conditions, whether they should see their PCMP right away, or what type of provider or care facility may be right for their situation. Additionally, CCHA *Plus* will promote **Colorado Crisis Services,** which provides 24/7 BH services, ensuring Members receive timely access to BH interventions during a crisis.

Currently, CCHA maintains a list of urgent care facilities that accept Colorado Medicaid. Providers receive of this information during their orientation and are encouraged to send Members to these facilities rather than an ER. Further, CCHA contracts with several urgent care facilities that provide both family medicine and urgent care services. At this time, these practices include Rocky Mountain Urgent Care and Family Medicine (7 locations) and NextCare Urgent Care (8 locations). These practices are a great resource and alternative to the ER for Members.

Dispatch Health

CCHA has established a ***partnership with DispatchHealth as another innovative way to offer after hours care to Members to reduce inappropriate ER utilization.*** DispatchHealth is a provider of mobile and virtual health care, providing on-demand home health care 7 days a week from 8am-10 pm. They have a team of board-certified physicians, nurse practitioners, and physician assistants that go to Members' houses to deliver non-emergency care and prevent unnecessary visits to the ER. Members can request care using the DispatchHealth mobile app, website, or by calling directly. The medical team follows up with a phone call to understand the Member's needs and get them the right care. On average, medical teams arrive at a Member's home within the hour where they are able to treat everything an urgent care facility can. They can call in prescriptions and notify PCMPs of the Member's condition or help the Member find a doctor if they do not already have one. DispatchHealth also informs CCHA of contact they have had with Members, and CCHA Care Coordinators follow up with Members and document in the care coordination tool.

Provider Testimonial

As the incumbent RCCO serving Colorado Medicaid Members in Region 6, CCHA brings invaluable experience, knowledge and proven success with bringing the community together to focus on solutions for expanding access to services and improving coordination of care. We have been pleased to be working with CCHA on a project to reduce unnecessary Emergency Room utilization among CCHA Members.
Dr. Mark Prather, CEO, DispatchHealth

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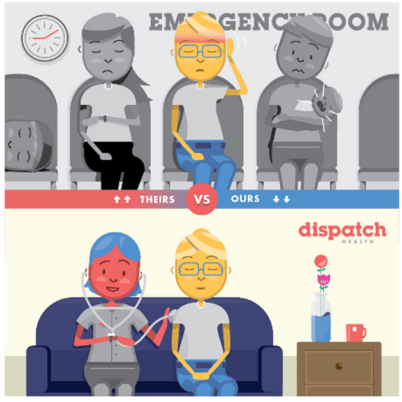


CCHA is in the initial year of this program and is currently piloting it in 16 zip codes in Jefferson County. The program is expected to result in reduced ER visits and significant cost savings for the State. CCHA *Plus* looks forward to sharing evaluation results with the Department and expanding the program to other communities as appropriate.

Rapid Response Team

CCHA *Plus* will offer a Rapid Response team for the next iteration of the ACC Program. The Rapid Response team works to reduce unnecessary ER services for Members with BH needs. If a Member with BH needs presents at the ER but does not meet criteria for admission, the Rapid Response team is notified. The Rapid Response team will go to the ER, assess the Member's needs, and triage the Member to the appropriate setting, including a psychiatric urgent care facility, if appropriate. Community-based Care Coordinators are available to help coordinate transportation to a clinic. Onsite CCHA *Plus* Care Coordinators will perform needs assessments and work with Members to identify and address clinical and social factors that interfere with their health, such as lack of personal identification, transportation, or stable housing.

Recognizing that a lack of housing often contributes to frequent hospital stays, Members with more than 12 inpatient bed days will have access to a short-term housing program. This alternative approach provides significant cost savings compared to repeated hospitalizations, as well as the opportunity for improved quality of life and outcomes.

This initiative has shown positive results for Anthem: ***Anthem saw a 25% decrease in BH ER visits from the peak in 2016 to January 2017, 1,600 diversions from the ER, and more than 1,000 psychiatric urgent facility assessments.*** *There was a* 20% decrease in BH readmissions from the peak in 2016 to January 2017 and a decrease in average length of stay from 7 to 6 days.

Network Management Process and Database

CCHA *Plus* will have multiple mechanisms to maintain Network oversight and comply with ACC Program standards. These mechanisms will be described in various CCHA *Plus* policies and procedures and will provide the guide for monitoring and complying with access to care standards.

We will bring extensive experience measuring and reporting on CMS Network Adequacy criteria required for primary care practices to participate in Medicaid. We fully understand the federal responsibility and requirements to monitor an organization's compliance with network adequacy requirements. CCHA and Anthem are accustomed to transparent reporting related to time and distance standards as well as providing Member ratios and specialty types. As a RAE, CCHA *Plus* will be able to accurately assess the Provider Network for gaps and implement solutions to address these gaps.

CCHA *Plus* will maintain a sophisticated network management process and database that feeds our Provider Network Directory and includes all contracted PCMPs and BH Network Providers. The Provider Network Directory will be updated routinely, made available online, and may be accessed by the Department at any time. The Provider Network Directory will meet the new federal managed care regulations by including the following information on all Network Providers serving the Region:

- CCHA *Plus* single toll-free, Member service phone number
- CCHA *Plus* email address
- CCHA *Plus* website address
- Which populations are subject to mandatory enrollment in the ACC Program
- Service area covered by CCHA *Plus*
- Any restrictions on the Member's freedom of choice among Network Providers
- Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit
- Provider Information
  - Provider's name and any group affiliation
  - Street address
  - Phone numbers
  - Website URL (as appropriate or available)
  - Specialty (if appropriate)
  - Whether a provider is accepting new patients
  - The provider's cultural and linguistic capabilities, including languages spoken by the provider or skilled medical interpreter at the provider's office
  - Whether the provider's office is accessible to people with disabilities

This information will be collected during credentialing and contracting, updated timely, and will be assessed routinely to ensure access standards are being met. In particular, we will use the database to proactively monitor our Network Providers' patient load and determine whether new providers need to be recruited to assure adequate access to all covered services. We will notify the Department of any unexpected or anticipated change or deficiency in our Network that could impact service delivery, access, or capacity. If a deficiency is noted, our Provider Support team will work to maintain required access standards for Members.

Network Adequacy Plan and Report

Consistent with RFP Section 5.7.5, CCHA *Plus* will create a single **Network Adequacy Plan** that includes all required information for both our PCMP and Behavioral Health Network, including the following information:

- How we will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract for all Members, including those with limited English proficiency and Members with physical or mental disabilities
- How we will ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities
- Number of Network Providers by provider type and areas of expertise, particularly:
  - Adult primary care providers
  - Pediatric primary care providers
  - OB/GYN
  - Adult mental health providers
  - Pediatric mental health providers
  - Substance use disorder providers
  - Psychiatrists
  - Child psychiatrists
- Number of Network Providers accepting new Members by provider type
- Geographic location of providers in relationship to where Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Members
- Standards that will be used to determine the appropriate case load for providers and how this will be continually monitored and reported to the Department to ensure standards are being met and maintained across the CCHA *Plus* provider network
- Case load for BH providers
- Number of BH providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how the CCHA *Plus* network of providers and other Community resources meet the needs of the Member population in the region, specifically including a description of how Members in special populations are to access care

CCHA *Plus* will also submit to the Department on a quarterly basis a **Network Report** that includes, at a minimum, the following information:

- Percent of PCMPs accepting new Medicaid Members
- Percent of BH providers accepting new Medicaid Members
- Percent of PCMPs offering after-hours appointment availability to Medicaid Members
- Percent of BH providers offering after-hours appointments
- Performance meeting timeliness standards
- Number of BH provider single-case agreements used
- New providers contracted during the quarter
- Providers that left the network during the quarter
- Additional information, as requested by the Department

CCHA *Plus* Will Meet All Section 5.7 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 12, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.7 that are not detailed in our response.

Section 5.8

COLORADO COMMUNITY HEALTH ALLIANCE

Health Neighborhood and Community

5.8 HEALTH NEIGHBORHOOD AND COMMUNITY

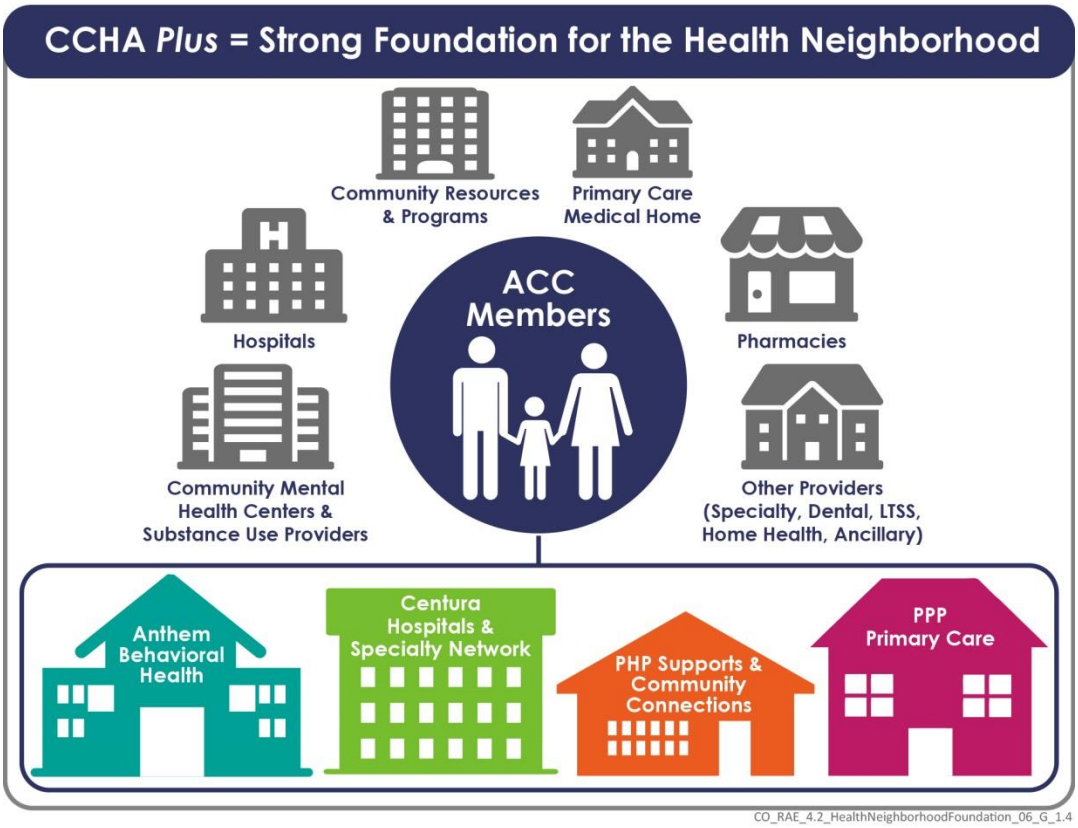
OFFEROR'S RESPONSE 13

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

Health Neighborhood and Community

By selecting CCHA *Plus* as a RAE, the Department will secure the foundation of the Health Neighborhood for the region with partnership and commitment of primary care, behavioral health (BH), specialists, and the largest hospital system in the state. We will align and coordinate with Network Providers to create a new opportunity to make the best use of scarce resources and reduce duplication, fragmentation, and waste. We will convene Health Neighborhoods in the region to deliver an integrated health solution that increases Member access to timely and appropriate Colorado Medicaid services and benefits and promotes healthy Communities.



CCHA *Plus* brings the experience of CCHA, one of the top-performing RCCOs, in establishing and supporting Health Neighborhoods. This is demonstrated by our **Letters of Support** from Health Neighborhood partners and the Department's independent auditor.

With the addition of Anthem, CCHA *Plus* has a new opportunity to expand access to BH care, building the independent provider network and supporting large providers like Arapahoe House, in expanding access to critically needed substance use services. Arapahoe House is the largest substance use provider in the region and supports our bid to be the RAE.

Here are just a few ways CCHA *Plus* will support the Health Neighborhood in Region 6:

- Engage in **strategic planning** to build on collaborative efforts already underway with **Jefferson** and **Boulder counties**
- Partner with **Arapahoe House** to explore innovative ways, including co-location in provider and community locations, to **expand access to substance use services**
- Expand the Jefferson County Hotspotting Alliance to include additional Health Neighborhood partners to help connect Members with BH services and primary care and **reduce inappropriate ER utilization**
- Expand the independent provider network by recruiting additional BH providers to serve Members
- Contract new BH and substance use providers to **expand access to Colorado Crisis Services** for the mountainous and sparsely populated counties of Gilpin and Clear Creek

Our Health Neighborhood brings with it a commitment to the success of the next phase of the Accountable Care Collaborative Program, including key delivery system innovations that will bolster integration, such as the Hospital Transformation program, the Primary Care Alternative Payment Methodology, the Colorado Opportunity Project, and the Colorado State Innovative Model (SIM).

Community Partner Testimonial

The strong support and active participation of CCHA as an MHHA board and executive committee member has been instrumental to our success, and demonstrates one of the many ways in which they have formed important partnerships in the communities they serve. Together, MHHA members are building a strong cross-sector coalition focused on collaboratively solving the most urgent community-identified health challenges in our region for low-income residents: access to specialty care, high utilizers, and integrated care. These priority areas align closely with the role of the current RCCOs and future RAEs.
Dede de Percin, Executive Director, Mile High Health Alliance

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Provider Testimonial

The care and compassion that CCHA has towards Members is apparent on a daily basis, and the Member's best interest is always their primary focus. As a homecare company, we work with many patients who do not have access to this program and see firsthand the benefits this brings to the community.
Erica Wagner, Client Relations Director, Epic Health Services

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Defining Health Neighborhood

We borrow from the 2011 Agency for Healthcare Research and Quality (AHRQ) to define Health Neighborhood with the Member at the center: "To achieve healthy communities (and health equity for vulnerable populations), individuals and families must be a part of the health care delivery system." Further, "a well-functioning Health Neighborhood must intuitively support overall population health through a sharing of resources and infrastructure."

"The Health Neighborhood" has three essential functions:

- Provide high-quality, cost-effective clinical services through its providers: PCMPs, BH providers, specialists, hospitals, ERs, and other acute care facilities
- Address the social determinants of health that are needed to optimize Members' health and well-being by expanding and coordinating services provided by community-based organizations and through health advocacy and policies enabled at the local and state levels
- Wellness, prevention, and risk factor reduction formulated through alliances between local public health departments and clinical providers, such as PCMPs and BH providers."

At the core of this model is well-executed care coordination requiring ongoing communication, collaboration, and shared decision making among components of the Health Neighborhood and the Member. PCMPs alone cannot be assigned this large task. Instead, the larger community must support the medical community in improving health and engage in the work collaboratively. ***As a RAE, CCHA Plus will convene Health Neighborhood in the region to focus not only on 'sick care,' but also to address social needs, promote health and wellness, and improve overall population health.***

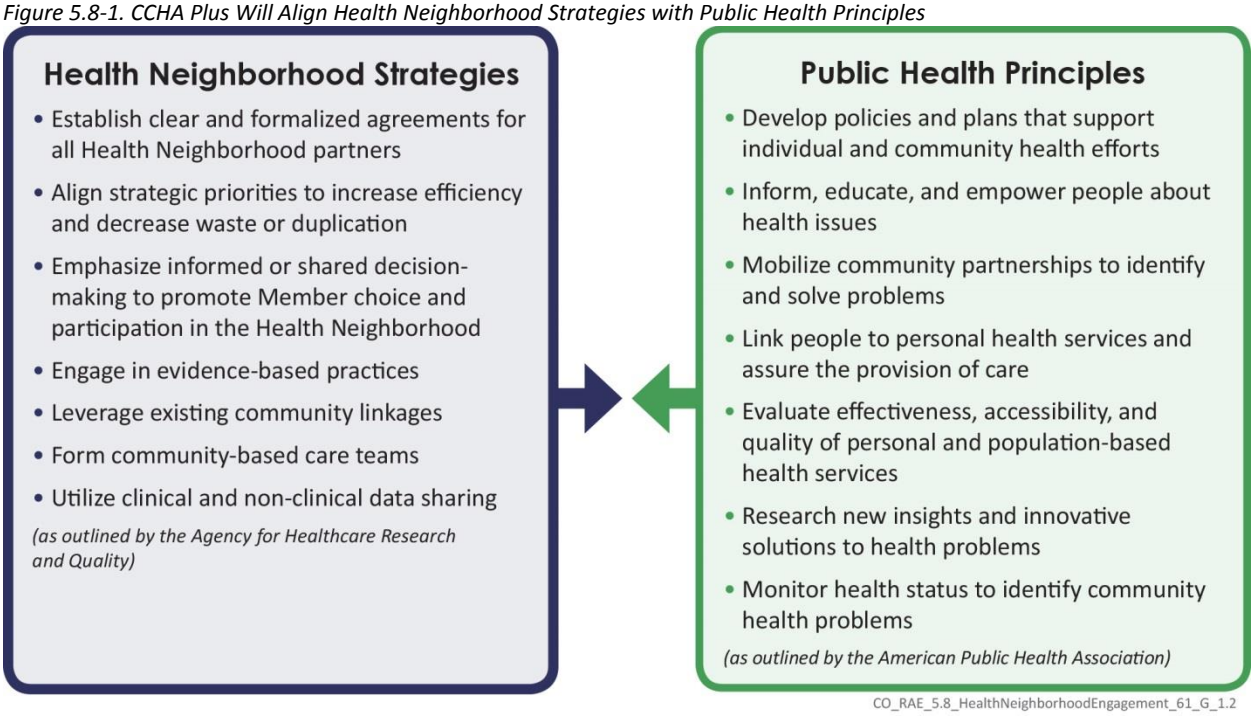
Partners in the Health Neighborhood will include specialty care, Long-Term Services and Supports (LTSS) providers, Managed Service Organizations and their networks of substance use disorder (SUD) providers, hospitals, pharmacists, dental, non-emergency medical transportation, community-based social services organizations, regional health alliances, public health agencies, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers.

As the RAE, we will bring commitment of primary care and BH providers, specialists, and hospitals in the region to participate in the Health Neighborhood, laying a strong foundation to bring additional providers such as pharmacists, home health workers, or personal aides who may see a Member more often than their PCMP. These providers can also play a role in engaging Members in their care and health promotion activities, as well as helping with adherence to the care plan.

Establishing Health Neighborhood Relationships and Partnerships

To facilitate successful engagement and utilization of the full range of Health Neighborhood providers, we adhere to proven engagement strategies as outlined by the Agency for Healthcare Research and Quality (AHRQ). ***We will engage in high-level strategic alignment among the Health Neighborhood partners with realistic, operational goals that are measurable and achievable*** as illustrated in Figure 5.8-1. To make sure we are truly supporting and promoting the health of Members and their communities, we will follow the Public Health Principles as outlined by the American Public Health Association. These strategies and principles guide our activities, programs, and partnership initiatives within the Health Neighborhood.

Figure 5.8-1. CCHA Plus Will Align Health Neighborhood Strategies with Public Health Principles

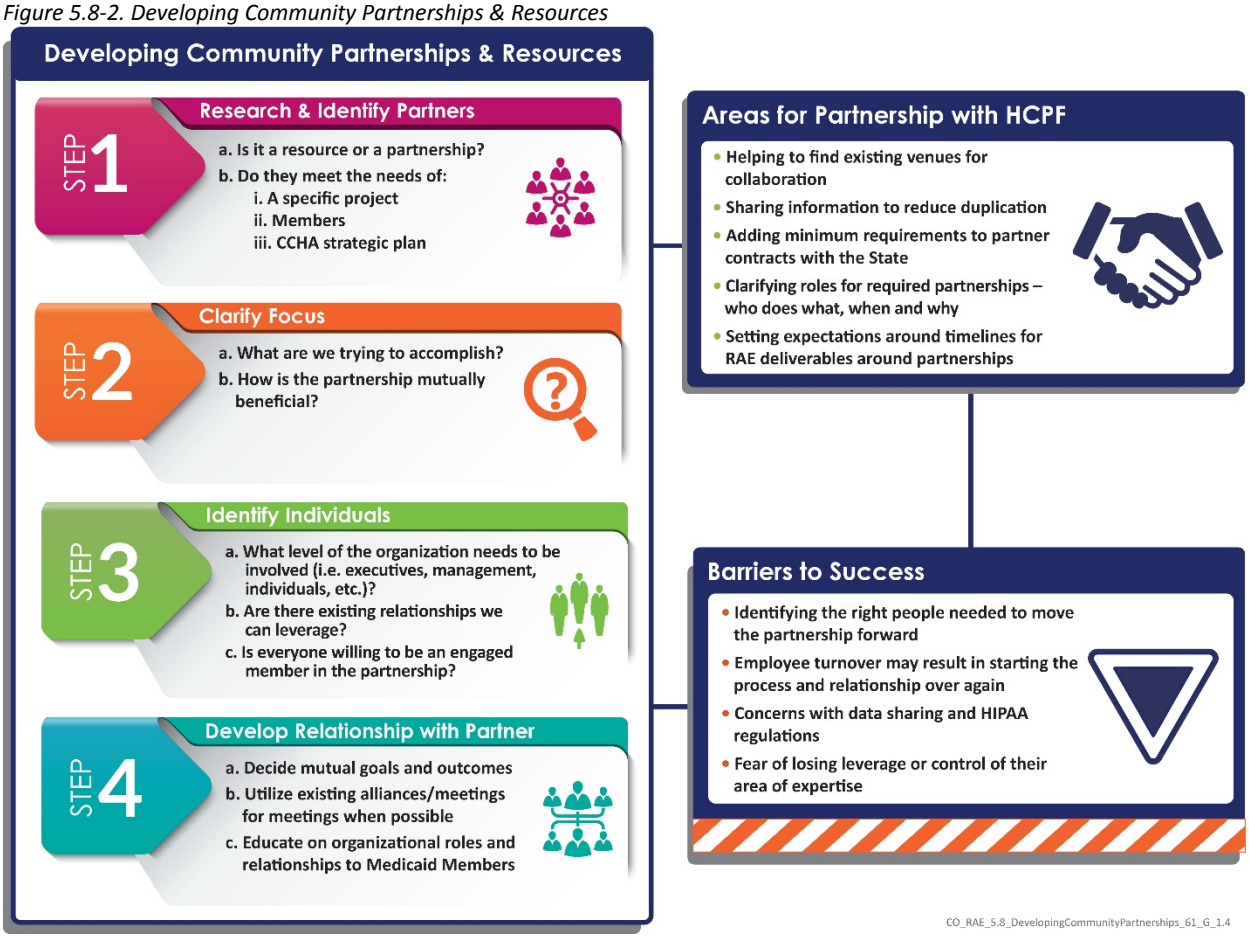


CCHA *Plus* Health Neighborhood and Community Engagement Program

The CCHA *Plus* **Health Neighborhood and Community Engagement** program will work to promote Members' physical and behavioral well-being by supporting a Health Neighborhood and Community consisting of a diverse network of health care providers and Community organizations providing social and other health needs within the region. As a RAE, CCHA *Plus* will bring primary care and BH providers, hospitals, and specialists to serve as the foundation for the region's Health Neighborhood. Our Health Neighborhood and Community Engagement team will work to strengthen relationships between Network Providers and Health Neighborhoods in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes. Our Community Liaisons will work to establish community resources and partnerships and then connect CCHA *Plus* Care Coordinators, Network Providers, and Safety Net Providers to these resources and partnerships as appropriate. We will work to avoid duplication of existing local and regional efforts and realize that leveraging the Health Neighborhood is a critical tool for controlling costs and using State resources wisely.

It is important to acknowledge the resources and time it takes to establish meaningful, functional partnerships. To establish a new partnership, engagement must occur at various levels of an organization (executive, manager, and staff level) and must be ongoing and mutually beneficial. There are hundreds of potential Health Neighborhood partners and thousands of resources available to Members. The following process in Figure 5.8-2 will be used for assessing, vetting, and providing guidance to determine which organizations we develop formal partnerships with and how to achieve meaningful partnerships.

Figure 5.8-2. Developing Community Partnerships & Resources



Local and Regional Health Alliances

Provider Testimonial

As a member of Prime Health's Safety Net Advisory Board, CCHA has contributed to defining the key needs of underserved communities and barriers to implementation that exist in the adoption of digital health technologies.
Steve Adams, CEO, Prime Health

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Whenever possible, we will seek to support existing collaborations with the potential to improve processes and avoid duplication of existing local and regional efforts. As a RCCO, CCHA currently collaborates with many local health alliances, some already established and thriving well before the ACC Program was implemented. These alliances provide an excellent opportunity to work with Health Neighborhood partners to align strategic priorities to increase efficiency and decrease waste or duplication.

Health alliances generally include representatives from major community providers, including PCMPs, specialists, BH providers, and hospitals, as well as county agencies and key community organizations. Alliances are usually focused on one or more health goals. ***As a RCCO, CCHA has experience working with many local and regional alliances in both urban and rural areas. As a RAE, CCHA Plus will continue to work with these Alliances and participate with many additional Alliances throughout the Region.*** Table 5.8-1 lists the local and regional alliances that CCHA currently participates in.

Table 5.8-1. Region 6 CCHA Health Alliance Participation

Alliance	CCHA Role/Focus
Mile High Health Alliance	CCHA sits on the Executive Committee and helps drive and support the Alliance's initiatives around specialty care access**, high utilizers, and access to care**, and the **SIM Regional Health Connector program.**
State Innovation Model (SIM)	CCHA sits on the Practice Transformation Workgroup for SIM to provide expertise in **best strategies and methods for working with primary care providers** and **implementing BH integration.**
Boulder County Community Health Improvement Collaborative (BCHIC)	The CCHA Chief Clinical Officer participates in this alliance, which is currently focused on **specialty care access issues**. Currently, BCHIC is working on recruiting specialists and developing a **secure electronic messaging system** to enhance communication between PCMPs and specialists.
Jefferson County Hotspotting Alliance	CCHA is one of the original founders and part of the executive leadership of this Alliance. For the past few years, the Alliance has run a successful **hotspotting program** for super utilizers in 2 hospitals in Region 6. In 2017, efforts will be expanded to focus on coordination of services for Members with complex care needs.
Longmont Community Health Network	This Alliance originally formed to support an **EMS home visiting program.** CCHA collaborated with the Alliance to coordinate services for Members receiving services from the program. Current efforts include working with Alliance members to improve transitions of care from the hospital and increase primary care utilization.
Broomfield Early Childhood Council Health and Wellness Group	The council seeks to develop a Broomfield County **integrated system of care** that promotes the health and well-being of young children, their families, and their providers. CCHA participates in monthly meetings to share resources, align efforts, and engage in strategic partnerships.
Jefferson County Aging Well Workgroups	The goal of these workgroups is to develop and implement strategies creating inclusive, livable communities through sustainable partnerships and integrated services. Each month, multiple workgroups meet to discuss **senior issues** in their topic areas. These workgroups are Basic Needs, Caregiving and Supportive Services, Health, Mental Health, Wellness and Prevention, Housing, Social and Civic Engagement, and Transportation (also known as the Local Coordinating Council for Human Services Transportation). The workgroups develop goals each year in the fall. They report out progress on the goals in the spring for an annual report that comes out the following fall. CCHA is an active participant in all of the workgroups.
Prime Health	CCHA serves on the **Safety Net Advisory Board** of Prime Health, a business ecosystem of administrators, providers, technologists, academics, entrepreneurs and investors dedicated to improving health care delivery through digital health innovations. Prime serves as a Digital Health Integrator, **accelerating the adoption and implementation of digital health technologies** that enhance access to care, improve clinical outcomes, and reduce costs.
Mile High Prevention Alliance	CCHA collaborates with the Alliance on the **Colorado Opportunity Project.** CCHA also provides financial support and participates in their specialty areas like Diabetes Management.
Boulder County No Wrong Door Task Force	The purpose of this group is to create **seamless access to LTSS** in Boulder County. Participants include CCHA, Adult Care Management, Imagine!, Boulder County Department of Housing and Human Services, Boulder County Area Agency on Aging, Aging and Disability Resource Center, and the Center for People with Disabilities. The group meets monthly and CCHA participates in these meetings and works closely with all above partners to serve the LTSS community.

Alliance	CCHA Role/Focus
B Healthy Broomfield Coalition	This group meets quarterly to support the **Broomfield Public Health Improvement Plan.** The 2017-2018 action plan goals include increasing community outreach and public awareness related to obesity prevention, improving nutrition and physical activity among Broomfield residents, enhancing worksite wellness programs in Broomfield, and enhancing health and human service clients' knowledge and awareness of wellness. CCHA participates in these meetings and assisted in the development of the 2017-2018 action plan.
JeffCo Head Start Health Services Committee	Jefferson County Head Start is a no-cost, comprehensive, child-focused, and family-centered preschool program for children ages 3-5. The Health Services Council advises the staff of Jefferson County Head Start on **health- and wellness-related topics and issues that impact children and families.** Additionally, the Council provides health information and resources for Jefferson County Head Start families. CCHA provides education for the Care Coordinators, attends monthly meetings, and advises on the strategic priorities of the committee.
Launch Together Steering Committee	The mission of Launch Together Jefferson County is to establish **community understanding of the benefits of early childhood social and emotional health** and develop a collaborative infrastructure that creates a lasting positive impact on the health of young children, their families, and the community. CCHA attends monthly meetings, is an identified partner in achieving community-based goals, and provides education to community partners on the role of the RCCO.
Home Visitation Workgroup	CCHA established the Jefferson County Home Visitation workgroup as part of their work on the Colorado Opportunity Project in Jefferson County. There are more than 20 agencies providing **home visits to pregnant women and families with young children.** Through this workgroup, CCHA is aligning the services to provide more effective and efficient service to families. The Home Visitation workgroup recently morphed into a Launch Together workgroup. The group additionally serves as the advisory council for Nurse Family Partnership, Parents as Teachers, and JeffCo HIPPY.
JeffCo Thrives	Jefferson County Public Health and Jefferson County Human Services support and communicate the work of agencies in the county on **social determinants of health.** CCHA participates in regular meetings, provides Care Coordination and partnership support to Members who fall within the special populations identified by this group, and works collaboratively with community partners that are engaged in JeffCo Thrives.
Jefferson County Public Health Prevention Workgroup	This workgroup supports the Jefferson County Health Improvement Plan in the area of **prevention.** CCHA participates in the workgroup and looks for new opportunities to connect Members with county prevention efforts.
Jefferson County Human Services Visioning	A group of community leaders was convened by Jefferson County Human Services as they envision their work into 2035. **County-specific data** will be gathered and analyzed, and scenario development revealing alternative paths for delivery of Human Services programs and client outcomes will be created. CCHA participated in several of these sessions (including the sessions focused on BH, homelessness, housing, and the final strategic sessions). CCHA connected with several community partners after the initial strategic planning and developed plans for better serving Members with housing initiatives (Metro West, Brother's Redevelopment) and mental health outreach (JCMH) in Jefferson County.
Mountain Resource Group	The Mountain Resource Group works to **improve the health, safety, and well-being of the mountain community** through collaboration, stewardship, and a shared commitment to providing coordinated care and support. CCHA

Alliance	CCHA Role/Focus
	has done several presentations to the group of community partners on the role of RCCO and providing support in the areas of Care Coordination and NEMT. CCHA external partnerships staff connects Members of the committee with CCHA Care Coordinators who work together to support shared Members.
Clear Creek Health Services Advisory Council	Support the work of the Clear Creek County Health Improvement Plan and assist Clear Creek County Public Health and Environment Department in addressing the health concerns of the county, including **poverty, housing, access to health care, employment, food, and transportation.** CCHA has participated in this group for the past 2 years and aligns strategic priorities with the work of the group.
Colorado Department of Public Health and Environment Tobacco Cessation Workgroup	The goal of this workgroup is to increase access to resources for **tobacco cessation**. CCHA attends this meeting regularly and has aligned its work with the Colorado Opportunity Project focus on pregnant women in Jefferson County. JeffCo Public Health has identified decreasing tobacco usage as one of the priority areas among pregnant women and new mothers. CCHA has engaged with this workgroup strategically and has connected state partners to local initiatives in Jefferson County.
Jefferson County Public Health Perinatal Tobacco Cessation	Work with Jefferson County providers and organizations to **decrease tobacco use during pregnancy** and the perinatal period. For CCHA, this work overlaps with the focus on the family formation state of the Colorado Opportunity Project. CCHA attends this quarterly meeting and provides guidance on strategic initiatives and helps connect community partners.
Department of Health Care Policy and Financing (HCPF) NEMT Workgroup	Discuss and problem-solve issues affecting Colorado Medicaid Members as they attempt to **access non-emergent medical transportation.** CCHA participates in this workgroup to discuss and find creative solutions to the NEMT issues of today. As a RAE, CCHA *Plus* looks forward to participating in the workgroup and partnering with the Department as it continues exploration of innovative new approaches to the NEMT benefit.
Clear Creek County Regional Health Connector (RHC) Council	CCHA works together with the Regional Health Connector in Clear Creek, Gilpin, and Park counties to **align efforts.** Since this group's inception, CCHA has participated and attended regular monthly meetings. CCHA provided RCCO Member demographic and utilization data to drive strategic priorities and will assist with the implementation phase.
Golden CO Health Collaborative	This collaborative group is designed to identify health related issues (such as **BMI, mental health, diabetes**) and to support healthy activities in Golden, Colorado. In coordination with several community partners, CCHA provides input and advice on the strategic initiatives and programs facilitated by the collaborative. CCHA aligns on programs specifically targeted to Medicaid Members in Golden.
Navigation Committee	Jefferson County resources collaborate to **better serve community Members.** CCHA Care Coordination employees attend monthly calls to discuss and coordinate care for shared Members, particularly those with complex needs.
Colorado Opportunity Project Steering Committee	CCHA Executive Director and Opportunity Liaison attend this meeting regularly to continue the partnership with the Department in **implementing the Colorado Opportunity Project** in the region.

CCHA *Plus* Program Improvement (Health Neighborhood) Advisory Committee

CCHA *Plus* will establish a local Program Improvement (Health Neighborhood) Advisory Committee with the explicit purpose of convening a diverse, multidisciplinary system of health care providers, community organizations, and other service providers that support Members in the region. The Health Neighborhood Advisory Committee will include representation from:

- Network Providers, including PCMPs and BH providers
- Federally Qualified Health Centers
- Corrections System
- Local Public Health Agencies (LPHA)
- Community Mental Health Centers
- Single-Entry Points
- Community Center Boards
- Substance use providers
- Dental Aid
- Pharmacists
- Area Agency on Aging
- Aging and Disability Resources for Colorado
- Non-emergency Medical Transportation
- Managed Services Organizations

State Auditor Testimonial

In addition, CCHA considers input from its Health Neighborhood Advisory Committee and participation in county health alliances and community boards of directors to evaluate opportunities with community partners.
Health Services Advisory Group Auditor for the Department

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The mission of the committee is to engage the community to strengthen and grow the Health Neighborhood, as well as effectively leverage the Health Neighborhood, to improve health and life outcomes for Members while controlling costs and utilizing State resources wisely. The Committee provides a forum for:

- Encouraging active Health Neighborhood involvement in the CCHA *Plus* ACC region
- **Determining how best to invest CCHA *Plus* incentive funds to support and strengthen the Health Neighborhood**
- Leveraging existing efforts of partners to strengthen the Health Neighborhood
- Establishing effective two-way communication with members of the Health Neighborhood and CCHA *Plus*
- Creating a Health Neighborhood leadership network within the region

Collaborating with Neighboring RAEs

The RAE will play a vital role in assuring access and continuity of care for Members when they move or seek care in another RAE region. We understand that Members may be connected with the services of Health Neighborhood providers, such as CMHCs and LTSS providers, that may be geographically located in other regions. ***CCHA Plus will work with other RAEs to develop standard policies and procedures that provide clear processes for RAEs to support one another in leveraging each other's Health Neighborhoods.***

As a RCCO, CCHA has demonstrated a commitment to the Health Neighborhood and their role in preserving continuity of care. For example, CCHA collaborated closely with a neighboring RCCO to support Members attributed to CCHA that seek care or services in Denver, which sits just outside Jefferson County.

As a RAE, CCHA *Plus* will look forward to a collegial and collaborative relationship with fellow RAEs that will enable us to work closely together on behalf of Members and share best practices for building up our respective Health Neighborhoods and Communities.

Improving Referral Processes and Access to Specialists

CCHA *Plus* has what it takes to be a leader in expanding access to specialty care. Managing partner Centura Health provides access to specialists. As a RCCO, CCHA has engaged in efforts to improve PCMP and specialty care communication as well as Member and provider experience of accessing specialty care. The Department's independent auditor specifically recognized CCHA for their work in expanding access to specialty care.

"CCHA staff members are innovative yet realistic regarding mechanisms to improve access to specialists. CCHA demonstrated that it had excellent medical director leadership that offered insight into the subspecialist environment and ability to engage specialists in physician-to-physician communications."

As a RAE, CCHA *Plus* will bring a distinct advantage in connecting Members to specialty care. With Centura Health as a managing partner, we will have access to approximately 187 Centura Health-owned specialty providers in Region 6. Anthem brings a new and expanded network for mental health and substance use providers to serve Members. Additionally, we will bring innovative approaches, like our **ECHO®** and our **Specialty Care Access program**, as well as new technologies like **LiveHealth Online** and **Partnership AccessLine (PAL).** We will also collaborate with **local health Alliances** seeking to increase access to specialty care services to make the best use of resources and avoid duplication of efforts.

Understanding Specialty Care Needs

As a RCCO, CCHA has seen that BH care, including mental health and substance use services, have been the specialty care providers in highest demand. Other specialty care services CCHA regularly works to connect Members with are optometry and ophthalmology; neurology; dental; audiology and Ear, Nose, and Throat (ENT); cardiology; and Occupational and Physical therapies (OT/PT). Less frequently, but just as important, Members have needed access to home health care, rheumatology, hematology, gastroenterology, endocrinology, pulmonology, dermatology, and podiatry specialties. For pediatric Members, the most common referrals are for Occupational, Physical, and Speech therapies (OT/PT/ST), as well as Applied Behavioral Analysis (ABA) therapy.

As the next phase of the ACC gets underway, CCHA *Plus* will first make sure we understand the specialty care needs in the region by conducting a comprehensive survey of Network Providers, Health Neighborhood, and the Community. We will consult Network Providers and the Program Improvement (Health Neighborhood) Advisory Committee. We will also speak with our local Member Advisory Committee participants to understand the needs and frustrations from a Member perspective. We will work with local Care Coordinators internally and externally to understand the barriers they encounter, and use GeoAccess to determine time and distances to specialty care in the region. This work will drive our efforts within the region to increase access to specialty care services.

For example, one of the most requested types of specialty care will likely be BH services. Thanks to our partnership with Anthem, CCHA *Plus* Care Coordinators will be directly connected to BH providers and can develop processes to refer Members to services and ensure they are connected to the care they need.

In Region 6, one of the most common physical health (PH) specialty care needs is cardiology. As a RCCO, CCHA established the Specialty Care Access program and is partnering with a Centura Health specialty

care group, Colorado Heart and Vascular, to gain access to needed specialty care and improve the Member and Provider experience through establishing best practices for PCMP-specialty care provider communication. As a RAE, CCHA *Plus* will have access to Centura Health specialists in the region and can expand the Specialty Care Access program to include additional Network Providers and specialty providers.

Facilitating Communication

Promoting the use of the Colorado Medical Society's Primary Care-Specialty Care Compact

Specialty care access challenges may be mitigated by promoting the utilization of the Colorado Medical Society's Primary Care-Specialty Care Compact. The Compact creates an expectation that PCMPs and specialists will mutually understand that a referral is for advice only, for transfer of care to the specialist, or for co-management, and codifies the roles of both parties.

As a RCCO, CCHA implemented this compact in Region 6 during the first phase of the ACC Program, and 226 compacts have been executed with Tier 1 specialty providers. This is an example of executing formalized agreements with medical providers that outline how, as a RAE, CCHA *Plus* will work collaboratively on behalf of Members. We will use the Program Improvement (Health Neighborhood) Advisory Committee, which includes PCMPs and specialists, to adapt and pilot the tools in practices and provide program specific education to primary care practices.

Promoting the use of the Department-adopted Electronic Consultation Software

We will also promote the use of the Department-adopted electronic consultation (eConsult) software through which specialists may receive reimbursement for timely review of clinical information and providing Member-specific recommendations of how a PCMP may manage a condition and whether a specialty visit is required. This type of system has been shown to reduce the need for specialty visits to some of the primarily cognitive-based specialty areas like Endocrinology. CCHA is currently working with the Mile High Health Alliance to determine how they might support improvements in the eConsult system, including providing financial support and the expertise of alliance members who are PCMP and specialty care physicians.

Expanding Project ECHO® and Other Telemedicine Solutions

CCHA *Plus* brings new telemedicine capabilities to improve the timeliness of Members' care, supporting them in primary care as well as home-based settings by offering direct interaction with PH and BH professionals. We will expand education and awareness among our Members and Network Providers to maximize the opportunities presented by telemedicine, and improve access to care and Care Coordination. We will continue to build strong partnerships with local service agencies and stakeholders to link Members to community resources and coordinate care across systems.

As a RAE, we bring the following telemedicine opportunities:

- We will encourage Network Providers to participate in the **ECHO® Colorado program,** which enables PCMPs to manage problems that might otherwise need to be referred to specialists. We will partner with the Department and the University of Colorado Anschutz Medical Campus to offer additional ECHO® opportunities, like the Chronic Pain Disease Management ECHO® program. We will also bring new opportunities for providers to engage in programming with the University of Washington (UW) and their **Innovative Psychiatry and Addictions Case Consultation (PACC) Project ECHO®.** This offers remote case review with clinical

case management for PCMPs who care for Members experiencing addictions, chronic conditions, and other concerns.

- We can offer the **Partnership AccessLine (PAL),** which is similar to the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program offered in some Colorado communities and provides a telephone-based children's mental health consultation system for PCMPs.
- We would like to expand access to the **Denver Health telephonic counseling program,** a telephonic counseling program for Members with depression or anxiety who are being treated in the primary care setting. We will seek to expand the types of therapies that Members can choose from and leverage the program to improve symptoms of depression and reducing all-cause hospitalizations.
- We can partner with **FasPsych** to offer remote telepsychiatry consultations from provider offices as an alternative to staffing BH clinicians in remote locations.
- We can offer our **LiveHealth Online** program, which provides 24/7 on-demand access through video-enabled computer, tablet, or smart phone, for a live audio and video consultation with a licensed, board-certified physician. The physician can diagnose, make medical recommendations, and prescribe medications for clinical conditions such as a cough, cold, fever, or flu.
- We will also facilitate training with PCMPs to improve their ability to manage dermatology, allergy, women's health, and common musculoskeletal issues through participation in our **Practice Support program.** The program leverages different types of technologies like educational webinars and interactive learning collaboratives to help Network Providers practice at the top of their licensure.

Sharing Data

We know that sharing claims data with PCMPs will help them in evaluating the need for the reduction or increase in specialty referrals. Pharmacy claims data can identify medication adherence problems as the reason for poor disease control. PCMPs may be able to address this problem first before considering referral to a specialist for advice in medication management. On the other hand, sharing data with PCMPs regarding Members who are high utilizers of hospital or ER services may identify those who are in need of referrals to help address these utilization problems. As a RAE, CCHA *Plus* will bring sophisticated data and analytics tools to help Network Providers make claims data actionable to help them in all areas of their practice including evaluating specialty care referral needs. See OR 17 for more information on these tools such as the Provider Performance Dashboard.

Addressing Barriers

Specialty Care Access Program

As a RAE, CCHA *Plus* will use Centura Health specialists in the region to expand our Specialty Care Access program to increase access to specialty care and improve the Member and provider experience. The program leverages Centura Health specialists and seeks to establish best practices around referral processes and the exchange of clinical information to improve PCMP and specialist communication. The program fosters proactive communication between providers of all necessary patient information including the reason for the referral request and relevant clinical information. This enables specialists to request additional information as necessary. Our Care

As a RAE, CCHA Plus will bring the Specialty Access Program to the Region to implement best practices around PCMP and specialist communication, reducing inappropriate or incomplete referrals and no-show appointments and improving the Member and provider experience. The Program is the perfect platform to roll out the Department's electronic consultation (eConsult) program. eConsult will take the Specialty Care Access Program to the next level by using shared technology to enable collaborative care coordination and planning between the PCMPs and specialists across diverse care settings. We are excited to collaborate with the Department to add eConsult to the Program. We believe that, over time, the Specialty Care Access Program, bolstered by eConsult, will improve physician satisfaction and support our efforts to recruit new specialty care providers to serve Members.

Innovative & Collaborative

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Coordinators will participate in the program to identify and resolve Care Coordination needs, including appointment adherence barriers, by arranging transportation and attending the appointment with the Member as needed. See Table 5.8-2 below for more details.

Table 5.8-2. Specialty Care Access Program

Overarching Goal of the Specialty Care Access Program	
•Increase access to specialty care for Members	
Specific Goals of the Specialty Care Access Program	
•Increase PCMP access to specialty care providers for their Colorado Medicaid Members •Create a uniform process for communication regarding Members •Reduce no-shows for specialty care appointments •Make sure specialists receive all required information •Reduce unnecessary specialty care referrals	
Program Components	
Referral Workflow	Similar to the Colorado Medical Society's Primary Care-Specialty Care Compact, this includes a standard referral form with required patient information for PCMPs to provide to the specialist; establishes direct provider communication to reduce unnecessary referrals
Connect PCMPs to Specialists	Connect select PCMP practices with participants in specialty care fields of high need within our region, with initial focus on: •Orthopedic surgery •Cardiology
Coordinate Patient Services Between PCMPs and Specialists	Provide coordination of services for Members, including transportation and translation services, to assure appropriate engagement with specialty care providers, addressing no-show appointments with Members and follow-up with the PCMP
Measure Success	Track program success through: •Number of completed referrals •PCMP and specialty care practice experience and satisfaction with the referral system •Patient experience and outcomes

Collaboration with Boulder Community Health Improvement Collaborative (BCHIC)

In Region 6, CCHA *Plus* will collaborate with BCHIC on a community-based model to expand specialist availability. As a RCCO, CCHA has participated in BCHIC and provided financial support to the collaborative. BCHIC participants include hospitals, specialists, community groups, and key providers like Clinica Family Health, Salud Family Health Centers, and Mental Health Partners. With support from local PCMPs and health organizations, BCHIC is approaching specialists to accept a limited number of new Medicaid referrals each month. BCHIC is also developing a secure electronic communication platform to track the number of referrals made to each specialist and the remaining number of open slots. This platform also facilitates bi-directional messaging between PCMPs and specialists. CCHA *Plus* will work with BCHIC and other alliances in the region to align specialty care efforts and avoid duplication with the Department's electronic consultation tool.

Collaboration with the Mile High Health Alliance

The Mile High Health Alliance brings together stakeholders from medical care, BH care, public health, and social and community services, to collaboratively address Denver's most difficult health challenges and achieve better health for all residents. CCHA sits on the Executive Committee and helps to drive and support the Alliance's work around specialty care access. Currently, CCHA is collaborating with the alliance to determine how CCHA might provide support to strengthen and expand the Department's eConsult program with the health information exchange. We know that some Members in Region 6 will seek care in Denver. Bringing CCHA's existing strong partnership with the Mile High Health Alliance gives us a distinct advantage in connecting Members to care and engaging in innovative efforts with Health Neighborhood partners to increase access to specialty care.

Community Partner Testimonial

The strong support and active participation of CCHA as an MHHA board and executive committee member has been instrumental to our success, and demonstrates one of the many ways in which they have formed important partnerships in the communities they serve.
Dede de Percin, Executive Director, Mile High Health Alliance

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Promoting Colorado Crisis Services to Providers and Members

CCHA *Plus* understands the importance of the Colorado Crisis Services system in ensuring Members receive timely access to BH interventions during a crisis. As a RAE, we will leverage CCHA's experience in working with Colorado Crisis System providers to integrate the system into our BH solution for Members, including established arrangements to ensure Members using the system receive timely follow up follow-up care. For more information on our BH solution, please see OR 18. We will also work with Network Providers, the Health Neighborhood, and Community partners to spread the word about the system and print free materials for all partners to use to promote the system with Members.

As a RCCO, CCHA has long established partnerships with the Region 6 CMHCs: Jefferson Center for Mental Health and Mental Health Partners that serve as crisis system providers. These partnerships include established arrangements with the CMHCs to coordinate follow-up care for Members accessing the crisis system. CCHA has faced significant challenges helping Members in Clear Creek and Gilpin counties access these services. As a RAE, CCHA *Plus* will work to expand the BH options available to our Members by building a stronger independent provider Network that can render services in addition to the 2 CMHCs in the region.

Coordination with MSOs for Access to Substance Use Disorder Treatment

As a RAE, CCHA *Plus* will bring significant experience coordinating with Colorado's Managed Service Organizations (MSOs), including Signal Behavioral Health Network and Mental Health Partners, to connect Members to specialized substance use disorder (SUD) treatment services not covered under the Colorado Medicaid benefit. We will help Members access multiple levels of care, including intensive outpatient treatment and inpatient programs as clinically indicated. We will bring our experience working with CMHCs like Mental Health Partners, to connect with local providers, including Sobriety House, Providence Network, and Mental Health Partners Addiction Recovery Center to engage in coordinated care for Members.

As a RAE, we will bring experience coordinating with MSOs, and we look forward continuing and expanding our partnership in Phase II of the ACC Program.

Coordination with Hospitals to Improve Care Transitions and Person-Centered Planning

We understand very well that hospitals are an essential part of the health care delivery system. As a RAE, CCHA *Plus* will bring the commitment of Centura Health to participate in the region's Health Neighborhood and work to leverage existing and extensive relationships with local public health agencies, the Health Neighborhood, and Community partners to improve the integration of hospitals into the ACC Program and support the Department's efforts to implement the Hospital Transformation program**. *CCHA Plus will also bring the commitment of Health Neighborhood partners like hospitals, specialists and BH providers, that are needed to expand access to much needed specialty care services, reduce unnecessary ER utilization, address super utilizers, improve care transitions, and engage in community efforts to promote the health and well-being of Members.***

We will continue to work closely with the Centura Health hospitals in Region 6: St. Anthony, St. Anthony North, Avista Adventist, and Longmont United. We will co-locate CCHA *Plus* Care Coordinators in the hospitals to reduce unnecessary ER utilization and coordinate with hospital Care Coordinators and discharge planners to improve transitions of care for Members. We will also continue our work with the other 28 hospitals located both inside and outside of our geographic boundary that serve Region 6 Members. As a RAE, we will seek to place more Care Coordinators in hospital settings and continue our work with key providers like MCPN, Clinica, Jefferson Center for Mental Health, and Mental Health Partners, as well as the independent primary care providers, specialists, and LTSS partners to engage in Team-based Care and further integrate all hospitals into the delivery system. Several of CCHA's existing integration programs with these providers can lay the foundation for implementing the Hospital Transformation program in Region 6.

Partnership with Children's Hospital Colorado (CHCO)

As a RAE, CCHA *Plus* will enter into a partnership with Children's Hospital Colorado (CHCO) to leverage their experience and expertise with serving children with complex and special needs, promoting the overall health and prevention services for the pediatric population, and increase efforts to integrate CHCO into the ACC Program. We have identified several opportunities to collaborate in the region:

- Work with Network Providers to **coordinate care for children treated at CHCO** to connect them and their family with follow-up PH and BH care and community supports. This partnership will involve expanded data sharing, collaboration on quality improvement, and joint efforts between the hospital and Network Providers aimed at reducing avoidable hospitalizations through intensive, upstream interventions.
- Work with CHCO's **School Nurse program** to expand access to care for Medicaid Members at schools in the region. The program provides

Helping a Member transition home to live her best life, her way

After a leg amputation below the knee due to vascular disease, Sandra needed help with all the changes in her life. Sherry, our Care Coordinator, knowing that navigating the system of services and supports can be confusing, listened to her concerns; created a person-centered care plan; helped her transition home from a skilled nursing facility with a personal care attendant; and coordinated PT, OT, skilled nursing visits, home health physician visits, and a prosthetist. She also arranged for a home modification grant and labor from Habitat for Humanity to make her home wheelchair accessible.

But while they were talking, Sandra became tearful and shared that she was struggling with all the physical and emotional changes. She said she wanted to regain her confidence and independence and that her personal goal was to go outside and care for her African Violets in her greenhouse – which she hadn't been able to do for a year.

So Sherry connected her with behavioral health support, and four weeks later, ***Sandra reported that the home modifications had been made; her mood was 100% improved; and she was sitting in her greenhouse as Sherry spoke to her, planting African Violets.***

Anthem **Member Centered**

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consultation, referral information, and training to staff to help children with complex health needs, including intellectual and/or developmental disabilities, to transition into the school and community environment.

- Use CHCO's Pediatric Oral Health Care program to **integrate dental care in primary care clinics** using CHCO's dental hygienists to establish dental programs within the clinics.
- Explore opportunities to leverage **CHCO's community relationships** and **extensive experience in promoting child health and well-being** throughout the state, including work to address Colorado's 10 Winnable Battles. The work of CHCO's Child Health Advocacy Institute, focused on building and operating evidence-based programs to create thriving communities for children, will help guide aligned or joint approaches with community partners.
- Partner together to ensure alignment of metrics and outcomes between the ACC Program and the **Hospital Transformation program,** and explore opportunities to leverage our respective Health Neighborhood and Community projects to inform and coordinate with the program.
- CHCO will serve on our Program Improvement (Health Neighborhood) Advisory Committee to make specific recommendations on how to promote the health and well-being of the pediatric population, and **where to best invest CCHA *Plus* incentive payments in the Community to support the pediatric population.**
- Collaborate with CHCO's **Pediatric Mental Health Institute,** which is in the midst of standing up a Center of Excellence for children's behavioral health, and will serve as a resource for Network Providers and other community partners. The Institute is also led by experts with expansive experience building wraparound programs for children in multiple states.

Care Coordinators in Hospitals

CCHA *Plus* will co-locate (or place) Care Coordinator nurses in hospital ERs and inpatient facilities to **reduce readmission rates** and **inappropriate ER utilization**, **connect Members to a Medical Home, assist with care transitions** and **address complex Member needs.** Populations of focus will include pregnant women and Members with complex needs, with a special emphasis on connecting Members with community-based BH services as appropriate. CCHA *Plus* Care Coordinators will be integrated into hospital teams to increase postpartum follow-up visits, connect mothers with needed BH services, and educate hospital discharge planners on processes to support all Members. For LTSS Members, our goal is to collaborate with the hospital to discharge the Member into the least restrictive setting possible, with appropriate supports like home health care. We will also help the hospital with navigation and helping our Members access community-based resources.

Member Discharge Needs Assessments

CCHA *Plus* will work with hospitals to complete a Member discharge needs assessment shortly after admission. It will evaluate the Member's needs and resources that will enable him or her to function at home, as well as BH factors (such as medication non-adherence, cigarette smoking, drug and alcohol use, and depression) that may have contributed to the need for admission, and it will stratify Members' risk for readmission. We will work with the hospital to address the identified needs at discharge and in the immediate post-discharge period for Members at high-risk of readmission to receive interventions appropriate to their risk level.

Admission, Discharge, and Transfer (ADT) Feed

We appreciate the Department's efforts to establish access to the health information exchange ADT feed. The feed needs analytics support and an electronic Care Coordination tool to complement it and make the data actionable for Care Coordinators. CCHA *Plus* will use the methodology that CCHA developed as a RCCO to make the best use of the ADT data. CCHA integrates the daily ADT data into

their database, which enables them to compare this data to a Member's ER history. The methodology fills in gaps where data was missing and isolates hospital events so CCHA can understand the reason for the ER visit. This ADT methodology has given new, actionable information to CCHA Care Coordinators to work with Members on ER utilization and has resulted in a reduction in ER utilization that helped CCHA as a RCCO hit Level 2 of the ER KPI.

The CCHA *Plus* electronic Care Coordination tool will establish specific tasks to enable our Care Coordinators to acknowledge and act on ADT information to follow up with Members. Network Providers, including Safety Net Providers such as MCPN, Clinica, Denver Health, and Kaiser, will also continue to receive the daily ADT feed with the methodology CCHA created to make the data actionable for providers. Our Provider Support program will work with Network Providers to incorporate the ADT data and action steps into their workflow.

Centura Health Urgency Centers

Centura Health has implemented 7 urgency centers across Denver and the Mountain region. Members seeking emergency care are triaged to the appropriate level of care, avoiding unnecessary and expensive ER visits. While Members have the opportunity to receive ER care at the Center, ***more than 70% of Members visiting these centers receive urgent care rather than ER care, resulting in significant savings for both the Member and the State.*** CCHA *Plus* will promote these urgency centers with Members to encourage them to receive urgent, after hours care at the centers rather than visit an ER.

Access to the Centura Health Electronic Health Record, EPIC

CCHA *Plus* Care Coordinators co-located in hospitals will have access to Centura Health's electronic health record, EPIC, to see the health history of Members who have visited the hospital and identify needs or gaps in care. This is a big advantage in Care Coordination efforts because currently most hospitals do not make their EHR available to RCCOs. In fact, most hospitals currently cannot determine which RCCO a Member is enrolled in. As a RAE, access to the EPIC system will make our co-location efforts in Centura Health hospitals much more powerful than that of other hospitals that remain reluctant to allow access to their EHRs. Our Care Coordinators will be able to see when Members are in the hospital, understand their health history and needs, connect with the hospital Care Coordinator, and visit the Member in the ER waiting room or their hospital room.

Jefferson County Hotspotting Alliance

As a RCCO, CCHA was a founding member of the Jefferson County Hotspotting Alliance in 2014. The Alliance was formed by local health care leaders to foster a coordinated approach to local health care issues in Jefferson County. The Alliance's members include thought leaders in health care who currently serve Members in the Jefferson County area. This includes Metro Community Provider Network, Jefferson Center for Mental Health, Jefferson County Department of Public Health, Arapahoe House, and St. Anthony and Lutheran Hospitals. The Alliance explores innovative concepts to address community inefficiencies in health care delivery. In recent years, the Alliance has worked together to reduce ER utilization and connect Members with PH and BH services in the right place and at the right time. Alliance providers have developed referral processes and feedback loops to connect Members to physical, mental and substance use services in the community. Currently, MCPN, Jefferson Center for Mental Health, and CCHA Care Coordinators are working together in a colocation program at St.

In selecting CCHA Plus as a RAE, the Department acquires a high-performing RCCO with strong county and community partnerships, along with the largest hospital system in the state, to sit at the table and design a Hospital Transformation Program. In fact, Centura already has many partnerships with providers and the community that may be selected as integration projects for the Hospital Transformation Program.

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Anthony hospital where they have established a team-based approach in working with Members to reduce inappropriate hospital utilization and improve the overall health of Members, reducing the need for hospital care.

As a RAE, CCHA *Plus* will continue to work with the Alliance and expand the Alliance to include additional Health Neighborhood and Community partners that can address Members' medical and non-medical needs and reduce the need for hospital services. CCHA *Plus* has the distinct advantage of bringing the commitment of the largest hospital system in the state to work together with the Department, Network Providers, Health Neighborhood, and Community partners to reduce unnecessary hospital utilization and coordinate care for Members through the continuum of care.

Hospital Transformation Program

We are excited about the opportunity the Hospital Transformation program offers to connect hospitals to Network Providers, the Health Neighborhood and Community and align hospital incentives with the goals of the ACC Program. CCHA *Plus* will work with all hospitals in the region to help determine priorities for the program, and select projects, interventions, and performance goals.

As the RCCO in Region 6, CCHA has convened Network Providers, the Health Neighborhood, and Community partners to help hospitals determine priorities and select projects, interventions, and performance goals. CCHA worked with the Boulder County Public Health Department to convene members of the Boulder community to discuss the program with Department leadership, local hospitals, and Safety Net Providers. Through the Jefferson County Hotspotting Alliance, CCHA convened the Jefferson County community to discuss the Hospital Transformation program opportunity with Department leadership. In all of the discussions with partners, CCHA has strongly advocated for the Hospital Transformation program and has identified existing integration projects that can help lay the foundation for the Hospital Transformation program in the region.

Aligning Hospital and Public Health Community Needs Assessments

We know that aligning Community Needs Assessments between hospitals and Local Public Health Agencies (LPHAs) is an important starting point for the Hospital Transformation program. Similar to the LPHA Health Needs Assessment (HNA), each of the 22 Centura Health hospitals in the state are also required to do their own Community Health Needs Assessment (CHNA) to help determine how they can serve the Community. Hospital CHNAs can easily duplicate the LPHA HNA and result in duplicative services in the Community. To prevent this, CCHA *Plus* managing partner Centura Health recently aligned all of their hospital CHNAs with the LPHA HNA in each of their service areas. Centura Health even changed the frequency of their CHNA process from every 5 years to 3 years to align with the LPHA.

Member Testimonial

The CCHA Care Coordinator team has helped my father by advocating for his medical needs, assisting our family with locating a skilled nursing facility for respite care, setting up a meal delivery service, and collaborating with all of the agencies involved in our family's life. Our Care Coordinator has also assisted us with various community resources.
Marty

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The Centura Health CHNA and the LPHA HNA are now developed collaboratively in each Community to see that they align and complement each other, as well as include opportunities for partnership.

As a RAE, CCHA *Plus* brings commitment from Centura Health to continue to align community needs assessment work and can rely on the RAE to use this as a starting point to implementing the Hospital Transformation program in the region. This work, along with all the integration projects that stem from the assessments, is a terrific and important step towards greater integration of hospitals into the ACC Program delivery system, Health Neighborhood, and Community.

Collaborating with LTSS Community-Based Providers: No Wrong Door Entities, Area Agencies on Aging, and Disability Resources for Colorado

We fully understand the need to improve coordination of long-term services and supports, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado. Our Care Coordinators and agency case managers must work as a team to develop holistic approaches to help Members achieve their health and wellness goals.

As a RCCO, CCHA currently has formal agreements with several No Wrong Door entities, including Single Entry Points (SEPs), Community Centered Boards (CCBs), home health agencies, hospice providers, and skilled nursing facilities (SNFs), to facilitate collaborative clinical Care Coordination and Member information sharing. These partnerships have enabled CCHA to exchange data to identify gaps in care, and CCHA Care Coordinators and case managers are able to share Member information and hold case conferences to serve Members.

Additionally, CCHA is currently partnering on the Accountable Health Community grant awarded in Denver to serve Members receiving Medicare and Medicaid services.

CCHA *Plus* supports the No Wrong Door project as an excellent opportunity to improve communication among LTSS entities, see that Members receive timely and consistent information, and create a common entry point for them. CCHA has expanded their partnerships with the Area Agencies on Aging (AAA) and the Developmental Disabilities Resource Center (DDRC) as part of our work on the No Wrong Door initiatives. They collaborate with Jefferson County Department of Human Services, Jefferson County Options for Long-Term Care, DDRC, Jefferson Center for Mental Health, Denver Regional Council of Governments (DRCOG), and Seniors' Resource Center to seek ways to improve coordination and collaboration on behalf of Members.

CCHA is currently an active participant in the Boulder No Wrong Door Task Force. Its mission is facilitating seamless access to LTSS in Boulder County by streamlining referral processes, educating those making the referrals, and staying mindful of changing landscapes. Planning must be done in a way that is sustainable and efficiently uses resources.

CCHA has also found benefit in participating in alliances, resource fairs, and workgroups to educate partners on the ACC Program and CCHA services, build trust in the community, and align efforts with existing community efforts. CCHA has participated in the following LTSS activities:

- **Jefferson County Aging Well Workgroups**
- **Medicaid Senior, Community, Organizations, Resources, and Education (SCORE) meetings**
- **Test Experiences and Functional Tools (TEFT) grant**
- **Eaton Senior Community Resource Fair**
- **Highlands West Community Resource Fair**
- **DDRC Resource Fair**
- **Imagine! Provider Resource Fair**
- **Aging Well Summit**

Community Partner Testimonial

CCHA and our Aging and Adult Services have a robust collaboration. Their care coordinators and our case managers conduct joint home visits with identified members, which is a great benefit to those who need resources and supports beyond the scope of our Single Entry Point (SEP). We have conducted joint trainings and meet and greets with both of our full staffs, in order to build more collaboration. We have developed and diagramed effective processes so that we can streamline the referrals between our agencies.
Lynn Johnson, Executive Director, Jefferson County Human Services

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As a RAE, CCHA *Plus* will bring vast experience delivering integrated PH and BH services that are coordinated with LTSS services for Members with complex and special needs.

CCHA already has formal partnerships with Adult Care Management, Inc. (ACMI), Complete Home Health Care, DDRC, Jefferson County Options for Long Term Care (OLTC), Imagine!, Professional Home Health Care, Personal Assistance Services of Colorado (PASCO), Mt. Evans Home Health and Hospice, and Vivage Senior Living/Skilled Nursing Facility Communities. As a RAE, we will build on these relationships to continue evolving the health delivery system towards Team-based care.

Facilitating Health Data Sharing

We understand the immense value that data sharing can bring to Health Neighborhood partnerships. CCHA *Plus* brings sophisticated data sharing experience and capabilities to take data sharing to the next level, making it actionable to increase collaboration and reduce duplication in the Health Neighborhood.

Examples of the type of data we will share include Medicaid claims and eligibility data, admission, discharge, and transfer (ADT) feeds, KPI reports, the Roster Report, Maternity List, and the Nurse Advice Line. Each partner must sign a Business Associate Agreement that includes HIPAA privacy clauses to make sure all personal health information is protected. Our data and analytics employees will provide technical support to collate Medicaid data sets with those of various Health Neighborhood partners. Combined data sets provide a more complete clinical- and population-based data set that we can use to set strategic goals, Member goals, and contribute to other state initiatives, such as Colorado's 10 Winnable Battles and the Governor's State of Health.

Table 5.8-3 contains just a few of the data sharing collaborations CCHA began as a RCCO and that CCHA *Plus* plans to continue as a RAE.

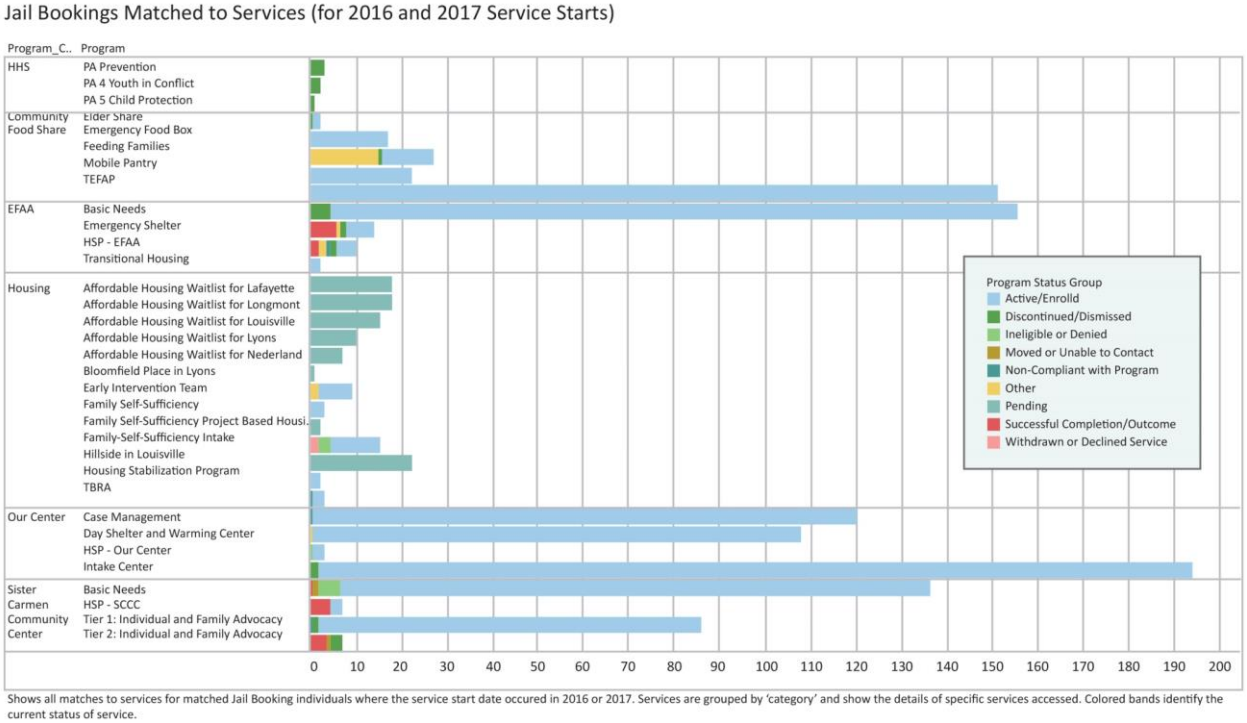
Table 5.8-3. Data Sharing Collaboratives

Organization	Purpose
Boulder County and Public Health and Human Services	Identify opportunities for partnership with the county to fill gaps in care and services. A project with the county jail is currently underway to connect Members with services upon release.
Jefferson County Local Public Health Agency (LPHA)	Align strategic planning processes between the LPHA and the RCCO and engage in shared interventions.
Colorado Community Managed Care Network (CCMCN)	CCMCN is the data association for the Federally Qualified Health Centers (FQHCs). CCHA has partnered with CCMCN to integrate claims data with FQHC EHR data to identify opportunities to improve performance on well-child visits and depression screenings.
Imagine!, Options for Long Term Care, ACMI	These LTSS providers are able to use our roster reports to identify shared Members so that we work as a health team on behalf of Members. Health team leads can be appointed, and Member home visits can be done together.
Broomfield County: Regional Health Connectors program	We have provided information on Network Providers serving Broomfield County in support of the State Innovation Model (SIM) Regional Health Connector program.
Gilpin and Clear Creek counties	CCHA has provided eligibility file information for both counties to help county officials identify PCMPs to serve the region.

As a RAE, CCHA *Plus* will bring previously established data sharing projects that have led to collaborative provider and community efforts to serve Members. Additionally, we will look to expand our data sharing efforts to include additional Health Neighborhood and Community Partners, including Arapahoe House—the largest substance use provider in the region and Children's Hospital.

Below in Figure 5.8-3 is an example of CCHA's data sharing project with Boulder County. The project merges Medicaid claims data with county correctional and social services data to identify gaps in care and services for Members. Using this integrated data set, the RCCO and County are able to partner to connect Members with medical and non-medical services. A county jail project is currently underway to connect Members with services upon release. CCHA *Plus* looks forward to data sharing projects like this with the counties in the Region and other Health Neighborhood partners to inform our collaborative efforts to connect Members with needed services.

Figure 5.8-3. Jail Bookings Matched to Services



Establishing Relationships for Non-emergency Medical Transportation (NEMT)

CCHA *Plus* will work closely with the NEMT provider in Region 6 to connect Members to NEMT services and strengthen the relationship between NEMT providers and the Health Neighborhood. We know that NEMT is a critical benefit for Members and providing transportation for medical treatment to low-income, elderly, and those with disabilities is cost-effective and improves quality of life. Missing a routine or preventive care service because of transportation can lead to poorly managed care, a need for emergency care, and preventable hospitalizations.

As a RAE, we will bring extensive experience working in counties where Veyo is the primary NEMT provider as well as experience working in communities where the county is responsible for NEMT services. We have experience working in the sparsely populated counties of Gilpin and Clear Creek to bring creative solutions to NEMT issues, like purchasing a community bus to take Members to medical appointments. In the urban communities, CCHA has collaborated closely with the NEMT provider, Veyo, to connect Members to rides.

As a RAE, we will collaborate with Veyo to explore innovative solutions to NEMT, including ride-sharing services such as Lyft. CCHA *Plus* will maintain close relationships with county officials in Clear Creek and Gilpin counties to make sure Members can keep their doctor appointments and see that the 'Prospector' bus is serving the needs of the community.

Establishing Relationships for Oral Health

We understand that oral health is extremely important to Member health and life outcomes. CCHA *Plus* will maintain a close relationship with the Department's dental benefit vendor, Dental Aid. Our Care Coordination team will be able to connect directly with Dental Aid to help Members access dental services. We commend the Department for expanding the Medicaid dental benefit to adults. We will work to make sure Members understand the benefit and are connected to dental care services. We also look forward to leveraging our existing relationships with CDPHE and local public health agencies to support oral health initiatives.

Many of the Safety Net Providers in Region 6, like Salud and MCPN, have established integrated clinics that include onsite dentists and dental hygienists to provide preventive oral health services. CCHA *Plus* will offer our support to these Safety Net Providers to provide integrated dental care. As a RCCO, CCHA has passed along the majority of the PMPM payment to these providers for financial support so they can offer integrated care. As a RAE, we look forward to our partnership with Children's Hospital Colorado to explore opportunities to help more Network Providers integrate dental services in their clinics.

Collaboration with Local Public Health Agencies

We understand the value Local Public Health Agencies (LPHAs) bring to Members, Network Providers, the Health Neighborhood, and Community. Collaboration with them provides an important opportunity to bridge the gap in the Health Neighborhood between health care and population-based public health, as well as reduce duplication of services in the region. CCHA *Plus* will collaborate closely with LPHAs in a variety of ways.

As a RAE, we will use the county's Health Needs Assessment (HNA) to identify specific target activities that meet the health and social needs of our Members in their communities. The HNA is a countywide effort facilitated by the LPHA to identify population health needs and develop strategies to address them. The HNA provides an excellent opportunity to align strategic priorities to increase efficiency and decrease waste or duplication. For example, we are able to use the HNA to identify overlapping goals between the county and the RAE, such as mental health or obesity. We can then collaborate with various county departments, including the LPHA, to identify opportunities to integrate county, LPHA, and RAE initiatives to help address the HNA areas of focus and make sure we are not duplicating activities.

Region-Wide LPHA Collaboration

Every county and community is different. As a RAE, we will have distinct efforts with each LPHA that align with the needs of Members, the Health Neighborhood, and Community. However, we are also committed to region-wide efforts to support LPHAs. For example, CCHA *Plus* will partner with the Department and with CDPHE to explore a new funding approach to further collaborative efforts between the RAE and LPHA. This approach will leverage Medicaid funding to provide a new funding stream to support LPHA activities, such as population health interventions in the community and outreach to PCMPs to support Colorado's 10 Winnable Battles and the State of Health. As the current RCCO in Region 6, CCHA anticipates piloting this approach with Boulder County LPHA. We hope this program is successful and can be replicated in other counties.

Additionally, we will provide direct funding to support LPHA programs as recommended by our Program Improvement (Health Neighborhood) Advisory Committee. The Committee, made up of local providers and community stakeholders, will provide recommendations for reinvesting KPI incentive payments the RAE receives from the Department. As a RCCO, CCHA has followed the Committee's decision to provide funding to sustain the GENESIS and GENESISTER programs in Boulder County.

We will also actively participate in and promote the statewide LPHA Mental Health stigma campaign, **Let's Talk,** which is funded by the Colorado State Innovation Model (SIM). We will distribute campaign materials liberally to Network Providers, the Health Neighborhood, and Community partners across the region and will supplement that through our social media outlets, like the CCHA *Plus* Facebook page, to spread the important message of eliminating mental health stigma.

CCHA County-based Efforts

Jefferson County

Jefferson County is the most populous county in Region 6 with 60.44% of the attributed Members. It has a robust system of care that serves Members. Upon award of the contract, CCHA *Plus* will engage in a strategic planning process with the County to develop a comprehensive plan, including formal processes and procedures, to connect Members with the diverse and high-value services the County provides. The Strategic Plan will include new opportunities to collaborate with the County on innovative efforts around health promotion and prevention services.

In addition to the strategic alignment work above, CCHA *Plus* will continue to align with Jefferson County on several Member-centric initiatives. Below are just a few examples of how, as a RCCO, CCHA has aligned with Jefferson County:

- CCHA is working with the Human Services eligibility staff to help Members receive assistance, navigate the system, and get the benefits for which they are eligible.
- Participate in visioning project: Human Services in 2035.

Colorado Opportunity Project

- Through work with the **Colorado Opportunity Project,** CCHA collaborated with **Jefferson County Public Health** to connect **pregnant women and infants** to key public health programs like perinatal tobacco cessation, home visitation programs, SUD services, high-risk pregnancies, and maternal depression.
- CCHA is educating Network Providers on Perinatal Tobacco Cessation, as well as sharing materials and holding forums for PCMPs to encourage pregnant women to stop using tobacco products and connect Members to available resources such as **Baby & Me Tobacco Free** and the **Colorado QuitLine.**
- The CCHA Care Coordination Maternity Team works with both **Prenatal *Plus*** and **Nurse Family Partnership** to cross-refer pregnant women, depending on their situation and the complexity of their pregnancy. The teams meets monthly for collaborative Care Coordination discussions to help stretch joint resources and eliminate wait lists by expanding our collective bandwidth. Discussions include gaps in care and how to connect Members to additional resources.
- CCHA has worked with Jefferson County Public Health to launch an initiative to **reduce duplication among Home Visitation programs** and develop a referral list for all programs to support the **LAUNCH together grant.**
- CCHA is working with the **SCL Health Lutheran Medical Center** Nurse Recovery program to reduce **substance use in pregnant women** and new moms. A co-located CCHA Care Coordinator (nurse) works closely with Lutheran's Care Coordination staff to receive referrals for Members who need BH supports and substance use treatment.

- CCHA is partnering with **Jefferson Center for Mental Health** and **Metro Community Provider Network** to better assess and treat women with maternal depression. CCHA has established warm handoffs to Jefferson Center for treatment. Collectively, the group is participating in an awareness campaign and working to see that all pregnant women are properly assessed and receive appropriate follow-up treatment through education and screening initiatives.

Boulder County

In Region 6, 33.75% of ACC Members currently reside in Boulder County.

The Boulder County Department of Housing and Human Services represents one of the first counties in the nation that merged its housing and human services functions into a single agency, as they recognized the impact of social determinants of health on the health and safety of its community. CCHA has been collaborating with the County and has leveraged their progressive approach in the many projects we work on. The following are some examples of CCHA's work with Boulder County:

- CCHA **shares Medicaid claims data** with the County for all Members residing there. The County integrates it with data on the services they provide to our shared Members. By comparing the data, we are able to identify gaps in care and collaborate to connect Members with the services they need. Our goals are **reducing ER visits**, **increasing well-child checks** for ages 3-14 years, and collaboration on services provided to **foster children** and individuals in the **criminal justice system.**
- CCHA and Boulder County **Healthy Communities** continue to work together to implement strategies to reach families whose children and teens have not completed their well-child checks. The **data sharing collaboration** is used to track progress on well-child check completion and other related metrics (for example, to understand whether families are using WIC or other public health programs). CCHA also provides Care Coordination support to shared Members if unmet needs are identified.
- CCHA provided critical bridge funding to keep the Boulder County **GENESIS** (for pregnant teens) and **GENESISTER** (for sisters of pregnant teens) programs alive. These proven programs **address health and social problems for both the teen and her baby.** An estimated 80% of children served by the two programs are enrolled in Colorado Medicaid. CCHA is working with the Department to find additional funds through the LPHA Medicaid funding opportunity. In the meantime, CCHA has provided bridge funding to keep the program alive on the advice of the CCHA Health Neighborhood Advisory Committee. CCHA has also connected Care Coordinators with the program to help with any health needs the Members may have.
- CCHA is collaborating with **Boulder** and **Broomfield counties** on their **Regional Health Connector (RHC) program.** Colorado RHCs are tasked with connecting primary care with community-based BH and social services. To coordinate and reduce duplicative functions, CCHA provided information on Network Providers in the region, and the CCHA Provider Support program facilitates communications with RHC staff and practices. Quarterly phone calls are held with the RHCs in Region 6 and information is shared on community projects to identify points of collaboration. CCHA also sits on the executive committee of the RHC program.

Provider Testimonial

Broomfield is historically a county with limited resources within the county proper. Therefore, having CCHA to support the access to different resources across counties is instrumental in achieving improved health outcomes and success for our families and children.
Jessica Jones, Council Director, Broomfield Early Childhood Council

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Broomfield County

In Region 6, 4.13% of ACC Members reside in Broomfield County.

CCHA has been working with **Healthy Communities** in Broomfield County to coordinate services. They have visited school districts together to define our scope of work, and are currently conceptualizing further population health-based work. CCHA also participate in the **Broomfield Early Childhood Council: Health and Wellness Group** and the **B Healthy Broomfield Coalition.**

In addition, CCHA is collaborating with the **Broomfield Regional Health Connector program.** CCHA sits on the executive committee responsible for helping the program achieve goals related to practice support around social determinants and other population-based initiatives in the community.

Clear Creek County

In Region 6, 1.03% of ACC Members reside in Clear Creek County.

CCHA has worked extensively with Clear Creek County in their efforts to **bring a PCMP to the county.** The county has signed an agreement with Centura Health and is **opening a clinic in the summer of 2017.** Additionally, plans are underway for **a new facility that will integrate PH, BH, and community resources in one location** that is easily accessible to residents.

CCHA has provided funding for the 'Prospector Bus,' which is a new service that provides intra-county rides and links with other transportation providers to get Members to their health care appointments. Non-Emergent Medical Transportation has been challenging, and the 'Prospector Bus' is now filling those gaps.

CCHA Care Coordinators make home visits to Members in Clear Creek County and work closely with **County Public Health** and **Human Services** staff. Further, CCHA is a member of the **Clear Creek County Community Health Assessment Council,** which engages in decision-making about community health priorities.

Gilpin County

In Region 6, 0.62% of ACC Members reside in Gilpin County.

Jefferson County provides LPHA services for Gilpin County. Over the years, CCHA has focused their work in Gilpin County on **securing primary care for residents** of this sparsely populated foothills and mountain area. Members receive care in neighboring Nederland, located on the border of Boulder and Gilpin counties. CCHA has also worked closely with a PCMP who serves more than 300 Members attributed to CCHA. The PCMP has received services from the **CCHA Provider Support program,** and CCHA partnered with Jefferson Center for Mental Health to **co-locate a BH provider in the office.**

The biggest public health issue in Gilpin remains **Non-emergency Medical Transportation.** CCHA works closely with the state NEMT contract manager and county to help Members access transportation services. The 'Prospector Bus' also serves Members in this area.

In addition, **CCHA Care Coordinators make home visits to Members** in Gilpin County and collaborate with County Public Health and Human Services staff to connect Members to public health and social services.

As a RAE, CCHA *Plus* will leverage these existing strong relationships with Jefferson, Boulder, Broomfield, Clear Creek, and Gilpin counties to continue integrating local public health activities into the ACC Program in Region 6. We will expand the **Colorado Opportunity Project** work to other counties, like Boulder and Broomfield counties. Additionally, we are committed to continuing our partnership with the Department and LPHAs to **leverage Medicaid funding that supports LPHA activities** that are aligned

with Colorado's 10 Winnable Battles and the State of Health. We will also continue to support the **Let's Talk** campaign in all our counties to help stamp out mental health stigma. We look forward to partnering with the **Healthy Communities** program in each county to educate new Members about the benefits and services available to them. We have a strong foundation for continued work with the LPHAs and other county departments and will have **executed formal agreements** that will allow us to share data and collaborate together. Our goals are aligned with our county colleagues, and we will continue to find new opportunities to work together to promote the health and well-being of Region 6 Members.

CCHA *Plus* Will Meet All Section 5.8 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 13, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.8 that are not detailed in our response.

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

Many Coloradans face roadblocks to being healthy, economically secure members of society. We agree with the Department that a prevention-based approach is necessary to identify and remove these roadblocks so that Members can achieve success throughout their lives. With limited resources in Colorado to serve the Medicaid population, our goal is to collaborate with local organizations to deliver a comprehensive set of medical and non-medical resources customized for each family based on each Member's unique needs, health condition, and life stage and circumstances.

We bring many years of experience working with, listening to, and serving Coloradans every day in their local communities. As a RAE, we will continue our work in local communities to address disparities and inequities by delivering wellness-focused interventions that promote overall health and well-being.

State Auditor Testimonial

CCHA has engaged in community partnership activities since inception of the RCCO and has built a solid foundation of numerous community and agency relationships to support both RCCO and local community objectives.
Health Services Advisory Group Auditor for the Department

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Through CCHA's efforts on the **Colorado Opportunity Project** and collaborations with key community organizations, including **schools, local public health agencies** and **human services departments, jails** and **prisons,** and **housing agencies,** they have seen significant success pulling our community together to address social determinants and reduce health disparities and inequities for Members.

Our establishment as a RAE was designed to reflect the Department's vision for the next iteration of health care delivery. We bring proven local and national approaches to integrated care under one, truly accountable entity dedicated to caring for Members. As discussed further in OR 15, prevention is a primary focus. We will screen for social determinants, as well as PH and BH conditions, and we will use our expansive Community connections to link Members with the services available to them. We will co-locate CCHA *Plus* Care Coordinators at Community organizations like The Action Center and Family Tree where Members and families go to receive services. We offer innovative technology platforms designed specifically to serve fully integrated Medicaid programs, provide advanced data analytic capabilities that drive operational improvements and population health strategies, and enable effective data sharing among the Community.

As a RAE, we want to leapfrog the Colorado Opportunity Project into the next era of integrated community health delivery systems. We will engage in disruptive innovation efforts that will pilot new approaches to enrollment in and delivery of services. We will work with community partners, especially County Public Health and Human Services Departments, to explore new ways of doing things. For example, we would like to see one lead Care Coordinator assigned to an entire family to connect them with the medical and non-medical services each family member needs based on their life stage and level of health. A combination of the Colorado Opportunity Project and 2Gen models that, if done right, will reduce duplication and remove roadblocks, so that ACC Members can achieve success throughout their lives. As a RAE, we will bring our success in Jefferson County and our penchant for innovation to the Department, so that together we can catapult this program to the next level of health and well-being.

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CCHA *Plus* offers to Region 6 the expansive Community partnerships CCHA has formed in our 6 years serving as a peak performing RCCO, as well as the support of the Community to serve as a RAE (see **Letters of Support)**. With Anthem, we add substantial experience working with

Members and Community partners in Medicaid programs in 18 states, and best practices and evidenced-based approaches that work for Communities nationwide. ***Together, CCHA Plus combines to deliver a RAE that is unmatchable in our local experience serving more than 135,000 Members, with proven practices for supporting thriving Communities.***

Defining Community

In our definition of Community, we include all community partners and resources that work toward achieving health equity and addressing social determinants, state agencies and departments, Primary Care Medical Providers (PCMPs), hospitals, specialists, health plans, faith-based organizations, policy makers, local health thinkers and innovators, and most importantly, Members and their multi-generational families. ***Our Community is defined in a very broad sense and includes all diverse individuals, organizations, and agencies that function and live within it. Members' Communities are unique and specific to them and their needs, culture, and preferences.***

Colorado Department of Public Health and Environment (CDPHE) Social Determinants of Health Model

We will use the CDPHE Social Determinants of Health (SDoH) model to address disparities and inequities. CDPHE obtained data from a diverse set of sources to identify disparities for vulnerable groups in Colorado using both local and national data sets. They included:

- The United States Census Bureau data on poverty, compiled by U.S. Department of Commerce, Economics, and Statistics Administration
- KidsCount in Colorado!, compiled by the Colorado Children's Campaign
- The Self-Sufficiency Standard for Colorado: A Family Needs Budget
- Diplomas Count – An Analysis of High School Completion, conducted by the Editorial Projects in Education Research Center
- Excerpts from the Robert Wood Johnson Foundation Commission to Build a Healthier America
- Several county-based data sets provided by local public health agencies and CDPHE

The following social determinants of health (see Table 5.8-4) are not exhaustive, but are identified as having an impact on the lives of Coloradans and disproportionately, Colorado Medicaid Members:

Table 5.8-4. Social Determinants of Health in Colorado

Economic Opportunity	Income, Employment, Education, Housing
Physical Environment	Recreation, Food, Transportation, Housing, Water, Air Quality, and Safety
Social Factors	Participation, Social Support, Leadership, Political Influence, Organizational Networks, Violence, Racism

Concurrently, the model identifies the following health factors (see Table 5.8-5) as also being influential and potential points for effective intervention:

Table 5.8-5. Health Factors for Coloradans

Health Behaviors and Conditions	Nutrition, Physical Activity, Tobacco Use, Skin Cancer, Injury, Oral Health, Sexual Health, Obesity, Cholesterol, and High Blood Pressure
Mental Health	Mental Health status, Stress, Substance Use, and Functional Status
Access, Utilization, and Quality of Care	Health Insurance Coverage, Received Needed Care, Provider Availability, and Preventive Care

Over the years, CCHA has established relationships and communication channels with hundreds of community organizations and partners to see that Members receive holistic care that enhances all areas of life. CCHA engages resources that provide food assistance, housing, energy assistance, childcare, education, job training, wellness courses and recreational activities, domestic violence support, clothing, and a multitude of other resources that support Members around social determinants. CCHA has also formalized partnerships and bi-directional engagement with current state initiatives that also work toward health equity, including Colorado Crisis Services, State Innovation Model (SIM), and Colorado Opportunity Project.

Supportive housing for vulnerable Member leads to recovery and job placement

Jonathan was homeless and struggled with substance abuse issues, medication and treatment noncompliance, and untreated mental health issues which resulted in frequent hospital and behavioral health facility admissions. He had approximately 90 days of inpatient hospital stays, including one continuous stay for several months due to a suicide attempt resulting in serious damage to his body which took several months to heal.

The day after our Care Coordinator, Maria, met Jonathan she found housing placement for him – which started him on the road to recovery. Maria also enrolled him in our integrated, complex Care Coordination program, and he began to receive regular medical and mental health treatment and to address his substance use issues.

During the first months on his way to healing and recovery, it did not come without any struggle. Jonathan had several relapses as well as inpatient admissions. With the continued assistance and encouragement of Maria and his PCMP, he continued to address his issues and attended all his medical and mental health appointments and maintained medication compliance.

Soon Jonathan started thinking about getting a job, and he attended the recommended job placement appointments. At the same time, he began to actively seek employment and submitted applications at numerous retail stores based on his previous work experience. After attending several interviews at various stores, he was offered a position. ***Jonathan started his new job in the stocking and freight department seven months after he met Maria, and he says he is happy to be employed and can continue to move forward with his life.***

Anthem Member Centered

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Understanding Health Disparities and Inequities

According to the Centers for Disease Control and Prevention (CDC) Community Health and Services program, health disparities are defined as ***preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.***

These disparities are created and perpetuated by multiple factors, including poverty, environmental threats, inadequate access to health care, individual and behavioral factors, and education inequalities. Health disparities and inequities are distinct in each region and unique within each Community.

CCHA works with CDPHE and Local Public Health Agencies in a variety of ways to understand our population and promote the health of local communities and populations. The Colorado Health Assessment and Planning Systems (CHAPS) is a tool CDPHE provides to help local public health agencies with health assessments and planning. The CHAPS provide indicators on a variety of health, environmental and social topics and is extremely helpful in understanding the disparities and inequities within each Colorado County.

These and other data will help to drive our collaborative efforts with Communities to address the unique health and wellness needs of Members and deliver interventions to optimize the PH and BH of Members at all life stages and levels of health.

For example, Clear Creek County has a higher percentage of households receiving food stamps than that of the state average. As a RCCO, CCHA has partnered with county officials to build a new PCMP office in Idaho Springs that will offer integrated BH and county social services. CCHA *Plus* Care Coordinators will be able to educate Members on this new resource in their community to renew food stamp eligibility and determine if there are other supports they are eligible for like WIC to help address food insecurity for the family.

Boulder County faces challenges with identifying affordable rent for Members and has a higher than average percent of renter-occupied housing units with gross rent 50% or greater than household income. CCHA *Plus* can work to identify Members that are eligible for Anthem's Low-Income Housing Tax Credit Program (LIHTCP), a partnership with state and national governments that has offered over $10.2 million in funding to Colorado residents to help with high rent costs in the state.

The data the Department provided for CCHA's partnership on the Colorado Opportunity Project indicated a higher than average rate of tobacco use among pregnant women enrolled in the ACC Program in Jefferson County. CCHA partnered with the Jefferson County Local Public Health Agency to increase enrollment in their Baby and Me Tobacco Free program. CCHA *Plus* will build on this partnership and expand Colorado Opportunity Project efforts to other counties as part of the next iteration of the ACC Program.

Implementing Initiatives to Promote Healthy Communities and Members

Achieving health equity among vulnerable populations remains one of the most substantial health care priorities for the provider community and delivery system in Colorado. ***We define equity as the opportunity for all to achieve their highest level of health and well-being, regardless of their individual social, economic, or environmental circumstances.*** CCHA *Plus* is committed to working to achieve health equity for Members in their Communities. We will work to leverage existing State programs, integrate BH and PH, engage in effective community collaboration, and support the provider community in efforts to reduce inequities. As a RAE, we will be trusted stewards of Colorado resources, will avoid duplicating Community efforts by collaborating with the Community to provide equity for Members so they may improve their health and life outcomes.

Provider Testimonial

Brothers Redevelopment Inc. is pleased to offer our support to CCHA in their bid to serve as a RAE for the next iteration of the ACC. Because housing is a social determinant of health, which means it is an underlying, contributing factor to health outcomes, CCHA has made great strides in building a collaborative relationship in bringing the community together to expand access to services.
Jeff Martinez, President, Brothers Redevelopment Inc.

CO_RAE_OR27_Martinez_39_COB_TST_7.2

Health Neighborhood and Community Engagement Program

CCHA *Plus* recognizes that to truly improve Member health and well-being and optimize our resources and resources in the Community, we need to know, understand, and implement initiatives to build local Communities. This is particularly true for those Members with complex needs that require services from a variety of agencies.

Our Health Neighborhood and Community Engagement program is charged with developing collaborative relationships with the Community to remove roadblocks that impact Member access to programs and services and fill gaps. *Our program is modeled after the CDPHE SDoH, driven by data and analytics, and relies upon aligning with current efforts in the Community and developing healthy and resilient Community partnerships.*

As a RAE, CCHA *Plus* Community Liaisons will work to establish community resources and partnerships and then connect CCHA Care Coordinators and Network Providers to them. ***Our Community Liaisons will also serve as part of our Provider Support Team to help PCMPs identify health disparities and inequities within their Member populations and develop plans to improve the PH and BH of Members.*** Using evidence-based frameworks and programs, our work with the State Innovation Model (SIM), the state Regional Health Connector program, the Colorado Opportunity Project, and Comprehensive Primary Care Plus (CPC+) will fill a critical gap for providers and enable them to focus their efforts on providing care.

We will establish collaborative relationships with economic, social, educational, justice, recreational, and other organizations to promote the health of local communities and populations. We know our communities, and we regularly collaborate with Community organizations to implement initiatives to optimize health and well-being, particularly for Members with complex needs who receive services from a variety of agencies. Below are some examples of the value the Health Neighborhood and Community Engagement program brings to local Communities and Members.

Housing

- Since 2006, CCHA *Plus* managing partner Anthem has partnered with the federal and state government to contribute **$10.2 million** to Colorado through **Low-Income Housing Tax Credit Program (LIHTCP).** Families, seniors, and Members with special needs are eligible to receive funding to provide stable housing for improved health outcomes. Nationwide, Anthem has contributed over $380 million in LIHTCP. This is an excellent resource Anthem brings that we will weave into our Care Coordination program. CCHA *Plus* Members will be connected with housing supports directly through the LIHTCP.
- CCHA *Plus* will partner with state agencies, including the **Colorado Department of Local Affairs (DOLA), Division of Housing (DOH),** and the **Department** to connect Members with other available housing resources, including housing choice vouchers and tenant-based rental assistance.
- We will work with local Community groups to create How to Search for and Obtain Housing guides.

Justice-Involved Population: Prison, Jails, and Community Corrections

As a RCCO, CCHA has gained invaluable experience collaborating with state and local officials to serve Members involved with the justice system. As a RAE, CCHA *Plus* will continue these efforts and add Anthem's expertise in BH to connect Members leaving the justice system with critical medical and non-medical services to help facilitate a successful re-entry to the Community.

- CCHA *Plus* will participate in the Transition Planning Collaborative with the **Colorado Department of Corrections (CDOC)** and CMHCs to share data and identify Members who can be connected with the RAE upon release
- We will establish collaborative partnerships with justice-related organizations in the region, including Jails, Community Corrections, and Parole offices throughout the region
- Activities include:
  - Participation in pre-release in-reach events at the facilities
  - Health Literacy events to educate Members (and staff) on Colorado Medicaid benefits and services at the community corrections facilities and probation and parole offices
  - Co-locating a Care Coordinator at Community Corrections and Parole Offices to provide navigation services to Members with high PH and BH needs
  - Collaboration with re-entry specialists, community care case managers, and the clinical mental health program at the corrections offices to engage Members who need primary care or other navigation services
- A Member of CDOC leadership will be invited to participate on the CCHA *Plus* Program Improvement (Health Neighborhood) Advisory Committee to represent the needs of justice-involved Members

Reengaging in education helps young Member heal and move forward

When Martha received an Anthem communication about getting GEDs at no cost, she was hopeful she could help her grandson. Jamaal had dropped out of high school in 2015 due to his severe depression and bipolar disorder and had just reenrolled in school in 2016 when his father was murdered. After six months of isolation, when Martha showed him the Anthem letter, he decided to prepare for school again and received an A- on his first prep course. Martha is thrilled saying, ***"Your commitment to Jamaal and our family is a blessing in our lives, and we are deeply grateful."***

Anthem Member Centered

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Education

- CCHA *Plus* will collaborate with local schools with high percentages of Colorado Medicaid Members to establish preventive screening incentive programs and promote population health interventions, such as classroom curriculum on sugary drinks.
- CCHA *Plus* will work with local Head Start programs to connect Members and families to RAE services.
- CCHA *Plus* will partner with the FQHCs to connect Members with support to complete their GED.
- CCHA *Plus* will join Longmont United Hospital efforts to train health professional to provide children and parents the Healthy Learning Paths curriculum at school. Healthy Learning Paths is a non-profit organization that believes health professionals have an obligation to empower children with health skills to prevent disease. The program works to eliminate Type 2 diabetes, obesity, and depression and help children achieve mental, physical, and social emotional fitness.

Community Partner Testimonial

At Family Tree we are excited to be exploring the possibility of working with CCHA to provide enhanced support and expertise for our clients through the utilization of CCHA's care coordination services and willingness to co-locate staff at our Women in Crisis domestic violence emergency shelter, as well as work with children and families in our Safe Care and Homelessness programs.
Scott Shields, CEO, Family Tree, Inc.

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Social Services

- CCHA *Plus* will co-locate Care Coordinators where Members and families go to receive Community services like the domestic violence and homeless shelters, the Action Center, Family Tree, or Benefits in Action.
- CCHA *Plus* will promote Centura Health Links to help Members navigate the public benefit system and assists in the application process for benefits, including WIC and the Supplemental Nutrition Assistance Program (SNAP).

Prevention

- CCHA Plus will support efforts statewide to train health care workers and targeted community members in Mental Health First Aid (MHFA) and motivational interviewing.
- Our population health plan will collaborate with LPHAs and Community groups to deliver health education and promote healthy living through our various population health interventions. For more information, please see OR 15.
- CCHA *Plus* will join forces with Longmont United Hospital and LiveWell Longmont to provide healthy food and nutrition information at Boulder County Farmer's Market and Ollin Farms, an affordable produce market. We will also focus on increasing access to healthier food retail using an assessment of current healthy food retail in the community.

***Reggie's Story:* Person-Centered Care through Coordinated Services**

After spending the last 10 years incarcerated, Reggie needed support in navigating provider and community resources and completing tasks using processes that were new to him. Based on Reggie's preferences noted in the Care Coordination Consent and Questionnaire form, Kiera, our Care Coordinator, reviewed available PCP clinics in the Boulder area, scheduled a new patient appointment with Rocky Mountain Urgent Care and Family Practice, completed a Non-Emergency Medical Transportation certification, reserved his first ride, and communicated this information to Crowley County's case manager and Boulder Community Treatment Center (BCTC) staff.

After Reggie's release, Kiera confirmed that he successfully connected with the PCMP, and collaborated on a care plan during a face-to-face visit to identify his needs which included dentistry, optometry, and a local recreation center. They also addressed Reggie's questions and concerns about his medications, knee pain, and nutrition, and Kiera encouraged Reggie to raise these issues with his PCMP at his 1-month follow-up visit. Kiera also coordinated with the PCMP office to ensure medication continuity.

Reggie attended his initial and follow-up visits with his PCMP and dentist, has obtained approval to go to the rec center 3 times per week to manage his high blood pressure, and received information from Kiera on community resources such as services provided by Emergency Family Assistance Association and local Christian churches. Kiera continues to coordinate with the county case manager, BCTC staff, and Reggie's PCMP to provide person-centered care and avoid duplication of services.

CCHA — Member Centered

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We understand the vast resources our Community offers Members. As a RAE, we will remain steadfast in our dedication to achieving health equity for Members. We will continue to establish relationships, communication channels, and formal partnerships, where appropriate, with Community organizations to provide resources such as food, housing, energy assistance, childcare, education, and job training in the region. We will collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Colorado Medicaid children and youth.

Regional Resource Directory

Supporting 2-1-1

To reduce duplication and enhance Member experience in accessing resources, CCHA *Plus* will continue to support Colorado 2-1-1 and other community organizations that catalog, compile, and engage with the hundreds of community resources that currently exist. As a RAE, we will work to enter a formal agreement with 2-1-1 so that we may share data, feed 2-1-1 usage data into our electronic Care Coordination tool so it may drive our Care Coordination efforts. Additionally, we would like to collaborate with 2-1-1 to provide a direct telephone connection for Members when they contact us for resources. Finally, we would like to promote the 2-1-1 smart phone application and website with all Members.

As a RAE, we would like to work with the Community to strengthen 2-1-1 to connect Members with more resources. We do not seek to establish a separate resource directory for Members and will collaborate in any state or community efforts to establish a regional resource directory for the region. However, we recognize that health care is local and there are many resources that are only available in specific Communities. In fact, the myriad resources available to Members can be quite daunting for Care Coordinators to navigate through clothing, disability, education and vocational, family and caregiver, financial, food, housing and homelessness, legal, senior, social services, substance use and BH, and transportation.

That is why CCHA *Plus* will continue with the **Community Resource Committee** established by CCHA to sift through resources available to Members and help educate our Care Coordinators about what is available for Members they are working with. The committee includes members of the Care Coordination team who are nurses, social workers, and community resource experts who work directly with Members and have a great understanding of needs and gaps. The committee also conducts a regularly scheduled audit of existing community resource information to make sure it is accurate and relevant to the needs of the Care Coordination team and Members. The committee has also created and facilitated community resource trainings for new employees and bi-annual community resource refresher trainings with local resources to enable Care Coordinators to meet contacts in community organizations.

CCHA *Plus* will look to take connecting Members to community resources to the next level, through new electronic referral management tools that not only connect Members to community resources, but community resources to each other. As a partner in the Denver Regional Council of Governments (DRCOG) **Accountable Health Communities (AHC)** program, we will explore with AHC partner tools like **Healthify,** an impressive new referral tool that many AHC grantees are using across the country to make quick and accurate referrals for Members who need additional help from social services. Healthify assists organizations with building a support network of community agencies and social services, sending eReferrals to trusted partners and participating organizations, tracking successful referrals, and implementing interventions with non-compliant cases.

In addition to leveraging 2-1-1 and collaborating with the community to identify the best resource referral tool for the region, CCHA *Plus* will bring our own vast community network to serve Members. As an incumbent RCCO, CCHA has developed strong relationships in the Region 6 Community. In Table 5.8-6, we have included a list of the many Community relationships CCHA has built over the years. Additionally, please see the many **Letters of Support** we have received from Community partners for our proposal (Attachment 4.2-1).

Table 5.8-6. Examples of Region 6 Community Partnerships

CCHA connects Members to community resources to support meeting their physical, behavioral, and social needs. **REGION 6**

Behavioral Health & Substance Use		
CCHA engages in partnerships with and makes referrals to the following organizations/agencies to increase access to behavioral health and substance use services. • Arapahoe House • Behavioral Healthcare, Inc.	• Boulder Community Treatment Center • Bridge House • Colorado Crisis Services/Rocky Mountain Crisis Partners • Colorado Quitline • Foothills Behavioral Health Partners • Jefferson Center for Mental Health	• Longmont Community Treatment Center • Mental Health Partners • Providence House • Senior Reach • Sobriety House • Tennyson Center for Children • Wiser Mind
Long-term Services & Supports		
Long-term Services & Supports: CCHA partners with LTSS providers to increase bi-directional access and align efforts to avoid duplication, operate as an expanded health team, and improve health outcomes. • Adult Care Management, Inc. • Apria: Home Respiratory Services • Argus Home Care • Boulder County AIDS Project • Boulder County Aging and Disability Resources for Colorado • Boulder County Area Agency on Aging • Carmel Community Living Group	• Center for People with Disabilities • Complete Home Health Care • Denver Regional Council on Governments —Metro Area Agency on Aging and Adult Disability and Resource Center • Developmental Disabilities Resource Center • Developmental Pathways • Eaton Senior Communities • Epic Health Services • Highland West Senior Community • Imagine!	• Jefferson County Options for Long Term Care • Longmont Senior Resource Center • Mount Evans Home Health Care and Hospice • North Metro Community Services, Inc. • Personal Assistant Services of Colorado • Professional Home Health Care • Regional Centers • Seniors, Inc. • Seniors' Resource Center • Veterans Affairs • VIVAGE Senior Living and Skilled nursing Facility Communities
Food Stability		
CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with resources to meet their nutritional needs. • Arvada Food Bank	• Emergency Family Assistance Association (Boulder, Broomfield) • FISH Food Bank • Growing Home • Mountain Resource Center • Outreach United Resource (OUR) Center • Project Angel Heart	• Sister Carmen Community Center • SNAP – Hunger Free Colorado and Latin American Research and Service Agency • The Action Center • TLC Meals on Wheels • Volunteers of America Meals on Wheels
Housing (Housing Stability) & Homelessness		
CCHA Care Coordinators refer Members to the following agencies/organizations to help support housing stability, prevent eviction and seek short and long-term housing options. We engage in partnerships to streamline access and collectively share resources to stretch capacity and improve overall quality. • Arvada Housing Authority	• Boulder Housing Partners • Brothers Redevelopment • Catholic Charities • Clutter Trucker • Colorado Coalition for the Homeless • Denver Rescue Mission • Family Tree, Inc. • Growing Home • Hope House	• Housing Authority (Boulder, Broomfield, Clear Creek, Denver, Gilpin, & Jefferson counties) • Interfaith Hospitality Network of Colorado Springs • Metro West Housing Solutions • Outreach United Resource (OUR) Center • The Inn Between
Educational/Vocational		
CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with resources to meet their educational/vocational needs. • Broomfield County Early Childhood Council • Child Care Innovations	• Child Find (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties) • Cleo Wallace Center • Department of Vocational Rehabilitation • Emerald Elementary School • Emory Elementary School • Family Advocacy Care Education Support • Growing Home	• Jefferson County Head Start • Lakewood Head Start • School District (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties) • Teens, Inc. • Workforce Center (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)
Clothing		
CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with resources to meet their clothing needs.	• A Precious Child • Deacon's Closet • Clothes to Kids of Denver • Outreach United Resource (OUR) Center	• The Action Center • Sister Carmen Community Center

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CCHA connects Members to community resources to support meeting their physical, behavioral, and social needs.

REGION 6

Interpersonal Safety (child, elder, and IDD abuse/neglect, domestic violence)

CCHA Care Coordinators collaborate with Department of Human Service employees when serving a mutual Member to form a health team.

- Department of Human Services (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)
- Adult Protection
- Child Protection
- Foster Program
- Kinship Program
- Family Tree, Inc.
- Project Safeguard
- The Parenting Place
- Safehouse (Denver)
- Women in Crisis

Transportation

CCHA Care Coordinators refer Members to the following agencies/ organizations to connect them with resources to meet their transportation needs. Care Coordinators provide additional assistance in navigating these resources to ensure transportation is not a barrier to accessing PN/BH care.

- Broomfield Easy Ride
- Lakewood Rides
- Seniors' Resource Center
- Via
- Veyo

Cultural

CCHA Care Coordinators participate with the following organizations/ coalitions to ensure care is provided in a culturally competent, person-centered manner.

- Boulder County Latino Coalition
- Center for African-American Health
- St. Vrain Latino Coalition

Family/Caregiver

CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with resources to support their family/caregiviers with respite and other resources.

- Colorado Respite Coalition
- Megan's Place
- Nurturing Newborns
- SafeCare

Financial and Utility Assistance

CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with financial resources to meet a variety of unmet/uncovered needs.

- Assurance Phone Services
- AV Hunter Trust
- Boulder County Community Foundation
- Boulder County Healthy Children and Adults Initiative
- Catholic Charities
- Child Care Assistance Program (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)
- Colorado Indigent Care Program
- Dental Aid
- Drive Smart
- Emergency Family Assistance Association—Boulder, Broomfield
- Evergreen Christian Outreach
- Friends of Man
- Low Income Energy Assistance Program
- Mountain Resource Center
- Rocky Mountain Children's Health Foundation
- TANF (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)

Legal

CCHA Care Coordinators refer Members to the following agencies/organizations to connect them with free or low-cost legal resources.

- Colorado Legal Services
- Legal Aid Foundation
- Metro Lawyer Referral Services
- The Action Center

Public Health

CCHA partners with local public health agencies to streamline access and align efforts to stretch collective resources further, avoid duplication of services for the same individual, and improve overall quality of services.

- Boulder County Genesis/Genesister
- Boulder County Housing and Human Services
- Broomfield Health and Human Services
- Children and Youth with Special Health Care Needs (Boulder, Broomfield, and Jefferson counties)
- Clear Creek County Health and Human Services
- Colorado Department of Public Health and Environment
- Gilpin County Department of Human Services
- Healthy Communities (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)
- Jefferson County Human Services
- Jefferson County Prenatal Plus
- Jefferson County Woman, Infants, and Children
- Nurse Family Partnership (Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties)

Criminal Justice

CCHA partners with the criminal justice system to increase timely access to PH/BH services upon reentry and align efforts to stretch resources further while avoiding duplication.

- Boulder Police Department
- Colorado Criminal Justice Reform Coalition
- Colorado Department of Corrections
- Denver Women's Correctional Facility
- Englewood Parole Office
- Intervention Community Corrections Services
- Jefferson County Jail
- Jefferson County Sheriff's Office
- Longmont Parole Office
- The Re-Entry Initiative
- Transition Specialist Program
- Westminster Parole Office

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As a RAE, we will use and build on these Community partnerships to start to break down the silos between Medicaid, public health and the social services delivery systems in our region. Our goal is to create a seamless experience for Members, where they are served by a single Care Coordinator who consults with a multidisciplinary team of Community service providers to connect the Member and family to the services available to them.

Evidenced-Based Interventions

Research indicates that effectively addressing social determinants of health calls for in-depth assessment and multi-level intervention plans that are both community engaged and evidence-based. Evidence-based models must be executed with community partner buy-in, trust, and engagement.

As a RCCO, CCHA has demonstrated experience engaging in evidence-based interventions, such as extensive work with the **Colorado Opportunity Project** and integrated Care Coordination approaches, which cross state and community agencies. In addition to CCHA's Health Neighborhood foundational work, they have also applied evidence-based principles to their work with social determinants.

CCHA *Plus* adds the invaluable experience Anthem brings from working to implement evidenced-based interventions in Medicaid programs throughout the country.

Supportive housing for vulnerable Member leads to recovery and job placement

Jonathan was homeless and struggled with substance abuse issues, medication and treatment noncompliance, and untreated mental health issues which resulted in frequent hospital and behavioral health facility admissions. He had approximately 90 days of inpatient hospital stays, including one continuous stay for several months due to a suicide attempt resulting in serious damage to his body which took several months to heal.

The day after our Care Coordinator, Maria, met Jonathan she found housing placement for him – which started him on the road to recovery. Maria also enrolled him in our integrated, complex Care Coordination program, and he began to receive regular medical and mental health treatment and to address his substance use issues.

During the first months on his way to healing and recovery, it did not come without any struggle. Jonathan had several relapses as well as inpatient admissions. With the continued assistance and encouragement of Maria and his PCMP, he continued to address his issues and attended all his medical and mental health appointments and maintained medication compliance.

Soon Jonathan started thinking about getting a job, and he attended the recommended job placement appointments. At the same time, he began to actively seek employment and submitted applications at numerous retail stores based on his previous work experience. After attending several interviews at various stores, he was offered a position. ***Jonathan started his new job in the stocking and freight department seven months after he met Maria, and he says he is happy to be employed and can continue to move forward with his life.***

Anthem **Member Centered**

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Alignment: Using Community Health Needs Assessments to Drive Strategic Priorities

In the next phase of the ACC Program, it will be vital for RAEs to support and align with current statewide initiatives, efforts, and existing infrastructure. At the local, county, and state levels, there have been tremendous efforts to begin conversations about population health, social determinants, and optimizing the health care delivery system to serve vulnerable populations. As a current RCCO, CCHA is participating in these conversations and in recent years has emerged as a leader in supporting Community efforts to serve the Colorado Medicaid population by encouraging collaboration and coordination among disparate community groups.

When determining how to leverage existing Community resources to serve Members, CCHA *Plus* will partner with county public health and human services departments to share data, analytics, and mapping resources to determine the social determinants and health needs of Members. Together, we

will be able to examine the resources available in the Community and the social services gaps and needs, which all help determine the priority of partnerships to build in the Community.

As discussed in OR 13, we will also look to each county's Health Needs Assessment (HNA) to identify population health needs and strategies to address them. Within the HNA, we are able to identify overlapping goals (such as mental health, obesity) between the county and the RAE. We will collaborate with various departments within the counties, including the Local Public Health Agency (LPHA), to identify opportunities for integration of county, LPHA, and RAE initiatives to help address the HNA areas of focus. We will also work to be included in the LPHA HNA planning process in each of the counties.

Through leveraging and aligning the full range of service providers, community organizations, state agencies, and existing resources and frameworks, we can positively impact Member experience. CCHA *Plus* will use HNA information to develop our population health management and Care Coordination strategies. We will depend on our experiencing working with LPHAs and CDPHE to plan, design, and use evidence-based interventions to impact social determinants.

Alignment with Statewide Health Infrastructure

CCHA *Plus* will participate in and align our activities with advisory groups and existing programs and statewide initiatives strengthen the health care system. We bring extensive local experience working in all of these programs and initiatives:

Managed Services Organizations (MSOs)

We understand the importance of substance use services for the health and well-being of our Members, and we have demonstrated our commitment to assuring access to substance use services. ***Last year when one of the largest substance use providers in the state was no longer able to provide detox services, CCHA provided financial support to see that Members did not go without these critical services. CCHA provided funding to the local Community Health Center in our region, Jefferson Center for Mental Health to take over administration of detox services and worked closely with them to connect Members to available services.***

As a RAE, CCHA *Plus* will connect Members with substance use services available through the MSOs, Signal Behavioral Health Network, Mental Health Partners, AspenPointe Inc. and other substance use providers in the state. CCHA *Plus* Care Coordinators will visit the MSO facilities, learn about their programs and intake processes, and share information about our Care Coordination services for Members. We will work to develop data sharing agreements and determine if a formal agreement with prescribed referral processes and Team-based Care Coordination approaches are appropriate. As a RAE, we will maintain a targeted list of substance use treatment community resources and a program directory that spans the whole continuum of care for adults and youth, including detox, residential, transitional sober living, medication-assisted treatment, intensive outpatient, outpatient, and community peer support groups.

As discussed in OR 11, we look forward to working to expand access to substance use services by recruiting and credentialing additional substance use providers to serve Colorado Medicaid Members.

Colorado Crisis System

CCHA *Plus* understands the importance of the Colorado Crisis Services system in ensuring Members receive timely access to BH interventions during a crisis. As a RAE, we will promote Colorado Crisis Services to Members and Network Providers to provide confidential, immediate support for mental health, substance use, or emotional needs. We will use our partnerships with community-based BH providers, Community Mental Health Centers, and Managed Service Organizations to further overall

strategic alignment to make sure Members are receiving the care they need and know how to appropriately use the crisis walk-in centers and 24/7 crisis line.

CCHA has already been promoting the system to Members and Network Providers. We will continue to print Colorado Crisis Services materials and share with Network Providers, the Health Neighborhood and Community partners for free to spread the word about the system with Members. We will also integrate these efforts with population health approaches to decrease stigma and promote the importance of emotional well-being.

Colorado State Innovation Model (SIM)

As a RCCO, CCHA is engaged in SIM in multiple ways and understands the importance of aligning closely with this statewide initiative to increase access to integrated primary care and BH services in more than 400 primary care practices:

- CCHA has partnered with the Department to provide direct payments to Network Providers participating in SIM. As part of this work, CCHA Practice Transformation Coaches provide support to ensure SIM practices are hitting SIM milestones.
- CCHA is partnering with the Regional Health Connectors, a practice support project of SIM, assigned to each of the counties in Region 6.
- CCHA leadership is appointed to the SIM Practice Transformation Advisory Committee.
- CCHA is a practice transformation organization (PTO) for SIM, with practice facilitation and Clinical Health Information Technology Advisor (CHITA) support for coached practices. CCHA is currently coaching practices for SIM Cohort 1 and will start coaching practices for Cohort 2 in September 2017.

As a RAE, CCHA *Plus* will continue to support Network Providers and partner with SIM and the Department to achieve the goals of the project. Additionally, with Anthem, we bring new opportunities to support practices with bi-directional BH integration efforts — *BH in primary care settings and PH in BH care settings*. We are committed to supporting all Network Providers, including SIM practices, in engaging in practice transformation activities to meet the SIM practice milestones:

- Building Block 1 — Engaged Leadership
- Building Block 2 — Data-Driven Improvement
- Building Block 3 — Empanelment
- Building Block 4 — Team-based Care
- Building Block 5 — Patient-Team Partnership
- Building Block 6 — Population Management
- Building Block 7 — Continuity of Care
- Building Block 8 — Access to Care
- Building Block 9 — Comprehensiveness and Care Coordination
- Building Block 10 — Integration and Compensation Reform

The CCHA Provider Support team includes Clinical Health Information Technology Specialists for SIM. CCHA *Plus* will capitalize on the experience of these specialists to provide support to Network Providers interested in integration work, regardless of whether they are participating in SIM. For more information on our Provider Support program, see OR 17.

State Auditor Testimonial

Colorado Opportunity Project maternity program—collaboration of community partners and providers to engage members in improving their health during pregnancy; includes member contact through organizations such as Healthy Communities and Nurse-Family Partnership.
Health Services Advisory Group Auditor for the Department

CO_RAE_HlthSrvAdvGroupAuditor14_61_COB_TST_14.1

Colorado Opportunity Project

As a RCCO, CCHA has partnered with the Department on the Colorado Opportunity Project since its inception in 2014. CCHA *Plus* is fully aligned with the project goal: to deliver evidence-based initiatives and community-based practices that remove roadblocks for all Coloradans, enabling everyone to have the opportunity to reach and maintain their full potential. ***The Colorado Opportunity Project is a natural extension of the work of the RCCO and now the RAE. It is an excellent opportunity to improve our partnerships across the Community to promote Member engagement with regional initiatives that address social determinants of health.***

CCHA *Plus* will build upon the solid foundation CCHA as a RCCO has built in Jefferson County and catapult this work to the next level. **CCHA has been the lynchpin for bringing community partners together and unifying them behind the goal of the Colorado Opportunity Project. Awarding the RAE to CCHA *Plus* will preserve the glue that holds these community partnerships together.**

Colorado Opportunity Project foundation built by CCHA and Community partners:

- CCHA partners with **Nurse Family Partnership (NFP)** to enroll Members in the right services, avoid duplicative Care Coordination and make the best use of limited resources:
  - For shared Members, CCHA Maternity Registered Nurse and NFP Care Coordinators work as a team to align efforts, identify gaps, and connect NFP Members with medical and non-medical services
  - NFP connects low-risk first time pregnant women with CCHA Maternity RN team to receive medical and non-medical services they need to have a health pregnancy and healthy baby
- CCHA partners with **Jefferson County Public Health,** including a formal, HIPAA compliant agreement to allow data sharing to identified shared Members and increase bi-directional referrals, reduce duplication of work, and increased Member engagement
- CCHA partners with **Jefferson County Human Services Department** to establish a direct referral process with WIC, resulting in a dramatic increase in Member referrals to food insecurity services
- The **Home Visitation Program Workgroup,** facilitated by CCHA to align the many, disparate home visitation programs in Jefferson County
- CCHA **Maternity Team Care Coordinators** are stationed at **Lutheran Hospital** and work as a team with the hospital's Recovery Nurse program to serve new moms and babies
- CCHA is working with the Jefferson County **Perinatal Tobacco Cessation** workgroup to educate Network Providers about providing tobacco cessation resources during the perinatal period
- CCHA Maternity Team participates in monthly meetings with Jefferson County Public Health Prenatal **Plus** to identify Members and increase bi-directional referral
- CCHA partnered with **Jefferson Center for Mental Health** and **Metro Community Provider Network** to better assess and treat women with maternal depression (CCHA and JCMH have established warm handoffs to Jefferson Center for treatment. Collectively, the group is participating in an awareness campaign and working to see that all pregnant women are properly assessed and receive appropriate follow-up treatment through education and screening initiatives.)

For the next phase of the ACC Program, our local CCHA *Plus* Colorado Opportunity Project Liaison will continue her work and serve as our point-of-contact for all of our efforts for the Project. She will be responsible for designing and implementing regional activities that align with and address the Colorado Opportunity Project Framework. With the addition of Anthem, CCHA *Plus* will have integrated PH and BH Care Coordination teams that will have a direct connection to critical maternal and post-partum depression services and **nationwide expertise in implementing evidenced based practices** that help remove roadblocks to Members economic success and self-sufficiency.

As a RAE, we want to leapfrog the Colorado Opportunity Project into the next era of integrated community health delivery systems. We will engage in disruptive innovation efforts that will pilot new approaches to enrollment in and delivery of services. We will work with community partners, especially County Public Health and Human Services Departments, to explore new ways of doing things. For example, we would like to see one lead Care Coordinator assigned to the entire family to connect them with the medical and non-medical services each family member needs based on their life stage and level of health. This combination of the Colorado Opportunity Project and 2Gen models will reduce duplication and remove roadblocks so that Members can achieve success throughout their lives. **As a RAE, we will bring our success in Jefferson County and our penchant for innovation to the Department so that together we can catapult this program to the next level of health and well-being.**

Comprehensive Primary Care Plus Program (CPC+)

CCHA *Plus* managing partner Physician Health Partners (PHP) is a strong advocate of the Centers for Medicare and Medicaid Services CPC+ model and supports 20 primary care practices that were selected to participate. We are able to leverage the expertise PHP provides to these practices. Practice Transformation Coaches work with practices across all of their lines of business, effectively creating a multi-payer coach that helps align ACC efforts with CPC+, SIM, EvidenceNOW Southwest (ENSW) and other practice transformation projects.

Additionally, in 2017, CCHA will partner with the Department to provide CPC+ Medicaid payments to participating Network Providers. CCHA Practice Transformation Coaches are already in these practices, helping them achieve project milestones, including ACC Program goals, SIM, CPC+, or ENSW.

CPC+ and SIM present new opportunities for CCHA *Plus* to connect Network Providers with our Provider Support program as well as Community resources and Health Neighborhood partners.

Community Living Advisory Group and LTSS Collaborations

CCHA *Plus* will bring valuable experience in the area of LTSS collaborations and the Community Living Advisory Group (CLAG). As a RCCO, CCHA participated in the Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP) and developed the Region 6 program alongside LTSS stakeholders to meet the unique needs of Members receiving LTSS. Anthem also brings experience working with LTSS members in other states. As a RAE, we will consider it one of our greatest successes when we are able to empower Members to self-direct their care and live independently in the community.

Through existing partnerships with the Single Entry Point (SEP), Community Centered Board (CCB), home health, hospice, and skilled nursing facility (SNF) organizations and agencies, we are in a good position to collaborate with the Department and the CLAG on changes to enhance community living options and provide feedback to the Office of Community Living. As our **Letters of Support** indicate, we have strong support from the LTSS community and Members to serve as a RAE and extensive experience working with the LTSS community. We are excited to work with the Department and the Office of Community Living to implement the CLAG recommendations.

Benefits Collaborative, Pharmacy and Therapeutics Committee, and Drug Utilization Review Board

CCHA *Plus* will lean on the expertise of our Chief Clinical Officer (CCO), who has 30+ years of experience working in Medicaid and BH to provide feedback to the Benefits Collaborative on the amount, scope, and duration of fee-for-service benefits and ensure covered services are evidence-based and guided by best practices. Our CCO will also be our lead in providing input to the Pharmacy and Therapeutics

Committee on Drug Utilization Review Board, given his extensive experience prior authorization criteria, prescribing guidelines and preferred drug lists.

Our Program Improvement (Health Neighborhood) Advisory Committee, including LTSS providers, hospitals, BHOs, CMHCs, FQHCs, local public health agencies, and other community-based organizations, will also be available to provide input on policies, understand changes to coverage and provide suggestions on how to educate providers about policy and program changes. Additionally, our Member Advisory Committee, which will be representative of regional demographics and will include Members, caregivers and families across the life stages and levels of health, cultures, and unique needs, will be available to provide input to the Department.

Utilization Management Experience and Collaboration: Nurse Advice Line and the Client Over-utilization Program

CCHA *Plus* will establish a relationship with the Utilization Management (UM) Vendor and communication channels, including a point of contact, so that we can make the best use of two key tools the Department makes available as part of the Health First Colorado Nurse Advice Line (NAL) and the Client Over-utilization Program (COUP).

As a RCCO, CCHA has engaged in an ongoing partnership with the NAL throughout the first phase of the ACC Program. CCHA promotes the use of the NAL in Member materials, on the CCHA website, in PCMP offices, and through discussions with Members. **CCHA currently receives a daily NAL data feed that allows them to see when Members have used the NAL.** A brief needs assessment is conducted to determine if there are gaps in care to be addressed. In many cases, they attempt to schedule a PCMP follow-up appointment. As a RAE, we will continue to receive the NAL data but would like to take our partnership further by establishing a direct connection between our phone line and the NAL so that the NAL can directly connect us with Members in need of RAE services. Having the data after NAL utilization has been helpful and allowed CCHA to follow-up with the Members. However, we would prefer to talk with the Member directly, after their health need is addressed by NAL (if determined not to require ER services), so that we can connect them with the follow-up services they may need. CCHA *Plus* views the NAL as a powerful tool and will make concerted efforts to promote the NAL with Members, Network Providers, the Health Neighborhood and Community, including the printing of free materials to share with Members.

CCHA *Plus* will work with the UM vendor to identify Members for participation in the **Client Over-utilization Program (COUP).** Our goal will be to understand to support the Member through Care Coordination to address identified needs. Our data and analytics team can determine points of intervention for Members enrolled COUP and track Member progress while enrolled in our Care Coordination program. We will also work closely with Safety Net Provider partners, such as the FQHCs, with whom more than 40% of previous COUP Members have been attributed in the past. Tracking and evaluating the interventions being executed by our team and partners is key to our strategy to effectively addressing the needs of Members identified for the COUP.

Health Neighborhood and Community Report

In the spirit of transparency and compliance, CCHA *Plus* will be pleased to submit the Health Neighborhood and Community Report to the Department every 6 months. This report will include the following information:

- Participation in Community efforts
- Creation of new Health Neighborhood and Community forums
- Collaboration with hospitals
- Efforts to use admit, discharge, and transfer data to improve transitions of care and results of those efforts
- Activities to engage 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
- Collaboration with hospitals on the Hospital Transformation program
- Collaboration with Local Public Health Agencies
- Activities to engage Members with evidence-based and promising practice programs in the Community to address social determinants of health, particularly those promoted by the Colorado Opportunity Project
- Identification of barriers to access of Health Neighborhood and Community resources and proposed initiatives to address the barriers
- Progress on reducing roadblocks to Health Neighborhood and Community resources

CCHA *Plus* Will Meet All Section 5.8 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR13 and 14, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.8 that are not detailed in our response.

Section 5.9

COLORADO COMMUNITY HEALTH ALLIANCE

Population Health Management and Care Coordination

5.9 POPULATION HEALTH MANAGEMENT AND CARE COORDINATION

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

As a RAE in Colorado, our approach to population health management will aim to ***improve the health of the entire population and reduce health inequities among population groups.*** To meet these objectives, CCHA *Plus* will analyze and act upon the wide range of factors and conditions that influence the health of Coloradans. We understand that each region has its own unique needs that are impacted by policies, programs, and social determinants of health within that community. Therefore, our program will include identification of social, economic, and physical environmental factors that contribute to health. Our population health management strategy will encompass a broad spectrum of interventions designed to meet ***all*** our Members' needs, wherever they may be in their health care continuum. Our interventions will be designed to engage Members to attain their individual goals and promote healthy behaviors. We recognize the impact that mental health and substance use conditions have on Members' physical health (PH) and their ability to engage in the services and supports that meet their holistic needs. As a result, we will not separate acute and primary care services from mental health, substance use disorder (SUD), and social services and supports.

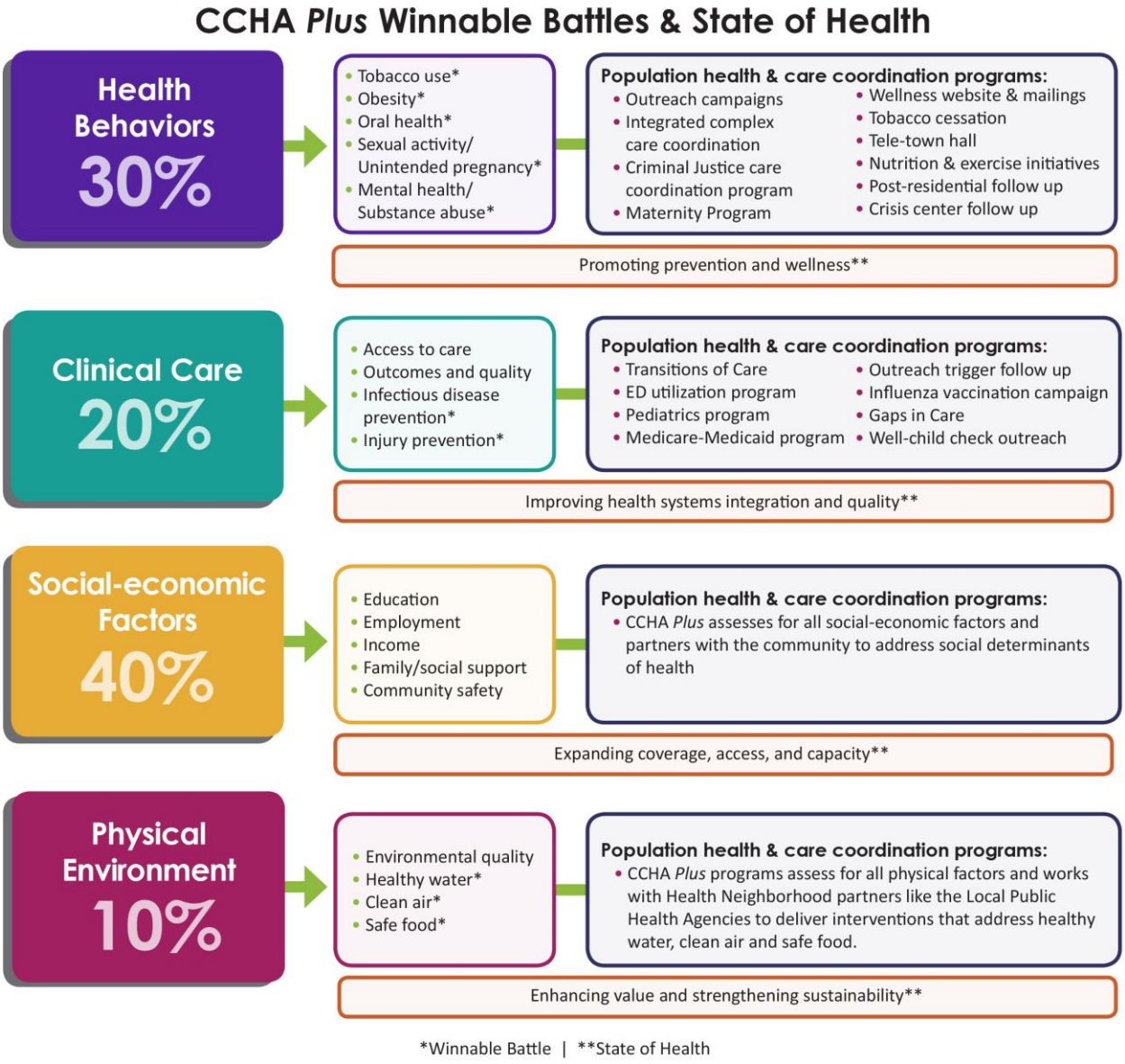
Provider Testimonial

CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their Members.
Elizabeth Clark MSN RN NCSN, School Medicaid Coordinator, Boulder Valley School District

CO_RAE_OR27_Clark_06_COB_TST_5.2

To truly improve the health and well-being of Members, we will collaborate with the Department, key stakeholders, and Network Providers to confirm that we understand the community and the overall health of the population. Above all else, ***we will listen to our Members, who drive their health care decisions*.** This will enable CCHA *Plus* to provide evidence-based, effective interventions leveraging the resources available in the Health Neighborhoods to improve health, control costs, and enhance the experience of care. As described in Figure 5.9-1, in our role as a RAE, we will use the Department's statewide stratification in conjunction with our sophisticated, proprietary predictive modeling tools to stratify the population and deliver evidenced-based interventions that align and support **Colorado's 10 Winnable Battles,** the **State of Health,** and the **Colorado Opportunity Project.**

Figure 5.9-1. CCHA Plus Winnable Battles & State of Health



Population Health Management Strategy

Community Partner Testimonial

We work closely with CCHA to provide continuity of service to our community members. Our members are well served and receive needed services much more quickly.
Lynn Johnson, Executive Director, Jefferson County Human Services

CO_RAE_OR14_Johnson03_61_COB_TST_5.1

We see our Members as unique individuals, not defined by diagnoses or conditions. We understand that Members of all ages face physical conditions that contribute to their BH needs, and have BH conditions that challenge them to fully address their PH conditions. To address Member needs, we will leverage the proven Population Health Management Model of our managing partner CCHA. It is a multidisciplinary, prevention-based, integrated care continuum-based approach to health care delivery. ***Our population health strategies will be integrated to seamlessly and holistically address community and Members' needs and build on statewide stratification to incorporate regional, county, and community differences.*** Because population health improvement requires action on multiple fronts — including medical care, health behaviors, and the social and physical environments — we recognize the importance of collaborating within the Health Neighborhood and Community to achieve improved outcomes. As discussed in OR 13/14, CCHA *Plus*, through our managing partner CCHA, will build upon a solid foundation for the Health Neighborhood and extensive experience coordinating and collaborating with Community partners to make sure Members are connected to the appropriate medical and non-medical resources in their communities.

We will work with the Department and stakeholders to develop a statewide stratification framework for the Accountable Care Collaborative Program (ACC Program) evaluation and to facilitate Members' transitions from one RAE to another. ***We will augment the State's stratification with internal predictive modeling tools to delve deeper and further customize our approach and interventions.***

The CCHA *Plus* population health management strategy we will deploy will delicately balance general population trends and individualized Member trends. It will rely on data from our predictive modeling tool, using data sources from enrollment files, claims, Care Coordination software, and enabling us to formulate a population view of patterns that are likely to impact individual Members. As Members move between levels of intervention and their needs change, our Provider Support team will continuously provide consultation, direction, and support to make sure they are successful. Our program will include health promotion and wellness resources for all Members, as well as complex Care Coordination for those with higher or more complex needs.

Our Population Health Management Strategy will focus on engaging Members, coordinating with Network Providers, and collaborating with local organizations to deliver a comprehensive set of medical and non-medical resources customized to each community's unique needs, population health conditions, life stages, and circumstances. We will capitalize on the resources of Health Neighborhood and Community partners such as local public health agencies to deliver health promotion and education services, as well as key Community organizations like the Action Center, Family Tree and Senior Resource Center to connect Members with non-medical resources. By collaborating with Health Neighborhood and Community partners, we will create the opportunity to develop a Population Health Plan that addresses health inequities and disparities in the Region and makes best use of scarce resources while reducing duplication and waste.

Key to Our Population Health Management Strategy: Understanding the Region's Population

In their role as a RCCO, CCHA has been collaborating with the State, Colorado Department of Public Health and Environment (CDPHE), and local public health agencies to understand their population and promote the health of local communities and populations. As a RAE, CCHA *Plus* looks forward to

furthering this partnership and collaboration. We will leverage data, such as the Colorado Health Assessment and Planning Systems (CHAPS) tool, Colorado Health Information Dataset (CoHID), Behavioral Health Factor Surveillance System (BRFSS), and the Colorado Health and Environmental Data portal, to inform our health assessments and Population Health Management planning. These and other data will help drive our collaborative efforts with Communities to address Members' unique health and wellness needs and deliver interventions to optimize the PH and BH of Members at all life stages and levels of health.

The CHAPS provides indicators on a variety of health, environmental, and social topics, and is extremely helpful in understanding the disparities and inequities within each Colorado county. As a RCCO, CCHA has used CHAPS data to target interventions and community outreach. For example, the data shows that in Region 6, there is a higher obesity rate than the State average. With this data, CCHA was able to focus one of their Population Health Management interventions on obesity, a statewide priority. ***CCHA used mapping software to identify a school with a high number of Members and collaborate with school administration to set up an educational outreach program to promote the importance of exercise and healthy food and drink, encourage well-child checks, and work with school leadership to create*** meaningful incentives.

As the RAE, CCHA *Plus* will build on that strategy to address the region's specific needs and collaborate with the local public health agency and other Health Neighborhood and Community organizations, such as the Early Childhood Center, schools, and food venues, to create customized interventions to combat the obesity rate there.

Jefferson County has a higher rate of low birth weight babies than the statewide average. To address this, CCHA created a specialized Maternity Care Coordination program for early identification of new pregnancies using the Department's maternity list and deployed their maternity specialized Care Coordination to outreach Members. ***Through CCHA's work on the Colorado Opportunity Project and their Maternity Care Coordination team, they connect pregnant women with LPHA services, such as Baby and Me Tobacco Free and programs like Nurse Family Partnership or Prenatal Plus.***

Multifaceted Approach to Risk Assessment and Stratification

Risk assessment and stratification processes are integral to our Population Health Management Model and will build upon the Department's overall stratification framework. CCHA *Plus* will use multiple data sources to identify and stratify Member risk initially and on an ongoing basis. Our sources will include enrollment and demographic data and Health Needs Survey results provided by the Department; results from our internal risk stratification and predictive modeling tools; claims history; and referrals and feedback from Members, family, Network Providers, and internal staff, such as Member Services and Utilization Management employees. We will also continue to use the risk scores from the BIDM to identify high-risk Members for timely and proactive outreach, and targeted interventions.

We will supplement the State's stratification system with our internal Chronic Illness Intensity Index (CI3) and other predictive modeling programs (described below) to proactively risk adjust Members and identify opportunities to assist them – and Providers – whether it is facilitating access to care, education about benefits and services, identifying additional community supports, or identification for Care Coordination and disease management. Our multifaceted approach will help ensure we determine the most appropriate level of outreach and support. A crosswalk of stratification levels and examples of major interventions we will have available for each level is provided in our Population Health Management Plan, attached as Attachment 5.9-1.

We will use the National Council for Community Behavioral Healthcare's 4-quadrant model, a clinical integration model that stratifies the level of interventions needed for Members based on their BH and PH risk status:

- Quadrant 1: Low PH risk/complexity and low BH risk/complexity
- Quadrant 2: High BH risk/complexity and low PH risk/complexity
- Quadrant 3: Low BH risk/complexity and high PH risk/complexity
- Quadrant 4: High PH risk/complexity and high BH risk/complexity

We will run our stratification model at least annually and as required by the State to capture changes to Member risk levels.

To determine what interventions and resources should be offered to Members to reduce risk and improve health, we will stratify them into these 4 quadrants. Quadrant 4 Members with both high PH and BH risk/complexity will be considered highest risk, while Quadrant 2 and 3 Members with either high PH or BH risk/complexity alone will be stratified as medium risk. Quadrant 1 Members, who are low risk/complexity for both PH and BH, will be considered at the lowest risk.

Corresponding interventions will be tailored to Member needs and preferences, based on several factors, such as presence, number, and type of chronic illness; analysis of diagnostic codes; Member and Care Coordinator feedback; and claims data. We will adjust levels based on a Member's recent hospitalization or ER visit, and any data received from electronic medical records. In addition, we will maintain real-time triggers to determine when a Member may need more or less intervention, based on risk levels. These triggers may include indicators of worsening/changing conditions (for example, a recent ER visit, a pregnancy, or a new diagnosis of depression). Other indicators for BH risk may include Members with a chronic disease who are late refilling required daily medications, failure to attend a PCMP or specialist visit or not attending one within 6 months, or indicators of worsening social status (such as evidence of new homelessness).

Adam's Story: Improved Communications and Coordination of Services

Natalie, our Care Coordinator, identified six-year-old foster child, Adam, through our predictive modeling tool. He was in crisis in the ER after threatening to kill his foster sibling. Diagnosed with disruptive mood disorder, ODD, ADHD, and impulsivity, Adam has had four inpatient psychiatric admissions in the last year, has ongoing outpatient therapy for children with special needs, and is case managed by a city agency. Natalie arranged a call between both organizations' medical directors to coordinate how to help this little boy and make sure he didn't fall through the cracks. Adam now receives behavioral health therapy in his home and has had no readmissions in the last month.

Anthem Member Centered

CO_RAE_OR16_Adam_34_COB_RS_2.2

CCHA *Plus* Predictive Modeling Tools

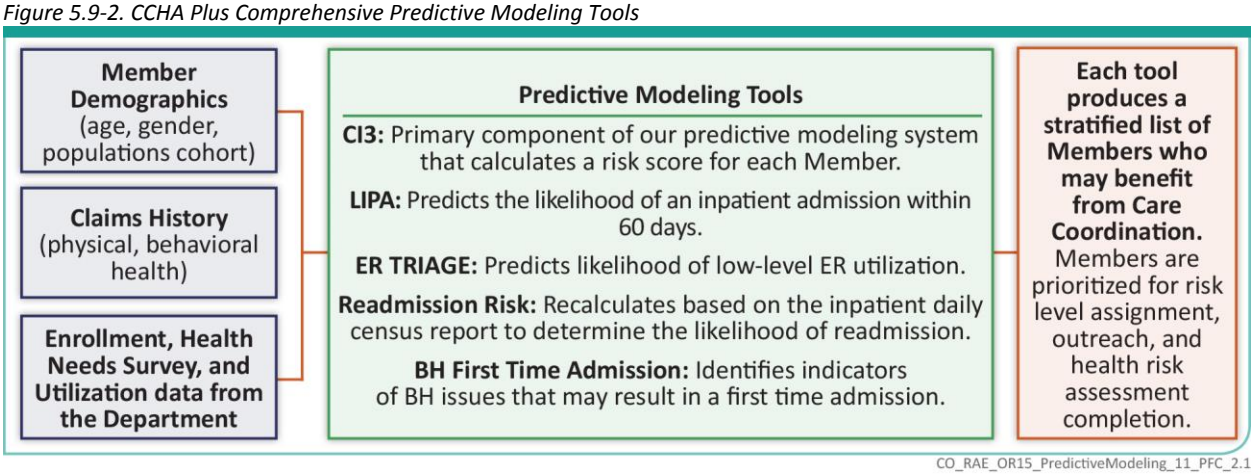
Our predictive modeling tools will enable us to identify individuals with the highest risk levels and proactively coordinate their needed services and supports to achieve optimal outcomes. With this data, we can calibrate solutions, tracking changes in Member risk levels over time to monitor response to interventions. For example, CCHA *Plus* will use data analytics to identify Members at risk for a ***first-time BH admission (FTA)*** and help them access services they need, such as housing, transportation, Care Coordination, and pharmacy to avoid an imminent admission. ***Through our managing partners' experience, we have learned that at-risk Members engaged this way are twice as likely to avoid a BH admission*.**

Other predictive modeling tools we will use include our **CI3 tool** to identify individuals at highest risk and coordinate the services and supports they need to reduce their risk level and achieve optimal outcomes; and **Likelihood of Inpatient Admission (LIPA),** an index that prioritizes Members for outreach by predicting the probability of an inpatient re-admission.

The CI3 is the primary component of our proprietary predictive modeling system, which synthesizes data to indicate a Member's overall illness burden and develop an individualized risk profile. It is based on the Johns Hopkins Adjusted Clinical Groups® Predictive Risk Scoring Model. It includes diagnosis, demographics, hospitalizations/readmissions, ER visits, over- and under-utilization of services, and expenditures.

In addition to the CI3, CCHA *Plus* will implement additional predictive modeling tools, illustrated in Figure 5.9-2, which will also generate risk scores to stratify the Member's risk level, prioritize outreach and assessment, and determine the level of interventions needed. Through our Continuous Case Finding process, we will mine data each month to identify and prioritize candidates for Care Coordination. This process begins each month with a review of all eligible Members from the previous month. We recognize that the status of Members' PH or BH risks and needs will fluctuate throughout their enrollment. We will generate monthly risk profiles for each Member and use our Care Coordinators' sound clinical judgment to identify changes in status and meet Members' changing needs swiftly.

Figure 5.9-2. CCHA Plus Comprehensive Predictive Modeling Tools



Other Methods to Identify Members for Interventions

We know that the human factor is one of the most important elements in engaging Members in healthy behaviors and self-care. Our programs will connect people to collaborative and coordinated whole-person care individualized to our Members' conditions. Through our ***no wrong door*** policy, Members and caregivers can contact any CCHA *Plus* employee and request placement in a Care Coordination program.

Members will be identified for our programs and interventions by a variety of sources in addition to our multi-faceted data analysis and self-referrals. This proactive approach will enable us to intervene quickly and engage Members in the level of support they need to achieve positive health outcomes and enhanced quality of life. CCHA has built strong relationships with Health Neighborhood Providers and the Community and current Care Coordination referrals come from these various sources. As an ACC Program RAE, CCHA *Plus* will continue to accept referrals from these and the following sources:

- Providers
- CCHA *Plus* Community Resource Experts, and other internal employees from Utilization Management, Care Coordination, or Grievances and Appeals
- Disease management referrals
- Health information lines, including Colorado's Crisis Support Line and Nurse Advice Line
- Hospital staff, including discharge planners and social workers
- Community/social service organizations and agencies
- Direct referrals from the Department or other State agencies

We will welcome all requests and referrals – regardless of risk stratification score – and will promptly assign a Care Coordinator to schedule an in-depth assessment. Based on assessment findings, we will assign the Member to a Care Coordination program, as appropriate.

Identifying Members for Care Coordination and Priority Outreach Comprehensive Health Risk Assessment

Using the methods detailed above, and leveraging data from the Department's Health Needs Screening, we will identify Members with complex conditions, specialized health care needs, or frequent ER use. As further detailed in OR 16, these Members will be assigned a local, Lead Care Coordinator with expertise aligned with their needs and knowledgeable about the unique services and supports they need. The Lead Care Coordinator will reach out to the Member and family, telephonically and in person when appropriate, to complete an in-depth Health Risk Assessment (HRA) and develop an individualized care plan based on the results. ***Initial HRAs will be completed within the first 30 days of engagement with Care Coordination and acceptance of the Care Coordination program by the Member.***

Care Coordinators will understand and be sensitive to our membership's diversity. All Member interactions will embody our philosophy of caring for them in a culturally competent manner, including their preferred method of education and information, in their preferred environment, and verbal and written information in their language of choice.

We recognize that the status of Members' PH and BH health risks and needs will fluctuate throughout their enrollment with us. Together with Providers, the Lead Care Coordinator is often best positioned to recognize when a Member's risk level and needs change. The Lead Care Coordinator may adjust the Member's risk level up or down, based on changes in symptoms, behavior, use of health care resources, or caregiver situation; screening and assessment results; and upon referral by the Member, family, or Network Provider.

Population Health Management Plan – Specific Interventions

CCHA *Plus* has documented our major interventions, segmented by adult and pediatric populations, in our Population Health Management Plan, attached as Appendix I. These interventions include:

- Integrated complex Care Coordination
- Wellness website
- Crisis center follow-up
- Outreach trigger follow-up
- Tobacco cessation (adults)
- Wellness Mailings
- Tele-town Hall
- Influenza vaccination campaign
- Gaps in care
- Community nutrition, exercise, and obesity initiatives
- Well-child check appointment reminders during a child's birthday month (pediatrics)
- Post-residential discharge follow-up for Child Mental Health Treatment Act children (pediatrics)

We value Member and Network Provider feedback and will elicit their review of our Population Health Management Plan through our Performance Improvement (Health Neighborhood Advisory) Committee and the Member Advisory Committee. The feedback they provide will help inform future interventions and refine our approaches. Our Quality Management Committee will perform an annual analysis of population demographics, public health data, and claims experience to ensure our interventions reflect the needs of the Members we serve. We will also review the plan annually with the

Department and submit any revisions for approval when changes are made. Upon Department approval, we will implement our Population Health Management Plan. As a part of the implementation process, we will run the stratification process in intervals no less frequently than required by the Department. We will continue to develop and refine our Population Health Management Plan to reflect the statewide stratification framework and will make certain Members are receiving the interventions as described. CCHA *Plus* will submit the stratification report to the Department quarterly, using Appendix J.

An example of a targeted intervention for each Risk Stratification Quadrant, a detailed description of our wellness website (Quadrant 1), crisis center follow-up (Quadrant 2), between visit monitoring (Quadrant 3), and integrated complex Care Coordination (Quadrant 4) is provided in the narrative below. We also describe our Gaps in Care program, which is an appropriate intervention for all Members, regardless of risk stratification.

Wellness Websites

CCHA *Plus* will offer an evidence-based Wellness Websites Intervention program targeting our adult and pediatric populations stratified as low-risk. The intervention will be part of our comprehensive Wellness and Education program, which will include options such as Member mailings, tele-health town halls, and evidenced-based Member education materials distributed through our Care Coordination programs. Through this program, we will offer Members access to several wellness and disease-based education websites that provide video and written self-management support content in English and Spanish on managing chronic diseases, such as hypertension, diabetes, and depression, as well as risk factor reduction programs on nutrition and weight loss, smoking cessation, reducing drug and alcohol use, and stress management. ***For example, our value-added benefit, Online Well-Being program, will be an evidence-based, online tool helping individuals manage their mental health conditions and modify behavioral risk factors. Our program includes web and mobile resources to help strengthen mind, body and spirit and offers personalized resources to help Members take an active part in improving their health and well-being.*** Known as "the health club for your mind," our Online Well-Being program provides Members with health education and prevention information that encourages strong connections between Members and primary care.

Wellness websites will be available on an ongoing basis. We will plan to solicit Member input on their website experience approximately every 2 to 4 months. This frequency will enable us to target most of the important risk factors and chronic conditions once a year and will regularly remind Members about the availability of these websites. If response to the campaigns begins to decrease, we will consider revising their frequency.

Wellness and disease management websites will make intervention available to a large number of our Members. It has been estimated that more than 75% of Medicaid recipients have access to a smartphone or other device that provides access to the internet. We will use campaigns to promote engagement with the website and focus it on important wellness/disease management activities.

We will track the number of Members who use the available websites and their frequency of usage. We will ask participating Members to complete baseline and monthly follow-up assessments using well-validated tools to assess success in reducing risk factors or improving disease control.

Crisis Center Follow-Up

CCHA *Plus* is keenly aware of the suicide rate in Colorado and we will collaborate with organizations focusing on suicide prevention. Based upon recent work with the Zero Suicide Institute and the National Action Alliance for Suicide Prevention, we know that the period immediately following discharge from a facility when one was admitted for suicidal ideation or the period immediately following contact with a

crisis team is a very vulnerable time, with high rates of death, suicide attempts, and readmissions. With this knowledge, we will implement our Crisis Center Follow-Up program.

Our Crisis Center Follow-up Program is a best practice intervention available to adult and pediatric Members who have contact with a Crisis Center. These Members are usually stratified as high BH and low PH risk. CCHA *Plus* Care Coordinators will follow-up with Members upon release from a Crisis Center. Through this outreach, we will reconnect them to their circle of care and Lead Care Coordinators. This intervention will also enable Care Coordinators to create or revise Members' care plans, if necessary.

To be effective, we will build a formal agreement and a data exchange process with the Crisis Centers so we know when our Members have requested assistance and when they are discharged from the centers. Upon crisis resolution, our efforts will support the discharge plans created by the Crisis Center. We will collaborate with the Crisis Center by assigning a Care Coordinator appropriate to the Member's needs and geographic region. This Care Coordinator will stay in contact with the Member for a minimum of 72 hours, or longer if indicated by the Member's condition and compliance with the prescribed discharge plan. The goal of this intervention is to make sure the Member is engaging with the provided after-care plan, as well as reconnecting to their circle of supports. The Care Coordinator will also reconnect the Member to their PCMP to facilitate closing all gaps in care.

CCHA has long-established partnerships with the Region's CMHCs, Jefferson Center for Mental Health and Mental Health Partners, which serve as Region 6 crisis system Providers. These partnerships include established arrangements with the CMHCs to coordinate follow-up care for Members accessing the crisis system. As a RCCO, CCHA has faced significant challenges helping Members in Clear Creek and Gilpin counties access these services. As a RAE, CCHA *Plus* will work to expand BH options by building a stronger independent Provider Network that can render services that complement the 2 CMHCs in the region.

Outreach Triggers

Our Outreach Triggers program is an evidence-based intervention that will target our adult and pediatric populations stratified as low BH risk and high PH risk. We will use data from a variety of sources, including member eligibility, claims feeds, BIDM, pharmacy data, and referrals from Providers and Community partners for specific outreach requests to trigger identification of PH and BH and will adapt the triggers to align with population health issues identified in the data and/or changing needs of the ACC Program. Members who might require outreach by one of our Care Coordinators include experiencing the following triggers:

- Unscheduled hospital admissions
- More than 2 ER visits within 3 months
- New pregnancies
- Newly diagnosed depression as determined by a diagnosis code or new start on a selective serotonin reuptake inhibitor (SSRI) medication
- Imminent release from the criminal justice system
- Targeted chronic illnesses such as CV, COPD, and asthma

All identified Members will receive outreach calls, and a structured phone assessment will help identify opportunities and barriers to addressing these problems. Members with potentially more serious or complex triggers, including a hospital admission, homelessness, or new depression diagnosis will receive face-to-face visits. These interventions have been designed to reduce hospital readmissions and ER visits, improve pregnancy and depression outcomes, enhance medication adherence, and address a significant social determinant of health.

Integrated Complex Care Coordination Program

Our Integrated Physical Health and Behavioral Health Care Coordination program is a promising practice that will target our adult and pediatric populations stratified as both high-PH and BH-health risk. We understand that behavior heavily influences activities such as medication adherence and adoption of healthy behaviors, including prescribed meal plans and exercise schedules. The Integrated Complex Care Coordination model will enable us to holistically identify and address our Members' needs. For our Members who live with ***co-occurring BH and chronic medical conditions*****,** we will use integrated screening processes and the individualized care team model. Whenever more than one Care Coordinator is involved with a Member, we will designate a single point of contact to lead coordination based on the Member's primary treatment needs. This will enable us to complete a whole-person assessment and facilitate continually evolving, integrated support processes that emphasize Member engagement and education, facilitate lifestyle change, and promote personal resiliency as the foundation of improving health and quality of life.

Members with complex BH and PH co-morbid conditions will work collaboratively with an assigned lead Care Coordinator to establish meaningful goals and develop a tailored plan of care to address and prioritize health-related concerns identified by them, their families/caregivers/significant others, and Providers. The lead Care Coordinator will communicate with the Member, Provider, and any other Care Coordinators conducting routine follow-up communications and tracking progress toward meeting goals. The Complex Care Coordination program will encourage Member education and self-care, using empowerment techniques centered on motivational interviewing and meeting Members where they are in their care and recovery for both PH and BH conditions.

To effectively coordinate services for Members with high PH and BH risk/complexity, we will co-locate Care Coordinators in the community, and in the same office, to function as one, integrated, cohesive team. At least monthly, during join case rounds, our PH and BH clinical staff will discuss whether those Members stratify as high risk/complexity. The lead Care Coordinator may elect to discuss these Members more frequently if it is beneficial to the Members.

Gaps in Care

Our Gaps in Care program will follow recommendations of the United States Prevention Services Task Force (USPSTF) and will be geared at reminding our adult and pediatric populations that have been identified as not receiving services pursuant to recommended clinical guidelines. Our Gaps in Care program will focus on goals identified by the ACC Program and appropriate for ***all risk levels*** of Members. To achieve these goals, we will deploy 3 strategies to close clinical gaps:

- Our Practice Transformation team will work with the assigned PCMP to conduct outreach to Members and make sure the care gaps are addressed when the patients are seen in the practice. In addition, we will share gaps in care reports and practice level key performance indicator (KPI) reports with the PCMPs to educate them on their population's overall health outcomes and identify those who have not been seen.
- Our Care Coordination team will proactively screen for gaps in care for all Members enrolled in one of our many Care Coordination programs. The Care Coordinators will work with Members to educate them on importance of receiving recommended care, assess barriers to seeking care, and assist as needed to resolve them.
- We have population health management tools that will have the ability to reach large targeted Member subsets, such as auto-generated mailings and scripted interactive voice recognition (IVR) calls. By deploying a combination of strategies, we will be able to reach a larger audience, track gap closures, and direct Care Coordination follow-up support if gaps in care are not addressed within a specified time frame.

Monitoring and Tracking the Delivery of Population Health Interventions

Our ability to continually assess and refine effectiveness of our Population Health Management model will be supported by our close collaboration with State partners and Community-based organizations that are the backbone of local community health and psychosocial services.

Our Population Health Management Plan will be developed by a multidisciplinary team of BH and PH professionals, Provider support staff, and clinical analysts. Once it is drafted and approved by the State, we will solicit input from our Member Advisory Committee and Performance Improvement (Health Neighborhood) Advisory Committee to help identify priorities, target interventions, and provide feedback in ongoing evaluation of the program, plan, and interventions. The Quality Management Committee will provide oversight, and on a quarterly basis, our Chief Clinical Officer will monitor activities identified in the annual Population Health Management Plan. Each program area leader will be responsible for improvement activities and will regularly report performance, noting any period-over-period trends and needed mitigation strategies. In addition, we will provide a copy of the plan to Network Providers, who will be represented on the Performance Improvement (Health Neighborhood) Advisory Committee.

Delivery of Population Health interventions for Members who have been stratified as High Risk/ Quadrant 4 will be monitored and tracked through our Care Coordination program, as further detailed in OR 16.

CCHA *Plus* will drive improvements in quality and health outcomes. As detailed in our response to OR 14, our strategic community collaborations will further support focus on prevention and help us implement solutions that address social determinants of health and reduce disparities. Our Quality Improvement program will serve as a central source of quality data, coordination, and performance improvement. We will leverage data, engage and support Providers in optimal delivery of care, and encourage Members to take increased responsibility. As detailed in our response to OR 17, we will also initiate an extensive array of value-based incentive programs that reward Providers for efficiencies and improvements in quality of care in areas important to the health of our Members and that align with Colorado's health priorities.

CCHA *Plus* Will Meet All Section 5.9 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 15, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.9 that are not detailed in our response.

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.

As a RAE, CCHA *Plus* has a pivotal opportunity to combine physical health (PH) and behavioral health (BH) Care Coordination efforts into one total health care coordination system providing whole-person care. We will continue to evolve CCHA's programs, which are tailored to meet the individual needs of all Members, including Members with nursing facility needs, end of life care, intellectual and developmental disabilities (IDD), and substance use disorders (SUDs). ***Our philosophy is to remain nimble, adapting to the changing needs of the Members and Providers, as well as the changing expectations of the Department.***

As discussed in OR 15, our Population Health Management Plan provides customized interventions for Members across the full continuum of care delivery and in all life stages. As part of the ACC Program, we will collaborate with the Health Neighborhood and Community to connect Members with services to promote health and address social determinants of health. For Members that require Care Coordination, our integrated services will range from coordinating whole-person care in the community and Member engagement in the home, to fully co-located and integrated Care Coordination at PCMP and BH offices; and in hospitals, Crisis Centers, and other community locations. We will also collaborate with Network Providers, local public health and corrections agencies, child welfare, and Long-Term Services and Supports (LTSS) to work as a community-based health team and avoid duplication.

Gina's Story: Coordinated Care for Individuals and their Families

At 33, Gina is new to Colorado and has diagnoses of a seizure disorder, fetal alcohol syndrome, epilepsy, cerebral palsy, anxiety, and depression, and she has a great fear of needles resulting from being abused as a child. Now in her first trimester, Gina expressed her wishes to change PCMP, neurology and OB providers to our Care Coordinator, Maggie, and to connect with a BH provider. Understanding her concerns and wishes, Maggie dedicated herself to supporting Gina to reduce her fear of needles, communicate her needs to her providers, and develop a birth plan. So acting as her advocate, she accompanied Gina to 11 provider appointments, 3 blood draws, and 8 care conferences.

Together, they worked with her providers to discuss Gina's fears/trauma that could have had a significant impact on her delivery. Gina was able to have a natural delivery, did not experience a seizure during birth, and gave birth to a healthy baby boy, Sean.

Due to her severe trauma, Gina was having issues with taking Sean to his doctor visits. They set up a care team for Sean with no male providers and Provider-Extender visits, so Gina could get to know the provider and the collocated therapist. Through the Nurse Family Partnership Program, Maggie also arranged for Christine, a BH Specialist, to meet with Gina in her home weekly. Gina also was connected with a Precious Child and WIC and received a new car seat through Drive Smart and diapers through Haven's Hope.

Gina has successfully attended appointments with her and Sean's doctors and continues to meet with Christine weekly. ***Through person- and family-centered care coordination, support, and a caring approach that reflects her preferences, Gina has been surrounded with resources and feels confident in raising her son in a loving, nurturing, and safe environment.***

CCHA **Member Centered**

CO_RAE_OR16_Gina_20_COB_RS_3.3

As a RCCO, CCHA has developed a program-based model to address the Department's priorities and impact the prevalent health conditions in Colorado. For example, CCHA created a specific Medicare-Medicaid Program (MMP) team to focus on the dual-demonstration project. They also developed specific programs to support maternity Members to complement the Colorado Opportunity Project.

CCHA *Plus* will enhance and build upon these and other Care Coordination programs and activities, leveraging the national resources and experience of our partners. ***Our Care Coordination interventions meet — or exceed — State, federal, and Statement of Work requirements.***

We acknowledge that Members and families have unique and specialized needs based on their unique life circumstances, level of health, and stage of life. To meet these needs, we offer a range of deliberate activities to organize and facilitate the appropriate delivery of health and social services. Our Care Coordination Model is program-based and tailored to meet the specific needs of the populations we serve. These programs are designed to support our Population Health Management Interventions and include:

- Integrated complex Care Coordination
- Transitions of care/post discharge management
- Emergency room (ER) outreach
- Maternity
- Pediatrics
- Medicare-Medicaid Program
- Rising Star – BH program
- Criminal Justice program
- Opioid Management program
- High intensity integrated team

a. Design, Deliver, and Track Care Coordination Activities Across the Full Continuum of Care

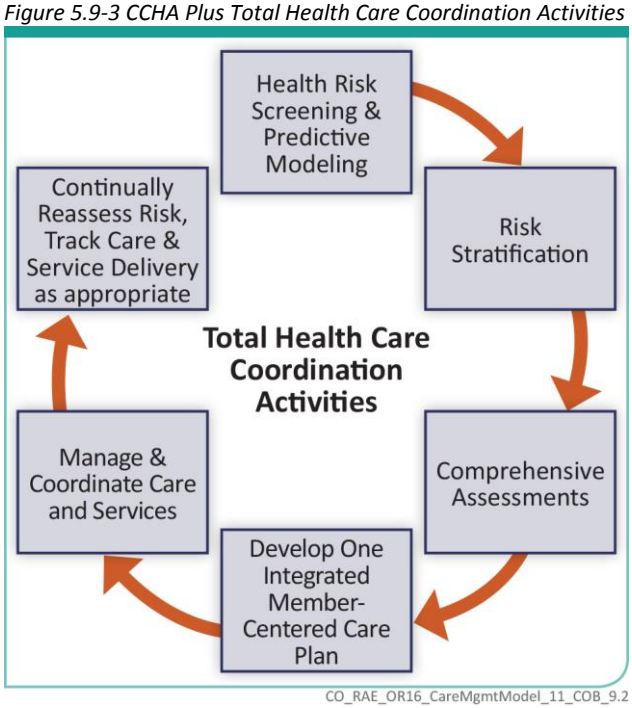
To support integration across the full continuum of care, our Care Coordination activities will be based on a solid understanding of the medical, behavioral, social, and environmental needs of our population — the result of recurring and comprehensive data analysis. With this information, we will develop and offer programs to meet our Members' needs across the full continuum of care. By developing programs that are Member-led and integrated with providers, we will support our Members — no matter where they are on the care continuum. Our Care Coordination activities will focus on:

- Improving Member experience and health outcomes
- Identifying underlying BH needs in Members through whole-person care
- Assuring those with Serious and Persistent Mental Illness (SPMI) have support and access to behavioral and medical services
- Targeting and proposing interventions for Members at risk of complications due to behavioral and psychosocial needs
- Preventing exacerbations of medical and BH issues
- Decreasing costs by supporting Providers' efforts to offer effective, whole-person care for Members
- Supporting Members in managing their health and wellness.
- Embracing the principles of recovery and wellness

We believe this integrated approach is crucial to improving Members' quality of care and outcomes while proactively managing costs and emphasizing Member choice, access, safety, independence, and responsibility through active engagement, communication, and coordination.

The CCHA *Plus* Care Coordination System (CCS) programs will support each Member's unique needs, service preferences, and health care goals. As CCHA does now, we will proactively identify and integrate comprehensive services for Members with, or at risk for, complex conditions, as well as those in need of preventive and wellness services. As detailed in our response to OR 15, our Population Health model stratifies Members based on their health status, identified risks and needs, and use of health care resources to match the appropriate intensity of Care Coordination support needed. Our Care Coordination activities require a total health team to support Members on their journey towards health and wellness. CCHA *Plus* Care Coordination activities, illustrated in Figure 5.9-3, will be wrapped around our Members and applied across the continuum of care.

Figure 5.9-3 CCHA Plus Total Health Care Coordination Activities



Designing Care Coordination Activities

Our unique program-based model puts the Member and family at the center of care and tailors the interventions to their specific needs ***regardless of the complexity of their health care needs*.** Our Care Coordination activities align with and support our Population Health Management Plan, are accessible and provided at the point of care wherever possible, and are designed to:

- Address the Member's short- and long-term total health needs
- Support the Member's goals in a culturally and linguistically appropriate manner that promotes Member choice and preference
- Facilitate, communicate, and coordinate across all systems and with all Providers involved
- Seamlessly link Care Coordination activities across multiple systems of care to prevent duplication (such as through LTSS and Home and Community Based Services (HCBS) waivers and other programs for special populations)
- Work with the Member and their care team to identify a lead care coordinator (as detailed further below) for those Members receiving Care Coordination across multiple systems and for co-occurring physical and behavioral health conditions
- Empower the Member to increase engagement in their health and well-being
- Encourage Members to engage with their Primary Care Medical Provider (PCMP) and BH provider, if applicable, and provide Care Coordination at the point of care whenever possible
- Advocate for Members to protect their privacy and see to their access to services
- Bridge the gap between Members' medical needs and non-medical (social, spiritual, educational, and developmental) needs by connecting them to their Health Neighborhood and Community resources

All of our programs are data-driven to streamline and tailor Member care across the various settings serving our Members and use resources wisely. Additionally, we will conduct analytics and supply reports to Providers to help them provide better care to Members.

We have designed Care Coordination programs that will address the diverse and complex needs of the Colorado Medicaid population. As the membership and needs have expanded in the ACC Program, CCHA has modified, enhanced, and supplemented these programs. One example of how CCHA programs are responsive to the evolving needs of the ACC Program is the Criminal Justice Program, which was created in 2016. The program provides Care Coordination wraparound support for justice-involved Members, including parolees of the Department of Corrections prison systems; Members statutorily discharged but not on parole; and those involved with county jails and judicial districts, on probation, involved in pre-trial and diversion programs, or living in community corrections and halfway or transitional housing. ***Goals of the integrated Criminal Justice program include addressing all of the physical, behavioral and social needs of this population, supporting timely access to care, reducing recidivism, improving ER use, and enhancing quality of life for this population.***

CCHA *Plus* will continue to refine these programs as a RAE and incorporate the BH organizational functions into our Care Coordination activities. This work will allow us to expand on existing programs and develop additional programs to meet the PH and BH care requirements of the ACC Program, thereby improving outcomes and our Members' experience, while becoming more cost-effective.

Reggie's Story: Person-Centered Care through Coordinated Services

After spending the last 10 years incarcerated, Reggie needed support in navigating provider and community resources and completing tasks using processes that were new to him. Based on Reggie's preferences noted in the Care Coordination Consent and Questionnaire form, Kiera, our Care Coordinator, reviewed available PCP clinics in the Boulder area, scheduled a new patient appointment with Rocky Mountain Urgent Care and Family Practice, completed a Non-Emergency Medical Transportation certification, reserved his first ride, and communicated this information to Crowley County's case manager and Boulder Community Treatment Center (BCTC) staff.

After Reggie's release, Kiera confirmed that he successfully connected with the PCMP, and collaborated on a care plan during a face-to-face visit to identify his needs which included dentistry, optometry, and a local recreation center. They also addressed Reggie's questions and concerns about his medications, knee pain, and nutrition, and Kiera encouraged Reggie to raise these issues with his PCMP at his 1-month follow-up visit. Kiera also coordinated with the PCMP office to ensure medication continuity.

Reggie attended his initial and follow-up visits with his PCMP and dentist, has obtained approval to go to the rec center 3 times per week to manage his high blood pressure, and received information from Kiera on community resources such as services provided by Emergency Family Assistance Association and local Christian churches. Kiera continues to coordinate with the county case manager, BCTC staff, and Reggie's PCMP to provide person-centered care and avoid duplication of services.

CCHA **Member Centered**

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At the center of the CCHA *Plus* CCS design is our commitment to retain Care Coordinators with expertise in specific areas that match the unique needs of the Members we serve. These Care Coordinators are trained to meet the Department goals as ACC Program needs evolve, such as correctional care and care for those with SPMI and serious emotional disturbances (SEDs). We are excited to bring Anthem's broad and effective experience in managing PH and BH services and will expand our Care Coordination talent to bring additional local Care Coordinators with deep experience in serving Members with behavioral health needs. As a RAE, we have a pivotal opportunity to combine PH and BH Care Coordination efforts into one total health care coordination system. CCHA *Plus* will capitalize on this opportunity and seek to partner with independent BH providers and CMHCs to incorporate local providers into the health team.

We will provide ongoing training and support, so that each Care Coordinator has the appropriate level of confidence to provide Care Coordination services in a specific setting or system and collaborate to plan transitions, coordinate services, and address Member issues or concerns. In addition to training specific to their area of specialty, each Care Coordinator will also receive training regarding how to effectively identify and integrate appropriate PH and BH services.

Our model allows us to effectively support the relationships between Members and all of the Providers in their Health Neighborhood, including primary care, BH, hospitals, specialists, LTSS, community resource partners, and other organizations engaged in a Member's health, such as counties, child welfare agencies, homeless shelters, food banks, and correctional systems. Our programs will assign a ***single point of contact*** to Providers throughout the health care system, which will help align communications and interventions to consistently meet needs in a person-centered and timely way.

Delivering Care Coordination Activities

Health Risk Screening & Predictive Modeling

As illustrated in Figure 5.9-1, and described in the OR 15 narrative, we will start the process of delivering our Care Coordination activities by in-depth analysis of the Department's Health Risk Screening results, together with our internal predictive modeling tools. Additional information analyzed will include sources such as the Business Intelligence and Data Management System (BIDM System); claims; information from Providers, hospitals, and community agencies; and referrals. We embrace a ***no wrong door*** approach to referrals and receive them from a variety of sources, including self-referral, families or caregivers, Providers, and our Member-facing staff. In addition to referrals, we will continually monitor Members for inclusion in CCS programs through our continuous case-finding tools. Specific triggers for Care Coordination include:

- Four Quadrant Risk Classification (described further in our response to OR 15 and below)
- Inappropriate or high use of health resources, such as ER
- Re-admissions to the hospital or other facility
- High total cost of care
- High-risk chronic diseases
- Multiple co-morbidities
- Children involved in the child welfare system – CMHTA
- Involvement in the criminal justice system
- Medicare-Medicaid Program enrollees
- Non-adherence to a treatment regimen
- Complex medical issues or treatment plans
- Impaired mental status, such as Members with dementia
- Members with insufficient support systems or community resources
- Pregnancy
- SPMI
- SED
- Chronic substance use disorder

Alyssa's Story: Collaborating Services to Meet Complex Health Care Needs

Alyssa was adopted as a toddler after experiencing severe abuse from her birth parents, and she has a seizure disorder, fetal alcohol syndrome, and a low IQ. She demonstrates aggressive behaviors, rages, and has a history of running away. Her complex medical and psychosocial needs often interfere with her functioning at home, at elementary school, and in the community.

Our Care Coordinator, Ava, first met Alyssa and her family at a care conference with multiple agencies and providers in attendance. Her family had requested out-of-home respite care every other weekend. The Developmental Disability Resource Center (DDRC) sent a request for services to nearly 100 contracted providers, but they were unsuccessful. During the care conference, Ava agreed to assist with finding respite care services and to provide care coordination for the family. Kathy, Alyssa's mom, also expressed a desire for advocacy – someone to work alongside her to advocate for her daughter when Kathy felt she wasn't being heard by all the professionals or they weren't communicating with one another. So Ava became the coordinator of the coordinators, helping the family navigate the complexities of multiple systems, eliminating confusion, and reducing their stress.

Ava collaborated with DDRC to contact 75 providers and found one that could meet Alyssa's complex needs – much to the relief of her family. While Kathy explored out-of-state residential placement, Ava explored alternative treatments and collaborated with Alyssa's psychiatrist, who recommended a special program at Children's Hospital. Over her 14-day stay, Alyssa experienced medication changes, and new behavioral techniques were recommended and implemented in all areas of her life – home, school, and therapy. Through this collaboration, Alyssa had her needs met. As a result of Ava's close coordination and collaboration with the family, multiple agencies, providers, and her school, all are working in concert to meet Alyssa's needs, and her family is experiencing the positive effects of these Wraparound Services.

CCHA Member Centered

CO_RAE_OR26_Alyssa_15_COB_RS_1.4

- Residential care
- Crisis Center services
- Newly diagnosed chronic conditions
- First psychosis diagnosis
- Homelessness
- Polypharmacy

Through these methods and triggering events, we will identify Members who may benefit from Care Coordination upon enrollment and throughout their time with CCHA *Plus*.

Risk Stratification

Based on our predictive modeling process, we will stratify Members into risk groups, with each matched to an appropriate level of Care Coordination and interventions, as described in OR 15. As part of this process, we will collect information to help Providers and our clinical team support Members, which includes:

- Demographics: Name, Member ID, phone, age, ethnicity, gender, county, and ZIP code
- Clinical severity: CI3 Risk Score, Risk Group, rank within Risk Group, and disease cohort
- Names of Network Specialty Providers, BH Providers, and community agencies that may be involved with the Member
- Specific chronic, manageable conditions within each Chronic Illness and Disability Payment System disease band
- Utilization data, including summary data for ER, PCMP, specialist visits, and inpatient admissions for each of the prior 6 months
- Current Care Coordination information, including intensity level and case status

At least annually and as requested by the State, we will review the past 12 months of claims data and consider historical information, including diagnosis and demographics, to predict possible future risks and Care Coordination needs. The output of our predictive modeling incorporates both clinical and non-clinical data and stratifies each Member in one of the National Council for Community Behavioral Healthcare's 4 Quadrants:

- Quadrant 1: Low PH risk or complexity and low BH risk or complexity
- Quadrant 2: High BH risk or complexity and low PH risk or complexity
- Quadrant 3: Low BH risk or complexity and high PH risk or complexity
- Quadrant 4: High PH risk or complexity and high BH risk or complexity

We will use this framework to stratify Members based on need and identify the CCS programs that would benefit the Member most. Once Members are identified as potential candidates for Care Coordination, we will reach out to conduct a comprehensive Health Risk Assessment to determine the level of care needed.

For Members in active Care Coordination, we will analyze risk adjustments monthly to re-assess risk levels and adjust as necessary. This assessment will provide us a refreshed stratification of the Member population at the start of each month.

Comprehensive Assessments

Our goal is make sure Members are receiving the right care, at the right time, and in the right setting to eliminate duplication, over-utilization, and encourage better outcomes. Our Care Coordinators will have extensive training in performing comprehensive assessments to screen for physical, behavioral, and social determinants of health. Using evidenced-based assessment tools, Care Coordinators will assess for factors ranging from fall-risk and depression to SPMI and SUD.

Our Care Coordinators will evaluate acuity by assessing the following factors:

- Complexity of PH and BH needs, including single or multiple chronic conditions or co-morbidities
- Members' defined problem, needs, and goals
- Acuity and urgency of the Care Coordination needs
- Disease versus social Care Coordination needs
- Activation of clients in making changes to their health care as based on the Patient Activation Measure (PAM)
- The Member's functional, social, and financial status and needs

Leveraging CCHA's current approach and processes, CCHA *Plus* will assess and engage Members using ***evidence-based*** Care Coordination techniques, such as ***motivational interviewing*****.** During meetings with our Members and their families, we will engage in motivational interviewing to build a connection with them and make sure we listen and understand their needs. With the current CCHA program, all Care Coordinators will be trained in motivational interviewing, and they have found this approach to be central to their success in working with the Colorado Medicaid population. CCHA *Plus* will follow the "OARS" process in motivational interviewing: Open-ended questions, Affirming responses, Reflective listening, and Summarizing. As the Department has acknowledged in encouraging a Member- and family-centered approach, our Members and their families must be the ones to choose to make a change, not be forced by an external person. Motivational interviewing is useful in our engagement with Members because it helps them and their families progress from one stage of change to the next and find the drive to make changes within themselves.

As we talk with Members, we will work to build a safe and trusting relationship of mutual respect**.** We will provide them with our contact information and invite them to contact us whenever they need assistance. We know that Members may not always contact us, so we will follow up and stay in touch. It is also important to let the Member set the pace of engagement. Most often, helping a Member with day-to-day needs (for example, understanding letters about Medicaid eligibility and benefits, or even explaining letters from utility companies) helps make a connection and enables further engagement.

Develop One Integrated Member-Centered Care Plan

Based on the results of the comprehensive assessments completed by CCHA *Plus* along with the Member's strengths, preferences, goals, and risk level, ***we will develop care plans — driven by the Member and individualized for the Member.*** The Care Coordinator and Member will work together to:

- Determine the most appropriate level of Care Coordinator contact (most of this contact occurs face-to-face, but depending on a Member's needs or preferences, it may also be telephonic or a combination of both)
- Develop a care plan that identifies the services, supports, and resources for the Member's needs, as appropriate, and integrates a review of other services the Member may be receiving to evaluate and eliminate any duplication of services

In addition to identifying goals and interventions, the care plan outlines the frequency and type of coordination that will be provided, whether episodic or long-term in nature. The plan is based on Member acuity, which determines intensity of interventions and assigns Members into the right program or service. To have a positive and meaningful impact, the care plan is person- and family-centered.

The Care Coordinator will work with the Member, family, and all Providers to determine the appropriate natural support to assist with coordination. This collaboration of systems decreases duplication. ***We recognize that for those Members receiving services across multiple systems, the number of providers and support staff that are involved in the Member's care may become burdensome or overwhelming to the Member. Therefore, we will work closely with the Member to identify a lead Care Coordinator who will help coordinate the Member's care plan and collaborate with all involved Providers or agencies.***

As a RCCO, CCHA has experience identifying and assigning lead Care Coordinators through their work for the Medicare-Medicaid Program. CCHA *Plus* will implement the same process, which is Member-led and begins by engaging Member feedback regarding who they want as their main contact. We will then collaborate with all involved parties, including providers, and government agencies to make sure all are aware of who is taking the Care Coordination lead.

The lead Care Coordinator will continue to identify gaps in the Member's care, needs, and goals and coordinate all services with the Member or caregiver. CCHA *Plus* will remain ultimately responsible and accountable for helping to assure all services have been addressed during engagement with Care Coordination.

We know the importance of understanding and responding to Members in a culturally sensitive manner. For that reason, all CCHA *Plus* employees will participate in annual CLAS (Culturally and Linguistically Appropriate Services in Health Care) training. Additionally, culturally responsive questions and care plan interventions will be included in our electronic CCS.

Russell's Story: Care Coordination Improves Quality of Life

Calling the CCHA call center was the beginning of quite a journey for new Member Russell who was stranded in Michigan with no way to get back to Colorado. His job as a long-haul trucker took him to Michigan where his employer required he get a physical which led to diagnoses of cirrhosis, GERD, peripheral neuropathy, a toe amputation and his hospitalization. He also has a history of PTSD, anxiety, and alcohol abuse and reported feeling depressed due to a recent relapse. So Russell lost his license and needed medical transportation back to Colorado where he had been homeless in Jefferson County.

Patrick, our Community Resource Expert, contacted Care Coordinator Julia to assess his needs while considering he had no PCMP and no family or sober friend support. She reached out to our External Partnership team to coordinate medical transportation; coordinated with the hospital nurse case manager and social worker; and spoke to Russel every day, assuring him we were working together on his behalf. Julia also found placement for Russell in a skilled nursing facility where he began physical and occupational therapy in a safe, stable, sober environment just 10 days after his call to CCHA.

Julia helped with his transition, coordinated his orthopedist, gastroenterologist, and prosthetist appointments; connected him to a PCMP, clothing programs, and alcohol support programs. Russell is thriving in his new home – calling bingo games, getting paid to work in the dining room, making friends, and serving as resident council president. He calls Julia his angel, and he is very grateful for making what he thought was impossible, possible.

CCHA **Member Centered**

CO_RAE_TeamBasedCare_13_COB_RS_1.2

Manage & Coordinate Care and Services

Our highly qualified team of CCHA Plus multidisciplinary health professionals will work across the entire continuum of care to support our Members' physical, behavioral, and social needs. Our Care Coordination team will include community resource specialists, social workers, nurses, and community liaisons, which connect ACC Program Members with the medical and non-medical supports they require. In addition, we will employ a team of Practice Transformation Coaches who assist Providers in

the population health of their entire patient panel, reaching Medical Home goals, and expanding access. ***The social workers, nurses, and telephonic resource and customer service teams not only understand our Community, they are often the first call that Providers make to receive assistance or support as part of the ACC Program.***

The Care Coordination team will join the Member on their journey to increased wellness and coordinate communication across Providers. This process can be as simple as assisting the Member to find the right PCMP or it may go on for months in order to support the Member with complex physical, behavioral, and social needs. Types of coordination may include a combination of:

- Single or multiple home or community visits
- Accompaniment to Provider, school, or community appointments
- Telephonic Care Coordination

Care Coordinators spend **90%** of their time in the community meeting with Members.

CO_RAE_OR16_CareCoord_COB_DP_1.1

We believe in the importance of meeting a Member where they are, so we will deploy our Care Coordinators out into the community. ***Currently, CCHA's clinical nurses, social workers, and BH Care Coordinators are co-located in Provider offices, hospitals, community agencies, and parole offices.*** In our role as a RAE, CCHA *Plus* will continue these practices of co-location and spending time in the community. We will continue to meet the Member where they are and work to meet their immediate needs. If Members prefer, we will also visit them in their homes. We will align with organizations that are important to the Member to create one Health Team and coordinate the Member-directed care plan.

As a RAE, we will continue CCHA's practices of strong local presence and integration in the community, establishing trust and respect with community partners, Providers, and agencies. As described in OR 15, we will collaborate closely with Crisis Centers to create a safety net of supports and services and monitor Members who have contacted them. Additionally, CCHA *Plus* will participate in workgroups and committees in the community and at the Department that convene to improve Care Coordination efforts for Medicaid Members, many of whom are served across multiple settings. We will leverage and build upon these partnerships to support Member needs, address any potential gaps in care, and help assure collaboration and communication. We will continue to support workgroups such as the Program Improvement Advisory Committee (PIAC) and the Department through these efforts.

Our partnerships range from a bi-directional referral relationship, to a formalized workflow for collaboration, or a fully integrated partnership. While we will invest heavily in our team of social workers and nurses to deploy in the community, we will approach each community provider in an individualized way. Our desire is to partner in a manner that avoids duplicating existing resources or disrupting relationships. In partnerships that have well-developed processes and Care Coordination resources in place, we will delegate these functions to the entities. These partnerships are an important element to the design of our CCS programs. CCHA *Plus* will have a team that is devoted to developing community relationships that aid in streamlined Care Coordination activities, just as CCHA has done to date. You will find an extensive list of our community partnerships and Health Neighborhood development in OR 13. ***We will provide true Team-based Care through our participation and integration into the systems, organizations, and Providers in our community that support both general and specific Medicaid populations*.**

Community Partner Testimonial

Our manager sits on the CCHA Health Neighborhood Advisory Committee, and their Community Liaison sits on our SEP Community Advisory Committee. She participates in two Aging Well workgroups. Our manager attended their external audit to provide in-person feedback on the value and benefits of our collaborative efforts.
Lynn Johnson, Executive Director, Jefferson County Human Services

CO_RAE_OR14_Johnson02_61_COB_TST_4.1

To help ensure integration, we will use ***Total Health teams*.** These teams will be comprised of clinical Care Coordinators with specialization in PH and BH issues, utilization managers, community resources, social workers, and provider relations staff. Teams will be assigned across the counties in Region 6 so that they fully understand the resources available and unique needs of their assigned population. This knowledge will allow them to become the expert in that area and be the primary resource for our Members. Teams will conduct weekly, integrated, rounds during which the team will integrate care for all Members with upcoming discharges from services. Advance knowledge about these discharges allows the Total Health team to engage the Member upon discharge to make certain the aftercare plans are understood and that any barriers to accessing care, such as transportation, can be addressed proactively.

Tracking Care Coordination Activities

Recognizing that Members' needs are unique and fluid, we will continually re-assess their needs to determine the most appropriate level of Care Coordination and interventions. Our Care Coordination team will drive Member changes in risk levels based on their engagement with Members and their clinical judgment. The process begins with a review of enrollment information, Health Needs Survey results, our predictive modeling based on claims data, and ongoing outreach. Members may move across the 4 risk levels and continuum of care and services as their needs change. As CCHA currently does, the CCHA *Plus* Care Coordination team will provide consultation, direction, and support to assure we identify and address the Member's initial and ongoing needs. We will continue to identify and stratify Members who may benefit from Care Coordination through our continuous case finding process. That process includes data mining, predictive modeling tools, and referrals from the Member, family or caregiver, Provider, and other sources.

CCHA has invested extensive resources to develop data and tracking technologies that are tailored to the Medicaid population we serve. As a RAE, CCHA Plus is committed to remain at the forefront in Colorado for data connectivity and output that supports Members, Providers, and community partners to help drive better health outcomes.

Just as CCHA does currently, CCHA *Plus* will continue to document and track all Care Coordination activities, medical and non-medical, in our electronic CCS. ***Having a single source of truth for all information related to the Member will help us confirm that the Member's services and supports are truly integrated and appropriate to the Member's needs and goals.*** Our sophisticated CCS will help guide the development, monitoring, and reassessment of Member care plans through the application of numerous evidenced-based assessments and tracking of workflows to make certain Members' needs are met in a timely, comprehensive manner. The Member's care plan will help us evaluate and address potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, financial, and spiritual needs to achieve optimal health, wellness, or end of life outcomes, as defined by the Member and their preferences. Additionally, our CCS will foster unified communication by acting as a platform to share Member information among the Care Coordination team and Network Providers.

As a RAE, we look forward to evaluating and measuring the impact of a fully integrated Care Coordination model. ***Our goal is to make sure we have capabilities to share data as applicable with members of the Total Health team that will help drive coordination of care, improve quality outcomes, lower costs, and reduce duplication.***

Care Coordination Activities Report

In order to demonstrate the activities and outcome of CCHA's CCS programs, we will create a Care Coordination Activity Report in a format outlined by the Department. CCHA has appreciated the opportunity to share stories, successes, and challenges with the Department through their current RCCO Care Coordination deliverable. CCHA has a track record of positive recognition from the Department about this specific deliverable. As a RAE, CCHA *Plus* will continue to report Care Coordination work, and we will adhere to the guidelines and submittal of the Care Coordination Activity Report as outlined in Section 5.9.4 through 5.9.4.2.2.

Because of our commitment to person- and family-centered Care Coordination, we feel confident about the intentional work currently being done to support Members' experiences. We look forward, as a RAE, to continuing to enhance our programs and report this information to the Department in a collaborative way.

b. Align and Collaborate with Care Coordinators from Different Systems to Reduce Duplication and Member Confusion

When it comes to data sharing and collaboration, we believe that we need to deliver "the right tool for the right job." We recognize that the information, data sharing, and collaboration needs of our Care Coordinators are very different than that of Providers, Members, and other stakeholders. To encourage widespread use, CCHA *Plus* will tailor our offerings for each audience and provide the information they need to supports understanding and action. ***We will deliver a suite of integrated data sharing and collaboration tools that allow us to extend our ability to coordinate with stakeholders beyond the Provider Network — including Members, caregivers, and other agencies or service providers.***

We will support and collaborate with Care Coordinators from different systems through a variety of means that assure the delivery of integrated care, promote the identification of Members at risk, reduce duplication of services, monitor and track behaviors and outcomes, and support the development of partnerships to influence behaviors. CCHA *Plus* will implement specific policies, procedures, and processes to promote two-way communication between our Care Coordinators and care coordinators from different systems, as well as between external Care Coordinators.

Adam's Story: Improved Communications and Coordination of Services

Natalie, our Care Coordinator, identified six-year-old foster child, Adam, through our predictive modeling tool. He was in crisis in the ER after threatening to kill his foster sibling. Diagnosed with disruptive mood disorder, ODD, ADHD, and impulsivity, Adam has had four inpatient psychiatric admissions in the last year, has ongoing outpatient therapy for children with special needs, and is case managed by a city agency. Natalie arranged a call between both organizations' medical directors to coordinate how to help this little boy and make sure he didn't fall through the cracks. Adam now receives behavioral health therapy in his home and has had no readmissions in the last month.

Anthem — Member Centered

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CCHA *Plus* will provide an information-sharing and collaborative platform where multidisciplinary team participants can review and contribute to the care plan, as authorized by the Member. The platform is operational today in several states serving Members with disabilities and mental health and substance use conditions, including individuals with IDD or those with a SPMI. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can support Members in directing a meaningful plan with their desired health and quality of life outcomes.

Our employees, tools, technology, processes, policies, and procedures will support Providers and external care coordinators in a manner that is accessible and drives their learning, evolution, and commitment to the population health model. In turn, this will promotes Provider and Care Coordinator communication, collaboration, coordination, and accountability. As a RAE, CCHA *Plus* will offer the following tools to Providers to enhance our Care Coordination efforts:

- **Provider Portal.** Our portal will be at the hub of our collaboration with providers. Through our secure Provider portal, Network Providers will be able to access the same information as our internal teams about their Members. Our Provider-facing Member 360°$_{sm}$ solution allows Providers to see a full view of the Member's current and historical health care, as available, including any care plans, screening and assessment results, needed preventive services, and service utilization across the full continuum of care. This view enables Providers to understand whether Members are complying with their care plan and allows them to reach out to the Member and the Care Coordinator when care plans may need changes. ***Since the Provider and our Care Coordinator are seeing the same data about a Member, collaboration on the care plan is facilitated, enhancing its effectiveness and making certain that services are integrated.*** Together, they are able to review a Member's engagement in the care plan and collaborate on suggestions or modifications that can improve care plan compliance (that will be reviewed with, and subject to the Member's approval). In addition to seeing Member health care data, the Provider can also use the portal to look up their claims, find utilization management criteria, review general BH information and clinical practice guidelines, and enroll in a training program though our Medicaid Training Academy.
- **Provider Training.** Our Medicaid Training Academy educates Providers on their role in and our expectations and methods for Provider communication with the RAE and Care Coordination team. This education includes providing information on medical necessity, clinical practice guidelines, follow-up care, our requirements for accessing Member clinical information securely, completing prior authorization requests for BH services, protecting and sharing information with other Providers involved in the Member's care, consulting with our Care Coordination team, using best practices, and completing referrals with Members.

As a RCCO, CCHA has been successful in convening the community of services and Providers to deliver more coordinated care to shared Members. As a RAE, CCHA *Plus* will continue to prioritize the Member, and we will work with other agencies and care coordinators in whatever capacity is needed for the Member.

CCHA has also integrated programs with LTSS Providers, meeting with Members together to avoid duplication and reduce Member confusion. These joint face-to-face visits with members avoid duplication by completing both the Medicaid and waiver recertification requirements, as well as the service coordination plan requirement for the Medicare-Medicaid Program. Many of the assessment questions are similar, and thus the Member is only answering them one time. Additionally, CCHA Care Coordinators work collaboratively with the LTSS Providers to create a care plan and clarify who will assist with which goal, and where we will support one another to assist the Member to meet their goals.

CCHA *Plus* will continue to assist care coordinators within our network to bridge multiple delivery systems and agencies. By having a better picture of a Member's overall health needs across care settings, we can provide more efficient, coordinated care — reducing inappropriate over-utilization of health care services, including hospital admissions or ER visits, and avoiding unnecessary or redundant testing or procedures. This more efficient coordinated care includes:

- **Collaboration with Providers within the Health Neighborhood,** as well as the BDIM, and Colorado Regional Health Information Organization (CORHIO), to implement processes and systems for sharing of client data across settings
- **Analysis and utilization of shared data** to more effectively manage the health of our Members, reduce unnecessary or inappropriate utilization, and ultimately lower total cost of care
- **Identification of Members with chronic illness** or other high risk factors, through the use of BIDM data and evidence-based criteria to initiate proactive Member outreach, engagement, education, and Care Coordination
- **Integration of PH and BH** through a diverse network of engaged Providers, predictive modeling to hot-spot Members with significant medical and mental health needs, and apply enhanced levels of care support and co-location of services

***One of the unique and important ways we will collaborate and align is by integrating and co-locating CCHA Plus social workers, nurses, and BH Care Coordinators within Network high-volume PCMP practices*.** These Care Coordinators will be physically located in the Provider offices, work in these offices, and be available real-time to the Provider, staff, and Members. These staff will function as part of the care team with Providers and therapists. This staffing supports the Provider's ability to address patients' needs during the office visit, builds trust with the Members and their Providers, and expands this work beyond the office when our Care Coordinator accompanies the Member throughout the community.

These co-located Care Coordinators will support the Provider staff in the integration and resolution of Member needs and share best practices to engage each Member to improve care and health outcomes. The Care Coordinators will also review quality outcomes, utilization metrics, and trends, and identify care gaps for the Provider to address. They will help Providers implement treatment plans and align these to Member-led care plans focused on Member-identified goals and milestones. The co-located Care Coordinators support and advocate for the Member at the Provider's office to confirm that the Member understands their benefits, rights, and responsibilities. They also link the Member to additional services and supports, facilitate referrals and appointments to other Providers, and remove barriers (for example, transportation) that may influence a Member's ability to achieve his or her goals. ***Results of co-locating Care Coordinators with Providers include:***

- Increased Provider satisfaction
- Increased Member satisfaction
- Right care, right place, right time
- Reduction in ER admissions, readmissions, and inappropriate use of resources
- Improved quality results (reduction in care gaps; improvement in HEDIS® measures)
- Increase in participation with social support system

CCHA has already expanded their co-locating approach to include other community agencies such as The Action Center in Jefferson County. Through this model, CCHA currently supports 8 practices that provide care for more than 10,997 attributed Medicaid Members. As a RAE, our plan is to continue to pursue other community integration opportunities and expand our integration approach and co-located staff with the BH team in the next phase of the ACC Program.

CCHA's CCS programs and teams currently work closely with Human Services departments throughout Jefferson, Boulder, Bromfield, Clear Creek, and Gilpin counties to find resources and manage benefits. They have worked closely with Mountain Resource Center to support Members' needs in mountain regions where access to resources is more of a challenge. CCHA *Plus* will leverage and expand on these relationships in our role as RAE.

c. Outreach, Intervene, and Monitor Members Who Meet the Criteria for Inappropriate Overutilization of Health Care Services

As detailed in our response to OR 23, CCHA *Plus* will monitor overutilization and underutilization of services using reports that identify Providers and Members with utilization patterns that fall outside the norms. The utilization norms will be adjusted to reflect regional and local practice variations and are compared to national benchmarks. We recognize that unmet BH needs of a Member may also fuel inappropriate utilization patterns. To proactively address this issue, our integrated Care Coordination team of PH and BH professionals will have extensive training in screening for and addressing BH needs.

When we identify patterns with Members that fall outside the norms, or receive a referral of a Member from a Provider, we will conduct outreach to the Member. This outreach will be designed to help us understand why the Member is using a service to excess, educate our Member on the appropriate use of benefits and services available to them, and support the Member to correct the situation. These interventions will be used for Members where there is the appearance of over- and underutilization of services. We will target intervention strategies to enhance appropriate utilization practices and provide Member intervention for cases of Member overuse and underutilization through Care Coordination or health education and outreach.

Member Testimonial

The CCHA Care Coordinator team has helped my father by advocating for his medical needs, assisting our family with locating a skilled nursing facility for respite care, setting up a meal delivery service, and collaborating with all of the agencies involved in our family's life. Our Care Coordinator has also assisted us with various community resources.
Marty

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Identifying and Outreaching to Members Meeting Criteria for Over-utilization

Over-utilization patterns are identified though comprehensive data analysis. We will review existing data and establish any necessary reporting that enables us to identify patterns of behavior that are outside of the norm. Routine review of utilization, ADT, and claims data will identify patterns of over-utilization, while anti-fraud software may help us identify cases of fraud and abuse.

In addition to data review, we may receive referrals for potential over-utilization by Members or Providers via multiple avenues, which can include mail, telephone, in-person contact, email, internet, or our compliance hotline. Referrals come from Members, Providers, employers, law enforcement agencies, and professional organizations. As an example, a Provider may call to report a Member who continuously sees multiple similar Providers, or a Member may call to report a potential quality of care issue that leads to the identification of over-utilization by a Provider.

CCHA *Plus* understands the importance of addressing utilization for Members residing in nursing facilities and nearing the end of life, and we will prioritize making certain these Members receive appropriate care and support. As a RCCO, CCHA has established relationships with hospitals, skilled nursing facilities, and other providers to support consistent communication and ongoing information and resource sharing to help assure that our Members receive the services they need, at the time they need them. Where appropriate, CCHA *Plus* will also offer Care Coordination to support discharge and transition planning to help return a Member safely to the community. We will build upon these relationships to confirm patterns of over-utilization are identified in time. Care Coordinators will educate Members about appropriate ER use and provide support to address end of life planning. We will continue to coordinate with involved Providers, including hospice and palliative care agencies, to see to

care plan collaboration and Member and caregiver understanding regarding Member benefits and appropriate use of services.

Interventions for Members with Inappropriate Over-utilization of Services

CCHA *Plus* is committed to identifying and correcting instances of over-utilization of services. When a Member's utilization pattern is outside the expected norms for the region and service code, a Care Coordinator will reach out to the Member to confirm that the utilization is inappropriate and provide support and education. The Care Coordinator will collaborate with the Member to develop creative alternatives; for example, working with their care Provider to carefully monitor their condition and prevent exacerbation. ***Care Coordinators will work closely with the Member and PCMP to address unmet health needs that may be fueling ER visits, or provide condition-specific health education on self-management factors that can reduce the need for services such as diet, sleep, and stress reduction. Care Coordinators will also address social determinants that impact a Member's utilization of services.***

Our co-located Care Coordinators will provide ongoing communication and collaboration with PCMPs. When a practice identifies high utilizers, they will provide a list to our team who will attempt to contact the Member to follow up and attempt to schedule a follow-up appointment with their PCMP. ***Through our Outreach Triggers Population Health Intervention, we will support Providers in this effort by contacting Members for triggering events that include gaps in care, a new diagnosis, and ER or crisis center admission.***

Through our Outreach Triggers Population Health Intervention, Members who meet the criteria for over-utilization of health care services will receive Care Coordination based interventions. This program recognizes that Members may simply be in need of resource information, or have questions regarding their benefits and where to receive care. As such, ***we will begin by connecting a Member with a PCMP or finding a PCMP, with the objective of the Member becoming an established patient, creating a Medical Home, and reducing over-utilization.***

Reducing Unnecessary ER Utilization

CCHA *Plus* will have one program designed to reduce ER visits among all Members, and we will use these tools in efforts to ***reduce unnecessary ER utilization.*** The goal is to reduce ER use for non-emergency reasons by educating Members and helping them access ER alternatives, when appropriate, such as their PCMP or urgent care services. To support this program, admission, discharge, and transfer (ADT) and claims data will be used for targeted outreach and on-call resources. The program will include many different interventions based on the unique needs and circumstances of individual Members. As detailed in OR 11, CCHA *Plus* will offer a Rapid Response Team for the next iteration of the ACC Program to reduce unnecessary ER services for Members with BH needs. This service will be available for Members with BH needs that present at the ER but do not meet criteria for admission. The Rapid Response team will go to the ER, assess the Member's needs, and triage the Member to the appropriate setting, including a psychiatric urgent care facility, if appropriate.

Integrated Pharmacy Management

We are also interested in working with the Department on integrating pharmacy management into the RAE. If appropriate data is made available, we may be able to implement several pharmacy programs to encourage the best health outcomes for Members. These include programs such as the Controlled Substance Utilization Monitoring (CSUM) program to help decrease controlled substance over-utilization, and in-house BH, diabetes, and asthma medication management programs that monitor,

evaluate, and encourage Member adherence to medications. We may also be able to offer another program that uses targeted, monthly communications to physicians with personalized, actionable information about their patients to promote coordination of care with information on appropriate use, compliance, and safety of medications for targeted conditions.

Client Over-utilization Program

CCHA *Plus* will partner with the Department to help administer the Client Over-Utilization program (COUP) for Members who meet criteria. As an existing RCCO, CCHA has developed a process for managing the COUP. CCHA *Plus* is committed to working with the Department and other partners to continue these efforts. Today, CCHA uses analytics to determine points of intervention and tracks progress on Care Coordination and the ultimate outcomes of each case. They also work closely with the FQHCs, who typically have 40% or more of the COUP attribution. The goal is to ensure that this population is being managed from a Care Coordination perspective. Going forward, tracking and evaluating the interventions being executed by our team and the FQHCs will be key to our strategy to effectively manage this population.

For Members who are enrolled in the COUP, our Care Coordinators will work to understand their needs and educate them about appropriate services. If we are unable to curb the utilization, we will work with the Department to lock into a PCMP or a pharmacy and continue to provide care coordination support to the Member.

Monitoring Over-utilization

Once a Member has been identified as over-utilizing care, a Care Coordinator will be assigned to the Member. The Care Coordinator will commence outreach efforts, Care Coordination, and care planning as warranted. The Care Coordinator will confirm that any necessary adjustments to the care plan, services, supports, and assistance are put in place to remove these barriers. Routine monitoring of a Member's utilization pattern provides data that can be used to adjust care plans, so that the treatment services can bring about the best outcomes. We will use analytic reports to identify high-risk Members, monitor for aberrant Network Provider utilization patterns, and identify population-specific prevalence of disease, social determinants, or behavioral issues that will continue to feed our Population Health Program and guide CCS program development.

CCHA *Plus* Will Meet All Section 5.9 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 16, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.9 that are not detailed in our response.

Section 5.10

COLORADO COMMUNITY HEALTH ALLIANCE

Provider Support and Practice Transformation

5.10 PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

OFFEROR'S RESPONSE 17

Describe in detail how the Offeror will support Network Providers in accordance with the requirements in Section 5.10, including descriptions of the types of payment arrangements the Offeror will make available to PCMPs and Health Neighborhood providers to support achievement of the Accountable Care Collaborative goals.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

At CCHA *Plus*, we place great emphasis on our role of delivering Network Providers support and practice transformation, as we know the goals of the Accountable Care Collaborative Program (ACC Program) will not be realized unless we bring Primary Care Medical Providers (PCMPs) and Specialty Behavioral Health (BH) Network Providers along for the journey. CCHA *Plus* will support Network Providers interested in integrating primary care and BH services, Health Neighborhoods, and enhancing the delivery of Team-based Care by leveraging our unique experience and expertise to provide general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support. CCHA *Plus* brings the sophisticated practice transformation capabilities of CCHA, a current RCCO and Colorado leader in Practice Transformation, as demonstrated through key performance indicator (KPI) measures and the strong support received by Network Providers supporting our RAE proposal. We also bring managing partner Anthem, Inc.'s national innovations in value-based payment arrangements and cutting-edge data systems and technology support that will be essential to support Network Providers in achieving the goals of the ACC Program, including the upcoming transition to the Primary Care Alternative Payment Methodology (Primary Care APM).

State Auditor Testimonial

CCHA has shifted emphasis to building quality in-depth relationships with existing providers and is encouraging network providers to increase their Medicaid panel sizes. To that end, CCHA has significantly enhanced its provider transformation program to include on-site practice transformation teams assigned to individual practices and a provider incentive program. To that end, CCHA has significantly enhanced its provider transformation program to include on-site practice transformation teams assigned to individual practices and a provider incentive program. Highly trained practice coaches meet with practices monthly, providing consultation on technical issues (e.g., billing and coding problems), assistance with Medicaid provider revalidation, and review of practice data reports and KPI performance; and establishing multidisciplinary QI teams. Care coordinators accompany practice coaches to on-site visits to offer collaborative team support. Data support teams have evolved from using State Data Analytics Contractor (SDAC) data to developing provider-friendly individual practice reports; and practice transition teams evaluate data, set goals with practices, and develop data-driven interventions. Practice teams facilitate data-sharing and sharing best practices among PCMPs and conduct an annual office systems review. Through these activities, CCHA staff realized the need for sensitivity related to issues being experienced by individual practices and that it could bring added value to practices by orienting support resources to address provider-defined needs and interests.
Health Services Advisory Group Auditor for the Department

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Additionally, the CCHA *Plus* Provider Support program includes a broad array of Network Provider resources and innovations that capitalize on both our local and national expertise, including our Medicaid Training

Academy and several data and technology innovations. We are committed to supporting PCMPs, BH providers, and Health Neighborhood providers locally in the field to advance their performance, improve Member outcomes, and engage in Team-based Care. We will detail our strategies in a comprehensive Practice Support Plan that is fully compliant with RFP Section 5.10.5 and updated annually.

CCHA *Plus* is happy to bring the strong support of the Network Providers CCHA has served in the region for the past 6 years. Providers tell us that CCHA's Provider Support program is unmatched among other RCCOs and in the State. Please see our attached Letters of Support for our bid to be the RAE for Region 6.

Independent Providers Need Support

On average, more than 76% of the ACC Program population statewide is served by independent Primary Care Medical Providers (PCMPs). While this can vary slightly by region, it is important to keep in mind that **federally qualified health centers (FQHCs) only serve 24% of Medicaid enrollees in the State.** A robust independent provider network is critical to ensuring Members have access to care. These independent providers do not have the resources of FQHCs and large Safety Net Providers, like MCPN or Denver Health, and require significant practice support and transformation teams to help them reach ACC Program goals.

The CCHA *Plus* Provider Support program will be flexible to meet the specialized needs of local independent physical health (PH) and BH providers to promote high-quality, integrated, and Team-based Care to Members and meet the goals of the ACC Program. Additionally, we offer a customized Provider Support program for Safety Net Providers, including FQHCs, to meet them where they are and help them improve their performance in key areas like the ACC Program KPIs.

Aligning Financial Incentives

CCHA *Plus* understands that financial incentives must align to drive continued transformation with practices. CCHA is already making value-based payments (VBPs) to Networks Providers through the CCHA Incentive Program, and Anthem is a national leader in VBP and incentive strategies with specific expertise and programs targeted at Member-focused outcomes through integrated PH and BH provider services. We will employ our local and industry-recognized expertise to develop and establish additional innovative VBP programs in partnership with the Department to accelerate integration, improve quality, reduce costs, and pay providers for the increased value they deliver. More information on how we intend to do this is provided later in this response.

The CCHA Incentive Program is preparing Network Providers for the Primary Care APM and incentivizing integration and improved quality performance. CCHA *Plus* will combine this local expertise with Anthem's national experience in Specialty BH Networks, including its BH Incentive Program, to help prepare both PCMPs and Specialty BH Network Providers for the health system of the future.

Supporting Network Providers

Our Tailored Provider Support Program

Today, CCHA is recognized as a local leader among RCCOs in supporting Network Providers in improved access to holistic, coordinated, and culturally competent care. As a RAE, CCHA *Plus* will continue in this tradition, serving all Network Providers, regardless of size or where they are on the Medical Home continuum. We know that every provider practice has its own culture and goals, so a one-size-fits-all approach is not the answer. We pride ourselves in being able to meet providers where they are by delivering a customized support team and approach to address the specific training and education needs of each practice. As a RAE, we will serve as an advocate for Network Providers, as the go-to source to

obtain the information, resources, tools, and support necessary to improve the care delivery and outcomes for Members. CCHA's established local Colorado experience and valued relationships provide CCHA *Plus* a solid foundation from which to expand and enhance our Provider Support program. We understand the importance of advocating for, preparing, and supporting Network Provider transformation that aligns with the State's goals of integrated care and will continue to meet State, federal, and contract requirements as a RAE.

We will encourage providers to engage in our practice transformation initiatives and those offered through the State and federal government, such as the Colorado State Innovation Model (SIM), Colorado Opportunity Project, Comprehensive Primary Care Plus, and EvidenceNOW Southwest. Our Practice Transformation Coaches will have a direct connection to all of the initiatives and the expertise and resources necessary to help practices align their efforts around multiple transformation projects they may be participating in. However, we will not leave practices who do not participate in these initiatives behind. All Network Providers will have access to our Provider Support program, which includes a multipronged approach for supporting PCMPs and other providers and is tailored to the needs of providers in Colorado.

Our Provider Support Team

When the ACC Program began in 2011, the Department required that providers meet specific requirements that aligned with the Medical Home standards to participate as a PCMP in the ACC Provider Network. The Department acknowledged that some providers would not be able to meet all of these requirements and asked RCCOs to work with providers to help them along the continuum of providing Medical Home level of care. As a result, the CCHA Provider Support program was created to include a multidisciplinary support team to assist PCMPs and their staff in navigating the Colorado Medicaid system.

Figure 5.10-1. CCHA Plus Provider Support Team

Anthem also brings expertise complementary to CCHA's. Their expertise will supplement the CCHA *Plus* Provider Support program to add the expertise and additional resources required to support a comprehensive ACC Program provider network. This network will improve our efforts to support providers in delivering fully integrated quality services to our Members in the region.

CCHA *Plus* will expand the Provider Support program to encompass all Network Providers, including both PCMPs and Specialty BH Network Providers. Each practice will be assigned a single point of contact, and we will add other roles to their Provider Support team, depending on the practice's needs and goals. ***All positions on our Provider Support team will be located in the community, in provider offices, and will work to complement and enhance resources in the community rather than conflict or duplicate.***

As illustrated in Figure 5.10-1, each Provider Support team may include one or more of the following, depending on the provider's experience, competency, and needs:

Network Relations Representatives

The Network Relations Representatives serve as the ***single point of contact*** for the practice; they assist all Network Providers (including PCMPs and Specialty BH Network Providers) in navigating the Colorado Medicaid system, act as a liaison between the Department and Provider Network, and advocate for the provider. The Representatives assists practices with issues such as Member eligibility and attribution, claims and billing questions and issues, provider portal education, and administrative changes (for example, revalidation) coming from federal or State departments. They help office staff with coding techniques to accurately document and capture acuity to the highest degree of specificity while maintaining CMS guidelines. They also work together with Practice Transformation Coaches to provide education on how to code appropriately for the KPIs. Each Network Relations Representative will be trained to support the specific types of providers assigned to make certain they have the expertise needed, whether that be to support PCMPs or Specialty BH Network Providers.

State Auditor Testimonial

From inception, CCHA's care coordination philosophy has been that the PCMP, in collaboration with the member, is the hub of effective care coordination.
Health Services Advisory Group Auditor for the Department

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Care Coordinators

These nurses and social workers provide extended Care Coordination support, so providers can focus on quality care delivery and free up schedules to expand access to care. CCHA *Plus* Care Coordinators will help Members navigate the Colorado Medicaid system and connect with medical and non-medical services. They also help Members understand their benefits, choose a PCMP that best meets their needs, set up appointments with the PCMP and other specialists or Specialty BH Network Providers, create care plans and wellness goals, and coordinate services for mental health, dental, home health, long-term care, and other identified needs.

Rather than working redundantly or in conflict with providers' efforts, our Care Coordinators will complement and support providers in addressing the needs of Members enrolled in Care Coordination services. Care Coordinators conduct provider outreach to monitor Member engagement and participation in the care and services identified in the care plan. They also work directly with providers to identify gaps in care, barriers that may be interfering with a Member's participation in appointments, and Member progress toward care plan goals. Care Coordinators also notify providers of any changes in the Member's utilization such as ER visits and hospitalizations.

Practice Transformation Coaches

Provider Testimonial

Our practice transformation coach assists the practice in quality improvement goal-setting, currently, obtaining VFC designation, and other initiatives to assist in meeting our KPIs, and ultimately working toward the positive clinical outcomes of our valued members.
Amanda Jackson, Clinic Supervisor, St. Anthony Health Center Evergreen

CO_RAE_Jackson02_56_COB_TST_2.2

Practice Transformation Coaches will help provider practices adapt to changes and establish sustainable systems, processes, and workflows to deliver comprehensive, Member- and family-centered care through data and continuous quality improvement efforts. Coaches function as change agents, and support providers and practice staff with RAE or ACC Program initiatives such as KPIs and PH or BH integration.

Practice Facilitators

The Facilitators will work closely with the Practice Transformation Coach, Care Coordinators, and Community Liaisons to identify barriers to coordinating BH services, find resources in the community, and help integrate BH care into PCMP practices.

Community Liaisons
Community Liaisons will work with providers on system navigation and educate them about available community-based resources. Resources include those that provide medical and non-medical services such as diabetes and nutritional education classes, food and clothing banks, childcare services, housing, transportation, and elder care services. They assist PCMPs and other Network Providers with identifying health disparities and inequities within their patient population and help develop plans to improve the physical and behavioral health of Members. In addition, Community Liaisons establish relationships and collaborate with economic, social, educational, and other relevant organizations to promote the health of our local communities and populations. Finally, a critical role of the Community Liaison is to support our efforts at connecting and aligning Network Providers with evidence-based based or promising practices identified through community projects such as the Colorado Opportunity Project. Understanding that our Members with significant BH challenges may be particularly impacted by social determinants of health, as a RAE, we will consider adding Housing and Employment Specialists as specialized Community Liaisons where needed to address community capacity in these areas.

Clinical Health Information Technology Specialists
Clinical Health Information Technology Specialists will help Network Providers and practices pull data from electronic health records (EHR) to create reports for outreach and population management. They will work closely with the coaches to understand the EHR system and its capabilities and work with practices and their EHR vendors to leverage all the functionalities the system offers, and pull out appropriate data for quality improvement initiatives. They will also encourage and support providers in connecting to health information exchange.

Behavioral Health Liaison
The Behavioral Health Liaison will serve as a resource to providers supporting Members experiencing addictions such as opioid addiction or chronic substance use, as well as other related BH concerns. They will work directly with existing substance use disorder (SUD) providers and provide outreach and technical assistance to expand the Network to include providers who have not traditionally participated in Colorado Medicaid. They may also support Care Coordinators in arranging specialized clinical case reviews between the PCMPs, SUD providers and others, as well as collaborate with the Community Liaisons to broaden availability of community resources related to social determinants of health particularly impacting Members with SUD and other systems barriers.

Provider Information and Administrative Support (5.10.6)

CCHA *Plus* will maintain an information strategy that connects Network Providers to existing resources and addresses any information gaps that have been identified. We will work closely with the Department through open, two-way communication including participation on committees and workgroups to assure our timely awareness of program changes and updates.

Our Communications department will produce timely communications, educational materials, and targeted information to supplement, not duplicate, existing resources. The Communications staff stays up to date with the latest Colorado Medicaid and CMS brand guidelines and applies these standards to all forms of communication created for providers and Members pertaining to Colorado Medicaid and the ACC Program. We will share information and support providers on a range of topics that includes all the requirements of 5.10.6, yet is flexible to evolve as needed to meet provider needs, including but not limited to the following:

- Information about the Department, Colorado Medicaid, and the ACC Program and its 3 integral components: Community Focus, Primary Care, and Data and Analytics

- Communications to help make certain providers understand the role of CCHA *Plus* and the support we offer, as well as the purpose, roles, and responsibilities of the Department's Subcontractors
- Clinical resources and tools such as BH screening tools, clinical practice guidelines, prior authorization requests, practice improvement activities, information sharing, templates, and trainings
- Processes for handling PH and BH adverse benefit determinations
- Administrative processes including claims
- Various forms of communication to help providers educate Members about the ACC Program, their Colorado Medicaid benefits, CCHA *Plus* services, and how to connect with a PCMP and other specialty providers
- Available resources to help educate Members about the ACC Program, their Colorado Medicaid benefits, the role of CCHA *Plus*, and the Network of providers and community-based resources to support their overall health and well-being
  - PCMPs, Specialty BH Network Providers, and Health Neighborhood providers including specialty care, LTSS, Managed Service Organizations and their Networks of SUD providers, hospitals, pharmacists, dental providers, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, and Aging and Disability Resources for Colorado
  - Community-based social services such as child care, food assistance, elderly support, employment and housing assistance, and utility assistance
- Practice transformation and process improvement resources, tools, and training on topics such as how to deliver integrated care and assure culturally competent care

We will systematically communicate information to Network Providers through multiple avenues, including the following:

Electronic Newsletters and Special Bulletins

We will deliver electronic newsletters with timely provider news and updates regarding Colorado Medicaid and the ACC Program, CCHA *Plus* services and events, new funding opportunities, and relevant local and national health care topics. When there is critical information that cannot wait until the next newsletter, we will send out special bulletins or direct communications from our Network Relations Representatives.

Network Provider Update Meetings

CCHA currently hosts Network Provider Update meetings to share ACC Program updates and help make sure providers are aware of and connected to the Provider Support program. Whether it is the new ePCMP program, the Colorado Medicaid name change, the Commit system implementation, provider revalidation, KPI changes, or the new Primary Care APM, providers attend these meetings to learn the latest from our leadership and the Department. Over the years, CCHA has had many Department officials attend these meetings to give updates and hear feedback directly from providers.

June 2017 CCHA Network Provider Update Meeting – the Department's Chief Medical Officer, Judy Zerzan, MD, sharing updates about the Primary Care Alternative Payment Methodology

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This meeting offers providers a forum for sharing their comments, concerns, and recommendations for the ACC

Program. Meetings also offer an opportunity to share evidenced-based and best practices, allowing providers to learn the latest developments in health care and connect with their peers to learn new solutions for addressing practice challenges. For example, at a recent meeting, the CCHA Provider Support team led a discussion around KPI best practices, which engaged providers in discussing new strategies to improve program performance. CCHA *Plus* will continue to hold these meetings to help keep providers informed. Following each meeting, we will survey attendees to receive feedback and help provide direction for future meetings.

Website and Social Media

The CCHA *Plus* website, CCHAcares.com, will be available to both Network Providers and Members. Providers will have access to a range of resources that are available both publically and behind a secure portal. They can access information about the ACC Program, benefits of being an ACC Program Provider, and CCHA *Plus* support services for providers and Members. They can also find answers to common questions, access key ACC Program provider resources, locate resources for Members, and request free Member education materials and provider tools.

CCHA is currently piloting the use of social media platforms, such as Facebook, to effectively connect, educate, and share critical information related to their services and the ACC Program. CCHA *Plus* will continue exploring social media and web-based options to share relevant, meaningful information. We believe by engaging the public, Members, and our partners we will build an effective conversation around health and health care that will help us achieve our vision.

Suite of Clinical Resources and Tools

We will provide Care Coordination, clinical, and operational tools to Network Providers to promote optimal health outcomes and help control costs. Our Practice Transformation team will maintain a database that houses the resources listed in *Appendix K – Practice Support Tools*. They will use these tools to promote evidence-based practices and help make sure providers are effective in the services they deliver. The tools offer a continuum of support for Network Providers, specialists, and ancillary providers. ***The database houses evidence-based PH and BH clinical guidelines; best practices; screening tools; and shared decision-making tools, templates, plans, and guidelines.*** As new tools and resources are identified, our coaches will add new documents to the database and share this information with practices.

Provider Training (5.10.7)

CCHA *Plus* is excited to be able to offer our **Medicaid Training Academy** to Network Providers in the next iteration of the ACC Program (Figure 5.10-2). Through the Academy's robust features, we will be able to offer required, regionally identified, population-specific, and culturally competent trainings. All of our trainings are customized based on the need of the region or the providers we are serving and are fully compliant with all requirements in RFP Section 5.10.7. Many of these trainings will offer providers the opportunity to earn CME or CEU credits.

We have learned that training programs should be conducive to adult learning and need to be reinforced throughout the year. Rather than providing just one training annually, our Medicaid Training Academy will provide education to Network Providers throughout the year. This schedule exceeds the requirement of 5.10.7.4 to provide required trainings every 6 months.

Our Medicaid Training Academy incorporates multi-modality delivery training processes and mechanisms for tracking, monitoring, alerting, and reporting compliance and completion of trainings. A record of training activities will be maintained and available to the Department on request. Trainings will vary in topic from clinical guidelines to process improvement, and vary in delivery modes including:

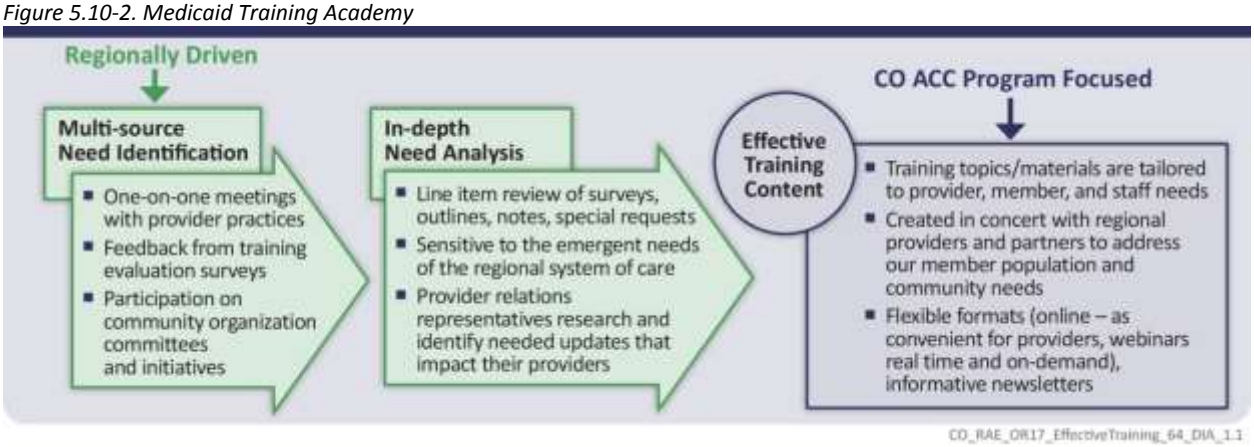
- Print communications (for example, newsletters, clinical and non-clinical educational materials)
- In-person trainings (for example, learning sessions, in-practice boot camps)
- Virtual trainings (for example, live or recorded webinars)

Topics include trauma-informed care, clinical guidelines, teaching PCMPs and other providers to recognize BH conditions, Care Coordination, VBP, and other person-centered topics that facilitate improved quality and outcomes.

Specific intentional trainings for targeted providers who support specific populations will be offered as needed to promote recognized practices of excellence. We will encourage providers to engage in our intentional training programs. These targeted training programs encompass 4 key strategies:

1. Integrated care training based on a library of offerings for specific providers such as Behavioral Health Homes
2. Targeted training libraries and content related to vulnerable subpopulations and population-driven health needs such as foster care, adoption assistance, and Serious and Persistent Mental Illness (SPMI)
3. Training to support value-based care and practices of excellence recognition programs that reward providers for their additional knowledge and capabilities related to quality-based management of specific conditions
4. Training related to specific Contract requirements, HEDIS® measures, and NCQA requirements

Figure 5.10-2. Medicaid Training Academy



We will continue to work closely with State partners, providers, communities, and other stakeholders to assure our education efforts are provider-focused. Our efforts will have the goal of delivering information needed to allow PH and BH providers to engage Members, work together for Members with PH and BH conditions, improve Member outcomes, and simplify practice management. We will regularly assess the effectiveness of Medicaid Training Academy trainings to assure they are meeting the local needs of providers, employees, and Members.

Additionally, we will encourage providers to participate in trainings available from local, State, and federal entities. As a RAE, we will strive not to duplicate existing resources in the community. We will continue to participate in forums across our communities so we can connect our Network Providers with all the resources available to them.

Data Systems and Technology Support (5.10.8)

We understand the hesitancies and challenges providers face when it comes to implementation and use of health information technology (HIT) systems and data. We target our support solutions to simplify HIT so providers and their staff can focus on delivering quality care to our Members.

CCHA *Plus* is on the cutting edge of HIT to help Network Providers make the best use of the data reports and systems available to them. We offer data and informatics support, risk stratification, and data analysis. We can also offer many tools to assist practices in meeting their goals. These tools include guides on empanelment and risk stratification, with an electronic report that runs their data through an algorithm including diagnosis, control of disease, and demographics.

As a RAE, we will maintain a data warehouse that integrates various data sets we receive from the Department, including the raw eligibility and claims files, the 834 file, BH encounter claims, and roster report. We will work to integrate new data sources as they are received from the Department or other partners, such as data from the Health First Colorado Nurse Advice Line and the Health Information Exchange (HIE) hospital admission, discharge, and transfer (ADT) feed. The data warehouse allows us to develop the provider dashboards that Practice Transformation Coaches will bring to practices to help them understand and improve their performance on key ACC Program criteria such as KPIs, access to care, and health outcomes. The data warehouse will allow CCHA *Plus* to share information with providers and other community partners.

We will provide technical assistance and training for Network Providers on using the State-supported HIT systems listed in the RFP. Below we have provided additional information on our efforts around these systems:

Sophisticated Care Coordination Software

CCHA *Plus* brings sophisticated Care Coordination software that is the backbone of our Care Coordination program. It includes an electronic component that supports our Care Coordinators in everything they do for our Members. It allows for bi-directional data sharing with the Department and other sources. Currently, the software has capabilities to integrate the following data sources: ADT, Health First Colorado Nurse Advice Line, and eligibility and claims data. It also allows users to record information about the Member's care team, including different providers serving the Member and the care team lead. Our Care Coordination software has the ability to evolve with the needs of the population and the health care system. As upgrades are available, we are able to add new functionalities as needs are identified by our Care Coordination team or Network Providers.

The Care Coordination software can be made available to providers in our Network who do not have a tool of their own. We are able to customize the tool to meet the needs of ACC Program Members and Network Providers. We will provide technical assistance and training around use of the tool, including:

- Training guides with detailed instructions and screenshots, regularly updated to accommodate version upgrades and customizations
- Training webinars that are recorded and posted online
- Subject matter experts available for live assistance and support

See OR 22 for additional details regarding our Care Coordination software.

Business Intelligence and Data Management (BIDM) System

As an incumbent RCCO, CCHA has provided extensive technical assistance and training for Network Providers on use of the State Data Analytics Contractor (SDAC), the tool that preceded the BIDM system. The SDAC has been a vital component of the ACC Program, providing the data and analytics RCCOs and practices need to provide high-quality, coordinated care to Members. The CCHA Provider Support team

has helped providers learn how to access the SDAC and set the expectation in provider contracts that the SDAC be used in the course of caring for Members.

As the SDAC has been retired and the BIDM comes online, CCHA has been at the forefront of providing technical assistance and training to Network Providers. The capabilities the BIDM will bring are exciting and CCHA is proactively preparing Network Providers for the system change:

- CCHA was the first RCCO in the State to provide a live demonstration of the new tool to providers.
- CCHA staff has worked closely with Department staff to test and trouble shoot the new system, participating in weekly meetings and offering constructive feedback and solutions from their team of experts in health information technology.
- CCHA staff, including members of the Provider Support team, have attended all the BIDM trainings.
- CCHA has provided regular updates on the entire systems change, including the BIDM, in the CCHA provider newsletter and special bulletins. CCHA has produced an FAQ guide. All Department resources and materials have been shared with Network Providers.
- CCHA informed all providers of BIDM trainings offered by the Department and strongly encouraged participation.

As a RAE, CCHA *Plus* will continue to advocate for Network Provider use of the BDIM. For practices that have high Colorado Medicaid attribution, Practice Transformation Coaches will provide annual assessments and training on the BIDM. As part of this annual assessment, a CCHA *Plus* Practice Transformation Coach will conduct an office system review with the practice staff or provider and will assess whether the practice staff is familiar with BIDM and how to leverage the tool. If the practice is not familiar or does not know how to fully use the system, the Coach will provide a one-on-one (or group if necessary) training to the practice staff and providers. CCHA *Plus* will conduct this assessment annually because staff turnover rates are high in the practices and information changes regularly. As part of this process, the Coach will also assess whether the practice is trained in delivering Culturally and Linguistically Appropriate Services (CLAS). If the practice staff has not taken CLAS training, the Coach will offer a self-paced CLAS training provided by the U.S. Department of Health and Human Services. In 2016, the CCHA coaching team trained 28 practices on the SDAC and referred 30 practices to the CLAS website. Additionally, coaches will measure access to care quarterly and help with process improvement activities if the data shows it is not in line with the Department's target goal.

Our Practice Transformation Coaches will help practices learn how to use the BIDM to its full potential. For example, we will help Network Providers use BIDM to identify Members and understand the utilization data the BIDM provides. We will also help Network Providers look at their entire patient population to identify potential population health interventions. The coaches will help practices look into the BIDM to find their scores on KPIs for the ACC Program, as well as other important measures. BIDM performance data will be used in regularly scheduled quality improvement meetings with practices to model to providers the benefits of using data and analytics to drive their practice work. The CCHA *Plus* Provider Support team will be in practices every day and will always be available to provide technical assistance and training on the BIDM.

Medicaid Management Information System (MMIS)

The CCHA *Plus* Provider Support team will provide technical assistance and training for Network Providers on the Department's Medicaid Management Information System (MMIS) to support providers with coding and billing challenges and help ensure timely and accurate payment. Our Network Relations Manager and Practice Transformation Coaches can help practices help trouble shoot problems and share best practices.

In recent months, as the Department has worked to update their MMIS from Xerox to DXC Technology, CCHA has acted as the messenger, liaison, and support system for Region 6 providers in the following respects:

- Leveraging a robust Provider Network communication infrastructure to prepare providers for the system change and keep them informed of Department resources and latest developments
- Participating in Department trainings on the new system and developing additional provider education materials, including helpful tips on how to track payments
- ***Coaching all contracted providers on the revalidation process required for Colorado Medicaid providers, leading CCHA's Provider Support Team to a 99.9% success rate in revalidating 266 independent providers in our Network***
- Working alongside providers experiencing payment delays and even supporting them as they connect with the DXC call center to resolve billing problems
- Partnering with the Department to help identify common problems providers are experiencing with the new system
- Escalating Network Provider problems with late payments to Department leadership for solutions to help avoid significant financial challenges
  - When one large Safety Net Provider experienced significant payment delays, CCHA worked with the Department to gain access to the provider's portal to help them track funds and identify billing problems.

As the system transformation continues, CCHA *Plus* looks forward to continuing our role as an advocate for Network Providers and a partner with the Department. We are excited about the new opportunities the Colorado interChange brings to help Network Providers become more sophisticated in their coding and billing practices and track performance at the individual provider level.

Multi-payer Data Aggregator Tool for the State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+)

CCHA Practice Transformation Coaches are already supporting Network Providers on SIM and CPC+ for Medicaid and other payers, including commercial and Medicare. Coaches work with practices, effectively creating a multi-payer practice coach that helps to align ACC Program efforts with SIM, CPC+ and other practice transformation projects. Soon the RCCO will be granted access to the multi-payer data aggregator tool (Stratus) so they can help practices meet the SIM and CPC+ goals. CCHA coaches have been trained on Stratus and are waiting for the practices to have access to the tool so they can support them. As a RAE, CCHA *Plus* will keep the expertise of the Practice Transformation Coaches on board and add Anthem's extensive experience in practice-level integration and VBP arrangements so we continue to lead the way in practice support for these innovative and important statewide initiatives.

Office of Behavioral Health Colorado Client Assessment Record (CCAR) Data Collection Tool

We are aware that Network Providers have faced challenges with the CCAR in the past. As a RAE, we are excited to bring Anthem's experience with specialized assessment tools to Network Providers. CCHA *Plus* Provider Support team members will come trained in assessment tools such as the Child and Adolescent Needs and Strengths (CANS), the Adult Needs and Strengths Assessment (ANSA), and Level of Care Utilization System (LOCUS). CCAR will be added to the list. CCHA *Plus* will also bring experience in helping providers enter CCAR information in the State's system for Medicaid, non-Medicaid, and block grants. CCHA *Plus* will include language in our contracts for BH providers to adhere to data collection requirements in order to:

- Satisfy federal reporting requirements for block grant funding of BH providers in the State
- Inform the State Legislature regarding policy, service quality, and effectiveness

- Answer questions posed by major stakeholders and special interest groups, such as the Mental Health Planning and Advisory Council, Colorado Behavioral Healthcare Council, and the Department about a variety of BH issues
- Provide routine reports to centers and clinics about consumer status and progress

Program Eligibility and Application Kit (PEAK)

CCHA *Plus* will proudly provide technical assistance and training to Network Providers around both the PEAK website and mobile app. The State of Colorado is a national leader for its integrated program eligibility site, PEAK, and we will be happy to be part of the team. The PEAKHealth mobile app was the first of its kind and is a tremendous tool for Colorado Medicaid Members and Network Providers. CCHA *Plus* will encourage providers to empower Members to engage in their health by using the PEAK website and mobile app, applying for, and managing their public assistance benefits online. We will provide PEAK training resources and outreach materials to help providers educate Members. Additionally, we look forward to participating in the PEAK Outreach Initiative, to provide functional PEAK training and education to organizations that serve Colorado Medicaid Members.

Regional Health Information Exchange (HIE)

CCHA *Plus* has the experience it takes to help providers in urban areas leverage their EHRs and engage in health information exchange. In other regions of the State like RCCO Region 1, providers are fortunate to practice within a closed system with a single EHR and connected Health Information Exchange (HIE). Providers in urban areas do not experience the luxury of operating in a closed system, and practices have implemented dozens of different EHRs throughout the Denver metro area alone. Network Providers in urban areas will require significant support from their RAE to make the best use of their EHR and connect to the HIE. CCHA *Plus* will bring this support to the ACC Program.

CCHA *Plus* will work with Network Providers to:

- Adopt use of an EHR and use of Office of National Coordinator for Health Information Technology Interoperability standards for PCMP EHR systems
- Connect to the regional HIE for exchanging of clinical alerts and clinical quality measures data
- Identify gaps in information sharing or data quality

As a RCCO, CCHA has been a leader in the State for PCMP support around health information technology by leveraging the vast experience of Physician Health Partners (PHP) in health information exchange. PHP, a CCHA *Plus* managing partner, has been involved in Colorado's HIE efforts since they began. Early on, PHP provided CORHIO with funding to cover ongoing monthly fees for all contracted Network Providers. They also worked with hospital partners in the community to make certain that PCMPs would not be alone in the decision to move forward with HIE. ***Many large hospitals in Colorado connected to CORHIO as a result of partnerships with PHP and their success in implementing PCMP practices with CORHIO.***

In 2010, CORHIO recognized PHP as a leader in primary care innovation and PHP was selected to be 1 of 7 Regional Extension Centers (REC). The REC program was created by the Office of the National Coordinator for Health Information Technology and the Centers for Medicare and Medicaid Services to help providers in clinics, small hospitals, and other settings improve care by implementing and using EHR systems. By the end of the program, the REC partners helped more than 200 providers implement an EHR system, attest to Meaningful Use, and get connected to the CORHIO HIE. As a REC, PHP gained valuable new expertise and was able to train practice staff in the areas of HIT system selection, implementation, and best practices.

Most recently, CCHA has developed a tool, **Patient Data Link (PDL),** which allows for comprehensive data extraction from several EHR systems. This technology allows clinical data to be aggregated, normalized, and made available for analysis and exchange in real time. Clinical data is reconciled with claims data received from the Department and can be shared with CCHA's Care Coordinators, management team, and Network Providers. PDL offers a unique view of a Members' longitudinal health record. This tool is critical in helping providers participate in HIE in open systems where many providers are using different EHRs. In the next phase of the ACC Program, CCHA *Plus* will make this tool available to Network Providers who wish to participate in the ACC Program.

CCHA *Plus* will lean on this experience in our work with providers on HIE, and we look forward to partnering with the Department and State leaders to move HIE efforts forward. ***Because the landscape of HIE is changing and evolving, we will participate in new ventures like PRIME and the Governor's new Innovations Office. We will also participate in the eHealth Commission and serve on the SIM Practice Transformation Committee.***

CCHA *Plus* is committed to partnering with the Department to elevate Colorado as a regional HIE leader nationally by enhancing our working relationship with Network Providers and supporting HIE efforts to facilitate the exchange of health information.

Electronic Consultations

As discussed in detail in OR 13, CCHA *Plus* will support the adoption of electronic consultation and referral tools and will provide technical assistance and training to Network Providers once these tools become available. CCHA is already participating in two specialty care access efforts through local health alliances. Both alliances are examining online consultation and referral tools. CCHA *Plus* will encourage the adoption of a statewide tool and will be supportive of the Department's eConsult pilot project with CORHIO. We will work with community health alliances to build support and identify resources needed to expand the project. We look forward to working with the Department and Network Providers to integrate electronic consultation and referral tools into the ACC Program.

Network Provider Supports for Managing and Using Data

CCHA *Plus* will provide several types of supports to Network Providers to manage and use data. The supports listed below are tools our Practice Transformation Coaches will use with practice quality improvement teams to help them reach the Quadruple Aim: better outcomes, improved Member experience, lower costs, and improved provider experience. Additional details are provided in the Practice Transformation section of this response. CCHA *Plus* will continue to use and enhance the following supports for managing and using data for both PCMPs and Specialty BH Network Providers, including:

Network Provider Portal: We will provide a secure portal for Network Providers so they can access the same information as our internal teams regarding their attributed Members. The portal will allow both PH and BH Network Providers to access a single view of a Member's data in an easy-to-navigate dashboard that includes HEDIS® care alerts, authorizations, prescriptions, and claims organized by type (for example, inpatient, ER, and office visits). It will also serve as our primary method for sharing Member Care Coordination information, including health needs screenings and the integrated care plan. This view will enable providers to understand how Members are doing from a population health perspective, and reduce duplication.

Practice level reports: CCHA *Plus* will use data from multiple sources (for example, BIDM, claims and eligibility files, EHR, and Member satisfaction surveys) to produce practice level reports. Data will be reported at the practice, provider, and Member level. CCHA Practice Transformation Coaches will

provide the reports to the practice quality improvement team monthly for population management and Member outreach. By merging these data sets, the providers will have the ability to identify real time gaps in care, discrepancies in utilization, and performance reports by practice and provider. Quality improvement teams will review these reports and set up action plans to close the gaps.

Population health, chronic disease management, and KPIs: CCHA *Plus* has a population management tool with capabilities of merging administrative data from claims to clinical data from EHRs. This tool provides comprehensive Provider Performance dashboards that display Network Provider performance as compared to the entire Network, practice, and peers. More than 300 standard quality reports are available for display, as well as risk stratification, cost, and utilization. Patient-level drill down capabilities include gaps in care, upcoming appointments, missed opportunities, and medication and problem lists. All of the improvement activity for these programs starts with data. CCHA *Plus* will use the data that is provided by the Department and internally develop reports to guide the trainings and improvement activities for PCMPs. Through data analysis, we will identify population health priorities, proactively target Members for chronic and complex Care Coordination, and implement effective strategies to improve KPIs. Data will be incorporated into the Network Provider quality improvement teams by our Practice Transformation Coaches. Our overall population health strategy is outlined in detail in OR 15 and 16.

Member identification for Care Coordination and additional services: CCHA *Plus* will systematically use claims data to identify utilization patterns and supplement it with clinical data from EHRs or admission, discharge, and transfer (ADT) data from the hospitals, when available. Our analytics team will query the claims data to identify Members for various categories, including high ER visits, those with no PCMP visits, Members recently discharged from the hospital, and Members who have not had their well-child screening completed. We will send reports to Network Providers on a daily or monthly basis, depending on the report. A few examples are the maternity list and the ADT data. Practices use the information to outreach Members or guide process improvement activity within their quality improvement teams.

Recently, CCHA embarked on a new project with the Department, CORHIO and the Colorado State Innovation Model (SIM) to conduct the first HIE Connectivity Assessment of ACC Program contracted practices in Region 6. CCHA *Plus* hopes to further this partnership with the Department to provide technical assistance and support to Network Providers to move them along the HIT continuum. We are excited to leverage the fruits of this project to support our Network Providers. As detailed in OR 21 and 22, we have the capability to use new and innovative analytics tools, such as the Patient Data Link, to assist practices with transformation. Any willing PCMPs will be able to combine their EHR data with Colorado Medicaid claims data to create a better picture of what is happening with their patients' health and health care utilization so they can help in the management of health outcomes and better cost control. The CCHA Practice Transformation Coaches and Clinical Health Information Technology Specialists will use these technologies to help create EHR-specific white papers to help drive best practices and improvement.

This comprehensive data set from EHRs in the community contributes to the Office of the National Coordinator of Health Information Technology (ONC) Outcomes goal by providing an important piece of an individual's longitudinal electronic health information when shared and combined with other important sources. Our Provider Support team will be able to leverage the BIDM and other Department tools, as well as the population management tool and Patient Data Link to revolutionize how data can be used in provider practices to optimize outcomes for our Members.

CCHA Provider and Community Data Sharing Collaborations

CCHA *Plus* knows a key RAE responsibility will be to empower providers and the Community with needed data to proactively address health in the region. We will have a defined and public process for providers and Community partners who request raw claims data extracts for shared Member populations. Today, CCHA shares claims data and key reports with Network Providers to help them take action to reduce ER visits and make sure their patients are receiving preventive care such as well-child visits, depression screenings, and postpartum follow-up visits.

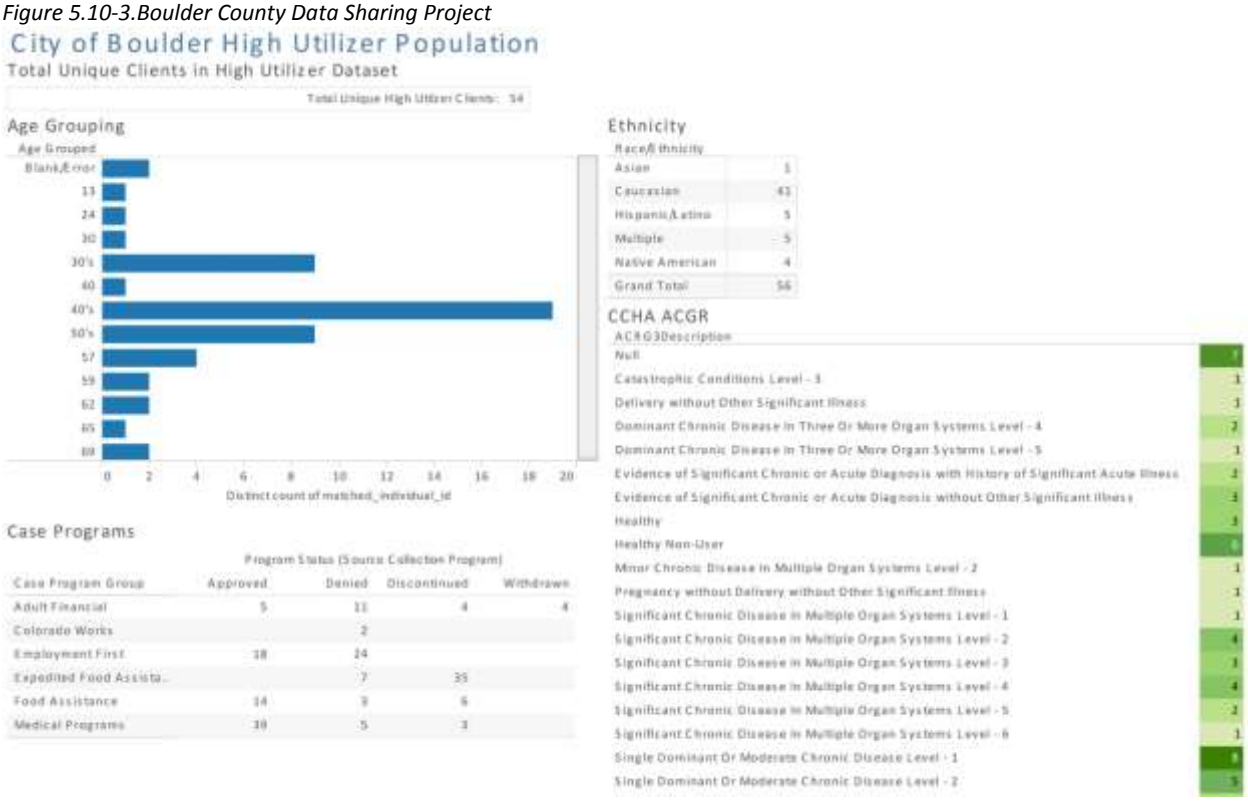
Over the years, CCHA has established many data sharing projects that have led to collaborative provider and Community efforts to serve Members. Examples of the type of data the RCCO shares include Medicaid claims and eligibility data, CORHIO ADT feeds, KPI reports, the Roster Report, Maternity List, and Health First Colorado Nurse Advice Line. Each partner must sign a Business Associate Agreement that complies with HIPAA to make sure all personal health information is protected. Below are just a few examples of CCHA's local data sharing collaborations.

Table 5.10-1. Data Sharing Collaborations

Organization	Purpose
Boulder County Housing and Human Services Department and Public Health Department	Identify opportunities for partnership with the county to fill gaps in care and services. A project with the county jail is currently underway to connect recently released Members with services to improve their health and well-being.
Colorado Community Managed Care Network (CCMCN)	CCMCN is the data association for Federally Qualified Health Centers (FQHCs). CCHA has partnered with CCMCN to integrate claims data with FQHC EHR data to identify opportunities to improve performance on well-child visits and depression screenings.
DispatchHealth – ER Partner	CCHA has engaged DispatchHealth to pilot their ER avoidance program with Members. We used data and mapping programs to identify 6 zip codes in Region 6 with a high concentration of 4 or more ER visits. DispatchHealth regularly receives a CCHA roster report for outreach to Members.
Jefferson County Public Health and Human Services	CCHA is partnering on the Colorado Opportunity Project to increase Member use of public health and human services and engaging in a strategic planning project with the county to align efforts on a myriad of county and CCHA program and services.
Imagine!, Options for Long Term Care, ACMI	These Long-Term Services and Supports (LTSS) providers are able to use CCHA roster reports to identify shared Members so that they work as a health team on behalf of Members. Health team leads are appointed and Member home visits can be done together.
Network Providers	While CCHA encourages Network Providers to use the BIDM to access reports, some of the larger practices benefit from receiving the following reports from CCHA: monthly KPI summary, daily avoidable ER reports and list of Members missing well-child checkups or post-partum follow up visits.
Foothills Behavioral Health Partners	Over the years, CCHA has shared Medicaid claims and roster data to support efforts to work with the Region 6 BH Organization to coordinate complex Care Coordination.
Jefferson County Hotspotting Alliance	CCHA and Centura Health have provided claims analysis and access to their hospital EHR system, EPIC, to support the partnership on this project around high ER utilization.
Boulder County Health Improvement Collaborative (BCHIC)	CCHA has provided data on specialty care and lists of specialty care providers to support a partnership with BCHIC to increase access.
Broomfield County: Regional Health Connector Program	CCHA has provided information on Network Providers serving Broomfield County to support the SIM regional health connector program.
Gilpin and Clear Creek counties	CCHA has provided eligibility file information for both counties to support county officials' efforts to identify PCMPs to serve the region.

BH services have been difficult to access in Boulder County with Mental Health Partners (MHP) serving as the primary provider. CCHA *Plus* will bring new opportunities to expand access to BH care by contracting independent BH providers in the area to offer additional options beyond MHP. Below is an example of how one of CCHA's data sharing projects helped provide critical insight into how we can better serve Members who need services to improve their health and well-being.

Figure 5.10-3.Boulder County Data Sharing Project

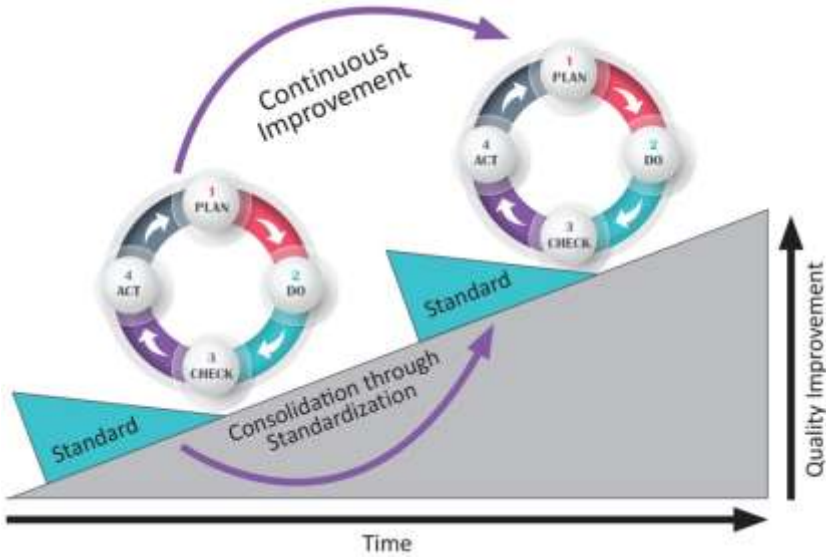


CCHA's ***Boulder County Data Sharing Project*** produces many reports that help track the gaps in care and needs of Members living in Boulder County. As a RAE, CCHA *Plus* will leverage this data-sharing project to connect Members to Network Providers for much needed BH services for the high utilizer population. CCHA's ongoing partnership with Boulder County Housing and Human Services and Public Health Department has enabled them to engage in collaborative efforts to connect these Members with other critical non-medical services. CCHA Plus will seek to establish similar efforts with counties and other partners in the Region.

Practice Transformation and Performance Improvement

CCHA has excelled in the area of practice transformation support, which will be critical to the success of the next phase of the ACC Program. As a RAE, CCHA *Plus* will build on our managing partner's success and add Anthem's expertise to provide support to Network Providers interested in improving performance as a Medical Home, embedding

Figure 5.10-4. Lean Principles



evidence-based guidelines into the point-of-care, and participating in local and national alternative payment models, including the Department's Primary Care Alternative Payment Methodology (APM). We will offer the expertise and resources necessary for practice support, ranging from assistance with efficiency and performance enhancements all the way to comprehensive practice redesign, customizing our level of support to the strengths, needs, and sophistication of each practice.

To achieve the Quadruple Aim, the health care system needs to work well for the Members and professionals who work in the system. Although there are many tools, methodologies, and philosophies in the community to support transformation work, ***our practice transformation team will use Lean Principles as the main foundation to help transform practices*** (Figure 5.10-4). Lean's core idea is maximizing value while minimizing waste. Lean principles help Network Providers improve business practices and workflows, as well as increase efficiencies and cost management. To achieve these goals, we will see that our employees are versed in Lean tools and invest in their continuing education through national institutions, such as the Institute for Healthcare Improvement (IHI), Improving Primary Care (IPC), and Improving Chronic Care Illness (ICCI). Medical Directors will meet with our coaches quarterly to help make sure they are always current on evidence-based guidelines and strategic interventions.

We know that one size does not fit all when doing practice transformation work. Prior to working with practices, we will make sure we align expectations and understand goals and processes we are trying to improve by observing, engaging, and conducting an in-depth office system assessment. This will help us determine the infrastructure, staffing ratios, practice panel size, and other pertinent resources available to the practice. Understanding practices on the front end will enable us to meet them where they are and customize our support or approach accordingly.

Provider Testimonial

Our Practice Coach supports us by streamlining our Primary Care practice. She has helped us initiate many new programs which focus on improving patient care and continuity; these initiatives in turn have help us to reach our KPIs. Our CCHA Care Coordinators have been key in getting referral programs running to improve access for our patients, as well as help us to get a colocation set up for behavioral health. Our Clinical Health Information Technology Specialist has been instrumental in our efforts to educate staff on our EHR system in order to process referrals and track data to improve our KPIs.
Scott Householder,
NextCare Urgent Care/Longmont

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Our practice transformation support of Network Providers will meet all requirements of RFP Section 5.10.9, including:

- Partnering with Network Providers to identify their existing strengths then design and implement practice transformation strategies that build upon these strengths to achieve individualized practice goals
- Offering expertise and resources necessary for practice transformation ranging from assistance with efficiency and performance enhancements to comprehensive practice redesign
- Helping Network Providers increase efficiencies and cost management at the practice and health systems levels
- Partnering with practices to establish feasible transformation goals that best fit their overall operational strategy and use those goals to drive a practice transformation plan

CCHA *Plus* will deliver transformation support to Network Providers to improve their performance as Medical Homes, participate in alternative payment methodologies, and work collaboratively to best meet the needs of our Members in the region.

Leadership Development and Change Management

For a practice to truly transform, it must have full support from its leadership team. Without this support, change starts, stops, and stagnates over time, while the lack of alignment undermines the sustainability of the change process. To see that change is sustainable over time, the practice must engage and empower its formal and informal leaders. It must also guarantee that everyone in the

practice understands the vision and the strategic plan, and that the key champions are empowered to make decisions and given dedicated time and resources to work on the strategic plan. CCHA *Plus* will work to inspire leadership among Network Providers, connecting them with physician leadership programs and using data and case examples to demonstrate return on investment of practice transformation efforts. Additionally, we will encourage Network Providers to participate in Department forums and exciting new practice innovation opportunities, including learning collaboratives and technical assistance. We are excited about the benefits that integration, technology, and alternative payment approaches will bring to the Network Providers, the health system, and our Members. We will continue CCHA's efforts, leveraging our talented, respected, and influential Chief Clinical Officer to inspire leadership engagement in practices throughout the region.

Quality Improvement Activities

Once practice leaders are identified, our Practice Transformation Coaches will establish a multidisciplinary quality improvement (QI) team led by a Provider champion. It is essential to identify a multidisciplinary team so that everyone has a stake in the process; moreover, allowing the people doing the work to identify the practice's existing strengths and weaknesses helps redesign a solid process that will achieve the goals of the team and practice. We will also strive to implement evidenced-based or emerging best practice strategies that will enable practices to sustain change over time. Practices must own their QI team and initiatives, so the changes extend beyond personnel turnover and become imbedded into their culture.

QI activities are comprehensive but here are some core initiatives that coaches work on with a practice:

- Patient recall for preventive or chronic disease care, improving access to care (such as no-show rates, well-child visits, expanded office hours, phone issues)
- Population management (such as empanelment, risk stratification, identification of high ER utilizers)
- Workflow improvement (including patient flow, documentation in EHRs, huddles, etc.)

Besides the activities, there are endless tools available to QI teams. Here are some examples of tools our coaches will use with industry-standard practices:

- Lean
- Plan Do Study Act (PDSA)
- What Matters Most
- Process Assessments and Mapping
- Practice Staff Questionnaires
- SMART (Specific, Measurable, Agreed Upon, Realistic, Time Based) Goal Setting
- Brainstorming
- Fishbone Diagram
- 5 Whys: A Six Sigma tool to facilitate root cause of a problem identification

Provider Performance Dashboards

CCHA *Plus* will offer robust data solutions to help providers enrolled in performance incentive programs meet quality and performance targets, measure gains, and implement targeted interventions. We will **provide performance dashboards** and other reporting tools online and **in practice quality improvement meetings.** These tools will offer a multi-dimensional assessment of a provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population.

We will also use our data sources to support providers by monitoring across our network for completion rates of key services. For example, we will monitor completion rates for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and HEDIS® services. Through our online provider portal, all providers will

have quick access to longitudinal data for each Member. Our episode treatment group® (ETG) report (described below in Figure 5.10-5) will also be run for all PCMPs. The Provider Support team will work with providers exhibiting low performance to develop an improvement plan or take other appropriate actions.

Figure 5.10-5. Quality Performance

Quality Performance - 40%

	ACC's Targets		Q3		Q4	
Key Performance Measures *	**Level 1**	**Level 2**	**CCHA**	**Practice**	**CCHA**	**Practice**
• ED Utilization		-5%	-3.5%	-34.4%	-4.7%	-34.1%
• Post-partum Visits	75.8%	78.8%	77.1%	75.0%	77.1%	60.0%
• Well Child Checks 3-9yrs	60%	80%	51.5%	0.0%	51.3%	0.0%

Team-based Care

CCHA *Plus* will be a strong proponent of Team-based Care, leveraging all Network Provider staffs and incorporating patient navigators, peers, promoters, and other lay health workers. The concept of Team-based Care is a new one for many Medicaid providers. Our Practice Transformation Coaches will work to establish a practice QI team to make sure all providers and their staff members are practicing at the top of their scope and see that the team has clearly defined roles and responsibilities. The QI team will define what needs to happen before Members arrive, during their visits, and afterwards for follow-up care. As part of the extended practice care team, the CCHA *Plus* Care Coordinators will help PCMPs practices implement new processes and workflows to achieve more coordination with other providers serving their patients. Integrating the CCHA *Plus* Community Liaisons and community based lay health workers will be another key area of our work with Team-based Care. These two groups are important in helping PCMPs develop new partnerships with organizations that can connect Members with available services in their communities.

Provider Testimonial

We have worked thru different patient care improvement projects with CCHA, and find their knowledge and support have contributed greatly to the success of the programs.
Vernon Naake, MD, Partner, The Women's Heath Group

Evidence-Based Data-Driven Decisions

Data and its use are a large part of practice transformation, and EHRs are integral to data use. We know that most practices purchase an EHR system but find the vendor's training support too expensive so do not fully maximize the full potential of their system. CCHA *Plus* will have dedicated staff, Clinical Health Information Technology Specialists, who help practices create templates, flowsheets, and reports so they can use data to inform their improvement plans. As mentioned above, various reports will be created by our analytical team and made available to the QI teams to focus on areas of importance and be able to measure improvement efforts over time. Practices will receive data that includes cost and utilization (over- and under-utilization), identification and recommendation of low-value services, clinical gaps for prevention and chronic disease conditions, and Member satisfaction. This information will help Network Providers increase efficiencies and implement evidence-based interventions to manage costs at the practice level. QI teams, with the assistance of CCHA *Plus* Practice Transformation Coaches, will be able to use the data to help the providers reduce utilization and delivery of low-value services.

Here are some examples of the work CCHA coaches have done in practices for quality improvement activities that CCHA *Plus* plans to build upon:

- Included Care Coordinators as part of the Provider Support team and QI meetings for practices that have problems with ER and readmit rates and then helped develop a process for referring to Care Coordination
- Helped practices create a workflow and dedicate one staff member to schedule all hospital (not ER) admit follow-ups in 48-72 hours after receiving an admission report
- Implemented Member education strategies to reduce ER visits
- Created processes for using practice census and discharge lists each day to do patient recall and outreach and make referrals to practice Care Coordinators or CCHA Care Coordinators
- Worked with the COHRIO ADT feed to track when Members get discharged and from where, using medical assistants or front desk staff to manage these lists and attempt to contact Members upon discharge
- Used the ADT feed to develop a hospital discharge report to help practices follow up directly with Members

Population and Disease Management

Understanding practice population is a key practice transformation activity. Without understanding the makeup of the practice population and panel size, the practice would not be able to improve its prevention measures or implement disease specific guidelines or programs. CCHA *Plus* Practice Transformation Coaches will work with practices to make sure they understand their population and have resources in place to meet the health outcome goals of the practice and the ACC Program. In this section, we are focused specifically on practice level population health, but our RAE population health strategy is provided in more detail in OR 15 and 16.

Our Coaches will work very closely with the practice quality improvement (QI) team and the Care Coordination team to empanel and stratify the whole practice population so they can identify the population and help set practice-specific goals to improve the health outcome of that population. As an example, a Family Medicine practice may be performing poorly on well-child checks because they are so focused on improving adult focused measures like breast or colon cancer screening. Stratifying and viewing the whole practice population and identifying gaps will allow the QI team to identify well-child checks as an issue for their practice. The Coach will then work with the QI team to understand the current state and reasons the practice is not meeting the target goal. The issues could be Members are going to other practices, the billing codes are not getting to Colorado Medicaid, Members are not

coming in for preventive services, or the Member has a different primary insurance and the codes are not getting to the Department. Once Coaches understand the root cause, they will work with the QI team to clearly define the problem further by reaching out to the Members to understand if it was an access issue, convenience, lack of knowledge on the importance of well visits, or other issues like transportation. Depending on the reasons given, the QI team could work on improving practice hours of operations, phone systems, or engage the CCHA *Plus* Care Coordinators for Member education or coordination of care. Below are some examples of the work CCHA Coaches have done with PCMPs.

- Set up processes for depression screening at Hall Medical, Lakewood Medical Center, and Wheat Ridge Family Clinic. ***Depression screening rates at Wheat Ridge Family Clinic increased from 7 Members the first half of the year to 103 Members in the second half of the year. Of this number, 16 screened positive and were referred to BH services.***

  The Coach worked with the QI team at Pediatrics West on no-show rates. The practice deployed proven CCHA strategies to outreach and engage Members prior to an appointment. ***This practice had an 81% decrease in no-show rates after implementing new policies and workflows.***

Provider Testimonial

Our Practice Coach offers support with building our Primary Care Practice. With the help of our coach we have implemented scheduling initiatives, Behavior Health Co-location, and streamlined our referral process. CCHA Care Coordinators aid us in bridging the gap with specialists in our area to better serve the needs of each individual patient, and our Clinical Health Information Technology Specialist acts as a great resource for data needs to monitor patient needs via claims data for all of our key performance indicators.
Erick Gomer, MD, PCP Medical Director, NextCare Urgent Care

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Physical and Behavioral Health Integration

As a RCCO, CCHA has supported community BH providers to improve integration of primary and BH services. The results have been tremendous for Members and Network Providers, making Region 6 a leader in the State for integration efforts:

- Adult and pediatric practices are starting to screen for post-partum depression, substance use, and anxiety
- CCHA has developed strong relationships not only with the Community Mental Health Centers, but also with community-based BH providers for the practice's entire patient population
- CCHA Care Coordinators are identifying Members needing BH and SUD services and connecting them directly with providers

In addition to our commitment to practice transformation supports, CCHA *Plus* is invested in deploying innovations to align the fragmented health care system so Members have a better health outcome. As a RCCO, CCHA has taken very opportunity to integrate PH and BH processes. In 2013, CCHA received the Adult Medicaid Quality Measures (AMQM) grant from the Department to work on increasing the screening and treatment of depression in the primary care setting. CCHA partnered with Foothills Behavioral Health Partners, the region's Behavioral Health Organization, to create processes and protocols for training PCMPs on referral processes, flagging barriers, data needed, and sharing best practices with other practices. ***CCHA implemented processes so that 640 Members were screened for depression, 110 treated for their depression in the primary care setting, and 30 referred to Jefferson Center for Mental Health or Mental Health Partners for further treatment with a BH therapist.*** Having learned from the AMQM grant, CCHA wanted to continue refining the process to coordinate follow-up care for Members who screen positive for depression. This project is discussed in detail in OR 23, and between 2015 and 2016, ***the Region saw a 20% increase in follow-up appointments after positive depression screening.***

As a RAE, CCHA *Plus* will bring new resources and innovations around access to BH care, which has been identified as a barrier in CCHA initiatives and integration efforts. Here are some examples of BH programs CCHA *Plus* can incorporate for Members:

- **Management of Treatment Access and Follow-up for Members with Co-existing Medical and Behavioral Health Disorders:** According to the CDC's publication *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention*, 2011-2015, an estimated 26% of Americans age 18 years or older report having a diagnosable mental disorder in a given year. The estimated lifetime prevalence of mental disorders among the U.S. adult population is:
  - 29% for anxiety disorders
  - 25% for impulse control disorders
  - 21% for mood disorders
  - 15% for substance use disorders

These disorders, especially depression, are among the leading global causes of life years lived with disability. The incidence and outcomes of chronic disease are influenced by mental illness, and the efficacies of interventions for mental illness are affected by the presence of chronic disease. The evidence is extensive for associations between mental illness and medical illness such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer.

Provider Testimonial

Our Practice Coach supports us by coordinating a streamlined referral process for our patients to receive mental health services. She navigated the systems of two separate not-for-profit health clinics to help us develop an internal system of communication that has helped us provide improved patient navigation services. She also is crucial in helping us navigate the changing reporting and quality requirements that Medicaid is developing. We could not maintain our Medicaid compliance without her assistance, and she is transparent, patient and excellent at her job.
Heather Goodchild, Clinical Director, Boulder Valley Women's Health

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As part of a comprehensive health risk assessment (HRA), Members will be screened for the following:

- History of BH disorder
- History of substance abuse
- History of inpatient stays for a BH related disorder
- Current symptoms of hopelessness, decrease in pleasure in activities, and anxiety

For Members who screen positive for any of these elements, CCHA *Plus* will determine how many of them were seen by a PCMP or BH provider where a BH diagnosis was billed or were prescribed a psychotropic medication within 60 days. Having this kind of information available will allow the Care Coordination team to better support the Member and achieve the goals of the ACC Program.

Aligning Practice Transformation Projects in Colorado

Colorado is fortunate to have a large number of organizations that are motivated to improve the health care system for our citizens. This has brought many exciting and innovative programs into the State that have been funded by public and private funds. This means that some practices have many different coaches and facilitators in their practice through programs such as CPC+, SIM, ENSW, and other local organization like HealthTeamWorks and Children's Pediatric Collaborative. As a RCCO, CCHA leaders are currently participating in many of the new projects at the leadership level to collaborate and coordinate with our community. The CCHA leadership team members sit on the following:

- ACC Program Improvement Advisory Committee
- SIM Practice Transformation Committee
- Regional Health Connector (SIM) Technical Advisory Committee
- Colorado Opportunity Project Steering Committee
- Colorado Health Extension Systems Committee
- Pediatric learning Collaborative
- Integrated Care Learning Collaborative

- Colorado Health Foundation - Health Insurance Literacy Workgroup
- Denver Chamber of Commerce - Health Care Committee
- Colorado Prevention Alliance workgroups
- Colorado Health Institute Safety Net Advisory Committee

Often practices can feel overwhelmed with multiple competing QI initiatives. As a RAE, CCHA Plus Practice Transformation Coaches will reach out to other coaches and facilitators assigned to practices, so that they can collaborate and not duplicate resources. The practices appreciate having a combined QI team, and coaches work together to align goals to not overburden practices.

State Auditor Testimonial

Within recent years, practices have been overwhelmed with practice coaches associated with separate Department initiatives—i.e., the regional health coordinator with the COP and the clinical health information technology advisor with the State Innovation Model (SIM)—as well as with other payer initiatives. In response, CCHA practice coaches have collaborated with other coaches working in each practice to align objectives and avoid duplication of efforts. CCHA has adjusted its process to coordinate with all practice coaches operating in a given practice, to ensure consistency in coaching approaches.)
Health Services Advisory Group Auditor for the Department

CO_RAE_HlthSrvAdvGroupAuditor09_55_COB_TST_9.1

CCHA has had a distinct advantage among RCCOs in aligning ACC Program practice support and transformation efforts with other practice transformation projects because one of CCHA's managing partners, Physician Health Partners, is engaged in nearly all of the state and federal projects impacting practices:

- Serves as a Practice Transformation Organization (PTO) and Certified Health Information Technology Advisor (CHITA) for the State Innovation Model (SIM)
- Serves as a Practice Transformation Organization (PTO) and Certified Health Information Technology Advisor (CHITA) for EvidenceNOW Southwest (ENSW)
- Supports 20 primary care practices selected for Comprehensive Primary Care Plus (CPC+)
- Supports NCQA Recognition for the following programs: PCMH, Diabetes, and Heart Stroke

As a result, CCHA *Plus* Practice Transformation Coaches will have a direct connection to all of these practice transformation initiatives and the expertise and resources necessary to help the practices align their efforts around multiple practice transformation projects they may be participating in.

Financial Support: Value-Based Payments

As a RAE, CCHA *Plus* will meet all requirement in RFP Section 5.10.10 and drive improvements in the system through payment arrangements with PCMPs, Specialty BH Network Providers, and Health Neighborhood providers that:

- Re-align the connection between price, cost efficiency and value with a focus on quality care and improved outcomes
- Embed payment for value in all reimbursement methodologies, not just pay-for-performance or risk-based arrangements
- Transform the economics of care delivery, moving away from a fee-for-service (FFS) model that rewards volume over health planning and right prevention investments
- Create the right incentives to foster and enable hospitals, health systems, and providers to make the right health planning decisions based on Member needs and evidence-based standards of quality and appropriate care

With the majority of Medicaid enrollees being served by independent primary care practices, CCHA *Plus* is the partner the Department needs to implement programs like the Primary Care Alternative Payment Model (Primary Care APM). These providers do not have the same resources as large providers, such as the Federally Qualified Health Centers, and need support of the RAE to effectively

transition to VBP arrangements. We are a trusted partner of these independent Network Providers and we bring the experience and expertise needed to support providers through payment transformations.

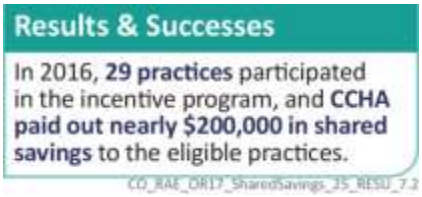
We support the Department's vision to provide administrative and value-based payment (VBP) incentives to support the provision of Medical Home quality of care and to incentivize improved outcomes. As a RCCO, we have worked to prepare Network Providers for a shift to VBP through programs like our CCHA Incentive Program. This pay-for-performance program for Network Providers paid out close to $200,000 in 2016 to large PCMPs serving close to 36,000 ACC Members in Region 6. Practice engagement levels have increased by 40% as a result of the program and performance on key metrics has improved. For example, depression screening rates increased by 24% in 2016.

CCHA *Plus* will also bring Anthem's experience as a recognized leader in Medicaid and other publicly funded programs in the use of VBP incentives and other performance-based incentive programs to drive improvements in evidence-based, clinical performance. Nationally, more than 3,700,000 Anthem affiliated Medicaid members are attributed to a PCMP or other provider who is participating in one or more of our performance-based models.

As a RAE, CCHA *Plus* is poised to work with the Department to implement other VBP arrangements in the ACC to drive integration, increase value, and improve health outcomes. Our innovative models will incent providers across the spectrum of provider types and services including PCMPs, ACOs and large health systems, obstetrical providers, BH providers and facilities, and include performance-based programs for LTSS providers. Through these various VBP arrangements, we have learned what motivates the providers to achieve the goals of the VBP arrangements. ***We will leverage the best practices and lessons learned to deploy impactful provider incentive programs that align with Members' needs and that promote healthy outcomes while realizing greater budget predictability.***

Current CCHA Incentive Program

The current **CCHA Incentive Program** is a pay-for-performance program for eligible PCMP network providers that was designed in consultation with physicians and is funded using incentive payments CCHA has earned for performance. PCMPs can receive performance payments of up to $10,000 to increase Care Coordination and BH integration efforts, use data to drive operations, increase access to care, and achieve KPI targets. The Program creates a nice foundation for CCHA to evolve administrative payments by tying a greater proportion of the dollars to value and aligning with other Department alternative payment methodologies.



To participate, practices must serve more than 350 CCHA attributed Members, be contracted with CCHA, and not be eligible for the safety net reinvestment program. They must also have a CCHA Practice Transformation Coach assigned to the practice and meet with them monthly on quality improvement.

PCMPs have scaled benchmarks to meet around the following areas of focus:

- Frequency of QI team meetings
- Engagement with a CCHA Practice Transformation Coach and Care Coordination team
- Integration of Care Coordination
- Integration of BH services
- Utilization of the SDAC and BIDM systems
- Availability of appointments for post emergency room follow-up visits

Practices are provided with a monthly dashboard to review with their CCHA Practice Transformation Coach during practice quality improvement meetings.

In the next phase of the ACC, CCHA *Plus* will continue to reinvest incentive payments with the Network Providers. We will partner with the Department to align the Incentive Program with Primary Care APM and other PCMP initiatives so that we may continue to evolve and integrate the ACC delivery system, maximize performance, and pay providers for the increased value they deliver.

New Behavioral Health Provider and Other Incentive Innovations

As a RAE, we will leverage Anthem's success with offering financial support to providers for co-location, and providing grants and incentives to support co-location of services using a prospective per member per month payment and participation in the VBP program. Anthem's VBP models will align payment to quality and efficient care and reward providers for their measured performance across these dimensions. VBP models will be categorized in accordance with the Health Care Payment Learning and Action Network (HCP-LAN) APM framework and measurement methodology. Nationally, Anthem has been a key participant in the Payer Collaborative subgroup of the APM Framework and Progress Tracking workgroup. Table 5.10-7 describes the array of programs that Anthem brings to the CCHA *Plus* array of VBP programs to consider.

Table 5.10-7. Anthem Value-Based Payment Provider Incentive Programs Drive Quality and Performance

Value-based payment Program	CMS APM Category/Description	Applicable Provider Type(s)
Pay for Quality (P4Q) HEDIS® Program	P4Q incentivizes providers for closing HEDIS® care gaps. Providers receive monthly care gap reports that identify members needing specified preventive or chronic condition interventions. Related education encourages participation in improving quality metrics and health outcomes.	PCMPs
Provider Access Quality Care Program (PAQCP)	PAQCP incentivizes smaller practices, focusing on PCMPs with at least 250 attributed Members. The program measures PCMP performance against a set of HEDIS®-like quality indicators. Providers receive both quarterly and year-end scorecard reports. Earned incentive payments are made annually.	PCMPs ACOs IPAs
Provider Quality Incentive Program (PQIP)	PQIP provides incentives for select PCMP practices to undertake systemic improvements that affect both health care outcomes and cost trends. Practices must participate for at least 1 year and have at least 1,000 Members to participate. PQIP uses a system of HEDIS®-like quality indicators and shared savings principles to encourage efficient, preventive, and cost-effective delivery of health care services, protecting the best interests of Members and reducing unnecessary utilization.	PCMPs Hospitals with PCMPs ACOs IPAs
Obstetric Quality Incentive Program (OBQIP)	OBQIP offers incentives to obstetrical (OB) providers with a least 10 attributed Members for improving access and quality of care and outcomes for Members with OB needs throughout all phases of their pregnancy. OBQIP providers receive periodic reports indicating interim performance throughout the year, and an annual performance scorecard. Providers receive earned incentive payments annually.	OB Care providers

Value-based payment Program	CMS APM Category/Description	Applicable Provider Type(s)
Behavioral Health Quality Incentive Program (BHQIP)	BHQIP incentivizes CMHCs and high-volume BH professional groups to improve coordination of Members' PH and BH needs and the quality of care provided to those with BH conditions. Providers receive incentive payments for achieving performance targets on specific measures. Earned payments are made annually.	BH providers
Behavioral Health Facility Incentive Program (BHFIP)	BHFIP incentivizes BH inpatient facilities for providing quality care and service to Members. BH facilities will be eligible to receive incentive payments for achieving performance targets on specific measures. Earned payments are made annually.	Hospitals Free-standing BH Facilities
Risk/Shared Savings (R/SS)	The negotiated R/SS arrangements use quality metrics as a gateway to shared savings eligibility to encourage efficient, preventive, and cost-effective health care practices. The provider can accept either upside-only risk or upside and downside exposure. When providers accept downside risk, financial solvency requirements exist and financial statements are reviewed beforehand.	PCMPs Hospitals with affiliated PCMPs ACOs IPAs
Delegated Risk/Capitation	The Delegated Risk/Capitation program globally capitates providers, delegates administrative functions to the provider, and incentivizes them to manage costs effectively within the budget allowed to them via the capitation payment. The program objectives include decrease medical and administrative spending, increase quality, and improve provider and Member satisfaction. Delegated activities may include credentialing, claims, utilization management; additional functions include Case Management, disease management, network development, and provider servicing.	Hospitals with affiliated PCMPs ACOs IPAs

CCHA *Plus* understands that successful VBP programs evolve over time to meet systems needs and priorities, as well as to adapt to the strengths of Network Providers in engaging with performance payment arrangements. While engaging in provider and stakeholder engagement for future planning, we will begin as a RAE by deploying the following two programs focused on BH in addition to the current PCMP program:

Behavioral Health Facility Incentive Program (BHFIP). This program will offer incentives to eligible BH inpatient facilities (such as Psychiatric Hospitals, Freestanding Mental Health Facilities, and Acute Care Hospitals with Psych Units) for providing quality care and service to Members with BH needs. BH providers participating in the program who meet quality, service, and utilization goals will be eligible to receive incentive payments.

Behavioral Health Quality Incentive Program (BHQIP). The BHQIP offers incentives to eligible BH providers such as Community Mental Health Centers and specialists for providing quality care and services to Members. Providers participating in the program who meet quality, service, and utilization goals will receive incentive payments based on objectives designed to improve the following:

- Clinical quality Indicators
- Member outcomes
- Focus on prevention and primary care
- Efficient and appropriate utilization of benefits

In addition to these two BH-focused programs, we are also in the process of developing a pediatric residential treatment facility incentive program.

As a RAE, CCHA Plus will continue developing appropriate incentives to providers to evolve and transform their practices in a manner consistent with their staffing and operational infrastructure, so they are able to address Member needs in a more holistic, less fragmented, and more comprehensive manner.

We look forward to further refining and developing an incentive and administrative payment strategy for Network Providers that allocates at least 33% of the RAE's administrative PMPM to PCMPs. We will work with providers to design VBP arrangements that over time tie a greater proportion of the dollars to value and align with the Department's Alternative Payment Methodology.

Provider and Stakeholder Engagement around Value-Based Payments

As a RCCO, CCHA has always included the voice of the providers in the creation of VBP programs. They currently have several forums to receive input from Network Providers, Members, and stakeholders toward the development of VBP strategies, including Provider Update meetings, the Member Advisory Committee, and Program Improvement (Health Neighborhood) Advisory Committee.

As a RAE, CCHA *Plus* will continue to ensure transparency and collaboration. We will offer advance notice of meetings and invite all interested parties from the community to participate. Meeting minutes will be posted on our website. Additionally, Department staff is always welcome and currently often participates in CCHA provider forums. CCHA *Plus* also looks forward to participating in the Department's Operational Learning Collaborative to learn from other regions and receive their feedback on our incentive administrative payment strategy.

Administrative Payments to PCMPs

CCHA *Plus* brings significant experience making administrative payments to PCMPs in Colorado. As a RCCO, CCHA has delivered the following payments to providers:

- Monthly per member per month (PMPM) payments for Medical Home level Care Coordination provided by 7 Safety Net Providers and Advanced PCMPs (Kaiser, Clinica Family Health Services, Denver Health, Metro Community Provider Network, St. Anthony North Family Medicine Residency, Salud Family Health Centers, and Rocky Mountain Youth Clinics)
- SIM and CPC+ payments to participating Network Providers
- CCHA Incentive Program payments for practices that achieve target goals related to KPIs, quality improvement activities, practice transformation, engagement with CCHA, and education

In all of these situations, CCHA has entered into a written contract with providers that details the payment arrangements and expectations of the providers. Additionally, the Practice Support team is available to answer any questions that providers might have around the payments.

CCHA *Plus* is committed to ensuring that administrative and performance payments required by 5.10.10 are included in all Network Provider contracts. In fact, CCHA currently engages into written contracts currently for any payments they provide to PCMPs, including through the CCHA Incentive Program or other practice transformation projects like SIM and CPC+. CCHA *Plus* will easily be able to accommodate the provision of reporting that details the distribution payments as per the requirements of the Quarterly Financial Report and the RAE Provider Payment Arrangements Report.

Our Provider Support Program for Safety Net Providers and Advanced PCMPs

CCHA *Plus* will offer our Provider Support Program to Safety Net Providers (federally qualified health centers like MCPN, Clinica and Salud and Advanced PCMPs (like Kaiser, Rocky Mountain Youth Clinics and St. Anthony's Family Residency).

> Over the last 6 years, CCHA has passed along more than **$9M of the PMPM** to these Safety Net providers.

Safety Net Providers and Advanced PCMPs typically meet ACC Medical Home standards and expect that the RCCO payment be passed along to them. As a RCCO, CCHA has passed along more than $9M in ACC payments to these providers in Region 6. Additionally, the CCHA Provider Support Program gave these providers resources and collaborated with them to align with the direction of the ACC and improve performance.

> **State Auditor Testimonial**
>
> *CCHA has responded by developing an attitude of support with delegates (safety net providers) and other entities by offering designated CCs to support members in practices, sharing data resources, and offering on-site consultation through a delegated practice liaison.*
> **Health Services Advisory Group Auditor for the Department**

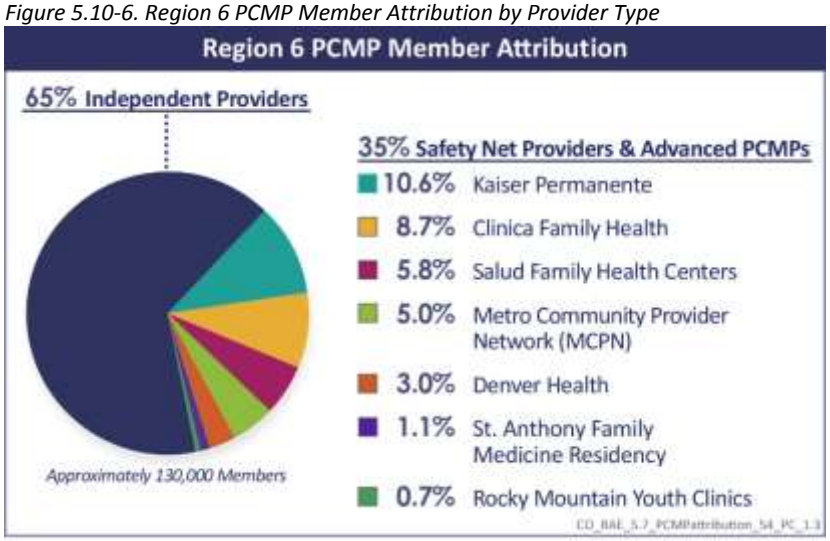
Safety Net Providers and Advanced PCMPs are an important component of the delivery system. As a RCCO, CCHA has acknowledged the sophistication of these providers and supported them in being successful in serving the community.

As a RAE, CCHA *Plus* will meet with each Safety Net Provider and Advanced PCMP to help them with administrative issues and work with them on quality improvement efforts. We will produce a ***monthly performance dashboard*** that informs the provider of their general Member demographic and performance measures as compared to other like providers and the overall regional performance. The dashboards will track performance of ACC KPIs over a rolling 12-month period. This information will help providers with their patient engagement processes by identifying trending issues and successes that are used to inform improvement strategies and best practices.

In the monthly meetings, CCHA *Plus* will:

- Provide the latest updates from the Department regarding the ACC
- Address billing *and* coding and revalidation issues
- Monitor monthly Member attribution numbers and address attribution problems, see Figure 5.10-6
- Review provider performance on ACC Key Performance Indicators
- Conduct a Care Coordination review, including annual audit
- Support integrated care activities (for example, Care Coordination workflows for sites with a BH provider onsite at the practice)
- Assist with various local, state, and national practice transformation projects such as SIM, Colorado Department of Public Health and Environment grants, etc.

Figure 5.10-6. Region 6 PCMP Member Attribution by Provider Type



- Connect providers with the Health Neighborhood and community-based resources
- Encourage providers to participate in new initiatives aimed at improving overall Member health and well-being
- Discuss Member engagement process improvement collaborations

Provider Testimonial

We are enthusiastic about the positive work CCHA and the ACC have accomplished and 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.
Peg Burnette, CPA, FHFMA, Denver Health

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As discussed in OR 23, KPI performance of these providers in the first iteration of the ACC has been varied. In most cases**, independent providers currently coached by CCHA are outperforming the Safety Net Providers on all three ACC KPIs.** As a RAE, CCHA *Plus* will continue to work with these providers to improve performance and will apply value-based PMPM payments to incent increased engagement and quality improvement efforts.

Beyond the services available through the CCHA *Plus* Provider Support program, we will seek to partner with Safety Net Providers and Advanced PCMPs to engage in integration and population health efforts, and share best practices across the region. ***We seek to help all providers learn from one another and move along the continuum of providing a Medical Home level of care.***

Some examples of the collaborative efforts CCHA has engaged in with the Region 6 Safety Net Providers over the years include:

- Established a KPI Reinvestment program that provided funding for implementing KPI improvement strategies to MPCN, Clinica, and Salud
- Administered the Women's Wellness Connection Grant offered by the Colorado Department of Public Health and Environment, which provides funding to MCPN, Clinica and Salud to implement outreach interventions that increase cancer screening compliance rates
- Offered Specialty Care Access projects to help connect providers with specialty care resources
- Held a CCHA Best Practices Roundtable, which provided an opportunity to connect with other community providers and share best practices around areas such as Care Coordination, practice transformation, and KPIs
- Hosted a back-to-school outreach pilot project together with an elementary school and a safety-net provider in Boulder County to improve well-child checks and Member attribution to a PCMP
- Piloted a project to outreach unattributed Members via Interactive Voice Response (IVR) using the voices of providers from Clinica to engage Members in developing a meaningful relationship with a PCMP

In addition, CCHA partnered with the Colorado Community Managed Care Network (CCMCN), the data arm of the FQHC association, in a data-sharing project designed to improve FQHC performance on ACC KPIs. CCHA provides CCMCN with all the Medicaid claims for every Member attributed to an FQHC, about 19% of the population in Region 6. CCHA has provided $20,000 to CCMCN to compare Medicaid claims and each Member's electronic health record to get a complete picture to identify gaps in care, like preventive screenings and well-child checks. CCMCN produces a dashboard for each individual FQHC to evaluate progress on reaching KPIs and identify opportunities to improve performance. CCMCN also provides practice transformation support to the FQHCs to make changes and improve scores. The project has focused on improving the well-child KPI. In the next phase of this project CCHA *Plus* will plan to expand the work to a common BH integration measure — depression screenings.

While we know that the majority of Members are served by independent providers who are not considered Safety Net Providers or Advanced PCMPs and need the support of the CCHA *Plus* Provider Support Program to meet the expectations of the ACC, CCHA *Plus* realizes the importance of supporting Advanced PCMPs and Safety Net Providers and is committed to continuing support of the Safety Net Providers and Advanced PCMPs of Region 6, like MCPN, Clinica and Salud who altogether serve 35% of Members in the Region to share our resources, including the Provider Support Program and collaborate on efforts to improve care for ACC Members.

Provider Testimonial

KPCO staff worked with CCHA as the RCCO for Region 6 over the last three years to address care coordination issues for our members to ensure members received the care they needed to maintain or improve their health. CCHA was a very good partner by keeping in regular communication with our team, focusing on solutions to expand access to services, and strengthening their care coordination program to treat the whole person.
Kathleen Westcoat, MPH,
Senior Director for Medicaid and Charitable Programs,
Kaiser Permanente

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CCHA *Plus* Will Meet All Section 5.10 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 17, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.10 that are not detailed in our response.

Section 5.11

COLORADO COMMUNITY HEALTH ALLIANCE

Primary Care Alternative Payment Methodology (Primary Care APM)

5.11 PRIMARY CARE ALTERNATIVE PAYMENT METHODOLOGY (PRIMARY CARE APM)

CCHA *Plus* Will Meet All Section 5.11 Requirements

CCHA *Plus* acknowledges that there are no Offeror Response questions associated with the requirements set forth in Section 5.11. We affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.11, specifically noting our obligations to the Department in:

- 5.11.1 Understanding that the Department will be transforming its approach to primary care payment in the Fee-for-Service system by implementing the Primary Care Alternative Payment Methodology (Primary Care APM)
- 5.11.2 Administration of the Primary Care APM by designating PCMP Practice Sites within their region eligible to participate in Track One
- 5.11.3 All of activities outlined in 5.11.3.1 through 5.11.3.6

Section 5.12

COLORADO COMMUNITY HEALTH ALLIANCE

Capitated Behavioral Health Benefit

5.12 CAPITATED BEHAVIORAL HEALTH BENEFIT

OFFEROR'S RESPONSE 18

Describe how the Offeror will administer the Capitated Behavioral Health Benefit within the broader Accountable Care Collaborative while ensuring the continued delivery of sufficient Behavioral Health services and successfully managing the financial risk. Specifically address how the Offeror will:

a. Administer the Capitated Behavioral Health Benefit according to the principles outlined in Section 5.12.4.

b. Deliver services in multiple community-based setting.

c. Ensure compliance with federal managed care regulations.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

Administering the Capitated Behavioral Health Benefit

As a RAE, ***CCHA Plus is well prepared to administer the Capitated Behavioral Health Benefit, making sure these funds are managed responsibly to confirm the delivery of medically necessary mental health and substance use disorder services that are localized, customized, evidenced-based, and above all, Member-centered and recovery- and resilience-driven.***

We look forwarding to partnering with the Department to build on the foundation established over the years and continue to evolve the Community Behavioral Health Program to ensure the delivery of high-quality, cost effective behavioral health (BH) services. We will work to increase access to BH and substance use disorder treatment for Members in collaboration with the State's Managed Service Organizations, the Office of Behavioral Health, and the Colorado Consortium to Reduce Prescription Drug Abuse.

Our established processes, technology, and resources assume risk for all covered inpatient and outpatient BH services; take responsibility for providing medically necessary BH services; and make certain capitated payments support Members in achieving behavioral health and well-being (and are not diverted to physical health services). Through sound fiscal management of capitated payments, we will fully support Members' care and service needs.

Building on the work completed by the State since the inception of the Community Behavioral Health Services Program, we will continue to evolve the BH services system with an integrated, whole-person, team-based, recovery-oriented approach. We will administer the Capitated Behavioral Health Benefit as part of an integrated model. ***Our multidisciplinary team will work as a single team to coordinate the full spectrum of care and services for Members, creating a seamless experience for Members and Providers.***

Through our person centered planning we will work with our Members to ensure their total health care needs are being met. In seeing that our Members' needs are met, we will focus on ensuring the least restrictive setting with access to community based care along with necessary social supports. Our approach to facilitating the delivery of services in community-based settings stems from years of experience serving Members with extensive needs. It is our goal that Members are receiving the necessary services to increase their tenure in the community while advancing their recovery journey.

As discussed in OR 11, CCHA *Plus* will bring national BH expertise in building a BH network on a local level. One of our primary goals is to build up the independent provider network in the Region to help alleviate BH access problems that exist today. We look forward to partnering with Community Mental Health Centers (CMHCs) and supplementing the network by contracting with additional independent BH providers so that we can expand access to mental health and substance use services. In fact, we received the endorsement of Arapahoe House, the largest substance use provider in the state who is looking forward to the fresh opportunity we bring to make the best use of state resources and collaborate with the provider to connect Members with substance use services.

Provider Testimonial

As the largest substance use provider in the state, Arapahoe House needs the support of the RAE to expand access to critically needed substance use services to Medicaid Members. We believe CCHA brings a fresh opportunity to make the best use of state resources and collaborate with Arapahoe House and the Managed Service Organizations to connect Members with substance use services quickly and efficiently. We look forward to a more streamlined administrative process with CCHA for delivering these much-needed services. We are happy to participate in their Health Neighborhood Advisory to strengthen coordination among providers and the community and to make recommendations on how best to invest RAE incentive payments in the community.
Mike Butler, President/CEO, Arapahoe House

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CCHA *Plus* recognizes that one of the ways to expand BH access is to support Primary Care Medical Providers (PCMPs) in their efforts to screen for BH conditions and to provide services in the primary care setting. We look forward to bringing our expertise in working with PCMPs to integrate BH services. ***With the combined local experience of CCHA and Anthem's extensive BH expertise (more than 23 years administering Medicaid capitated BH benefits and as a leader in integration), we are bringing a truly integrated model to Colorado designed to improve Members' access to BH services by building a comprehensive, independent Provider Network, while managing capitated payments responsibly.***

Anthem's BH experience and expertise will bring value to the ACC Members and the Department

- Providing **fully integrated PH and BH services** for approximately 5.6 million Medicaid Members in 18 states
- Supporting more than 303,000 Members diagnosed with **SPMI** in 13 states
- Managing **wraparound and rehabilitative** services for more than 56,000 Members with **SED** in 14 states
- Supporting more than 61,000 Members diagnosed with **IDD** in 13 states
- Offering services according to the principles of **trauma-informed care** for more than 56,000 children, youth, and young adults in foster care and adoption assistance in 10 states
- Overseeing **crisis services and outpatient therapy** for families and children in 16 states
- Offering **intensive psychiatric rehabilitation** in 12 states
- Managing **1915(c) waiver services** in 9 states
- Coordinating **peer support services** in 8 states

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Anthem's extensive experience managing capitated BH covering 5.6 million Medicaid beneficiaries includes serving Members who have complex physical, behavioral, and social support needs, such as those with serious and persistent mental illness (SPMI) and those with serious emotional disturbance (SED). ***Anthem Medicaid has received recognition nationally as an accredited Managed Behavioral Health Organization (MBHO) by NCQA,*** which demonstrates the success and proficiency Anthem brings to CCHA *Plus* across Quality Management, Care Coordination, Utilization Management, Credentialing, and Members' Rights and Responsibilities (all of which received scores of 100% on associated NCQA standards).

Anthem's robust Medicaid BH programs with a focus on community based care throughout the country have used wraparound services for health, social, and alternative services, such as intensive case management, assertive community treatment, housing programs, peer support, and vocational services. Anthem also brings extensive experience in managing 1915(b)(3) waiver services as well as keen understanding of and experience in recovery and resiliency strategies. Anthem's programs have received many awards and industry recognitions.

We applaud the work the Colorado Consortium to Reduce Prescription Drug Abuse has done to address opioid use in the state. We look forward to joining the fight against opioid addiction in the State. ***As a RAE, CCHA Plus brings Anthem's Opioid Over-utilization Management Program. The Program was recognized in March 2017 for "Excellence for Care Management Strategies" by the Pharmacy Benefits Management Institute. Several programs were cited in the 2016-2017 Best Practices Compendium by the Institute for Medicaid Innovation, including the Primary Care Integrated Screening, Identification, Treatment, and Evaluation (PC-INSITE) program as well as the COACHES program for youth transitioning from foster care to adulthood. In 2016, Anthem was among just 27 organizations recognized with the 2016 Disability Employer Seal by the National Organization on Disability.***

Understanding the complexities and nuances of BH (especially SPMI or SED) takes integrated care that explores all aspects of the Member's life. We will use a whole-person, collaborative, team-based approach where PH and BH clinicians work together, so we can better detect, identify and coordinate care and reduce gaps to offer a continuum of targeted interventions, education, and enhanced access that will end occurrences of inappropriate care and effectively control costs. Our approach includes:

- Promoting the effective and efficient delivery of quality PH, BH, and social services and supports
- Delivering tailored, person-centered care plans that include the Member's strengths, needs, goals, and preferences
- Tailoring the intensity of Care Coordination interventions based on a Member's risk factors and needs
- Including programs for Members with specialized health care needs, such as Members with co-occurring conditions, who are pregnant, with complex BH conditions (such as SPMI or SED), and who are in the child welfare system
- Monitoring Member progress to identify and address opportunities for service, program, and process improvement

Full integration begins with our philosophy on and ability to integrate BH into our infrastructure as a RAE, including policies, procedures, processes, training, and systems. We will follow this methodology by assuring the understanding and participation of our Providers through effective and ongoing education and training, and by offering meaningful resources for practice transformation, as well as BH quality incentives.

We support the integration of PH and BH across all areas of our organization, our Provider Network, Health Neighborhood, and the Community. As described in this section, we will deploy strategic programs, best and promising practices, and activities to administer the BH benefit and drive quality care and better outcomes.

a. Honoring Behavioral Health Principles

We will administer and coordinate all BH services as a core part of our function as a RAE, using unified structures around Care Coordination and management, utilization management, payment, and reporting. We applaud the State's commitment to best practices and principles in health care delivery and will administer the Capitated Behavioral Health Benefit according to the principles outlined in Section 5.12 of the Statement of Work.

Principles of Recovery and Resilience

Recognizing that recovery and resiliency principles extend across all ages and settings, we will coordinate care and services across systems to support Members' wellness, recovery, and resilience with the understanding that every member can recover. Through the lens of self-determination and a focus on community inclusion, we will support Members by providing information on their benefits and available services and facilitating their active participation to choose services and providers; accessing community resources; building their care team; and focusing the team on their strengths, protective factors, preferences, abilities, motivations, and personal goals. We adopt the Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of recovery and incorporate it in our Network Provider trainings — ***a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential*.**

We believe that a strong support system is the foundation of recovery and resiliency and work closely with our Members and — with their permission — their families or support system, caregivers, and other natural supports to identify and meet our Members' needs. We also respect Members' choices to not to participate in wellness or recovery, encourage patient activation, and support their decision-making throughout the wellness and recovery journey.

Our Care Coordination model takes every aspect of a Member's life into account. In their journey to achieve health and wellness, we support Members through an integrated assessment, Care Coordination, and service delivery process that links them to preventive care, safe and stable housing, meaningful daily activities, and their community.

Our BH clinicians will use evidence-based practices to provide the level of support most appropriate for each Member based on the Member's desired outcomes, identified needs, and personal recovery efforts. A recovery philosophy — strengths-based and committed to Member self-determination, empowering relationships, and a meaningful, productive role in the community while eliminating stigma and discrimination — represents the foundation of our work.

During assessment and care planning processes with Members and their support system, we will explore with the Member and family their readiness to change, and we will facilitate their work in identifying their strengths and areas where they see the need for change. We will coordinate services through a team that involves the disciplines necessary to meet the Member's needs holistically, and which allows us to share a comprehensive view of the Member's health, functional status, and recovery.

Principle of Trauma-Informed Care

According to the National Council for Behavioral Health, trauma is a near universal experience for individuals with BH needs.[1] Our person-centered approach engages Members based on where they are in recovery and recognizes Members as primary contributors in their care. Members identify goals and motivations and drive development of their care plans to address physical, behavioral, social, and spiritual needs. Care plans address social determinants of health, such as resources to meet individual needs, proactive strategies to mitigate or manage crisis, and day-to-day flexibility to respond to ever-changing needs. We will use a trauma-informed engagement approach and embrace strategies such as Motivational Interviewing. We will team with our Providers, local governmental resources, community resources, and faith-based partners to wrap supports around Members. These supports are delivered face-to-face by caring and qualified people building real relationships with Members that are grounded in the community.

Person-centered PH/BH Care Coordination improves new Member's health and quality of life

When Maria, our Care Coordinator, met new Member Eva, she knew Eva could benefit from our help. Eva has diabetes, weighs 650 pounds, and has an extensive history of physical and sexual abuse. She is unable to ambulate, living in her bed, and needs help with all activities of daily living. Her previous PCMP released her due to treatment non-compliance, and she had stopped outpatient mental health therapy.

Using motivational interviewing techniques, she listened to Eva's concerns and her goals for her mental health, weight loss, and quality of life. Maria arranged for a stay at a long-term acute facility for wound care and weight loss, and after 10 months, Eva's health and outlook had improved. She had lost 200 pounds, was reengaging with mental health services, and was ready to go home. And thanks to Maria's Housing First approach – stopping Eva's impending HUD apartment eviction – she returned home with PCMP home visits and home health services to continue on her path to better health and quality of life.

Anthem Member Centered

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Through our Colorado Medicaid Training Academy (Academy), we will educate staff and both PH and BH Providers on trauma-informed care to recognize the vulnerabilities and triggers of past trauma. Our Trauma-Informed Care Model includes:

- Staff who receive training on trauma in order to view each Member through a trauma informed lens
- Dedicated trauma-trained Care Coordinators and outreach case specialists who work with Members in foster care
- Identification of Providers that have trauma-informed practices and development of a comprehensive guide on preferred Providers and specialists that are considered trauma-trained
- Trauma considered and treated concurrently with other serious chronic and complex conditions

Our managing partner Anthem brings experience delivering trauma-informed care to more than 56,000 children, youth, and young adults in child welfare systems across the nation. We will leverage their experience and use a trauma-informed approach as a valuable best practice in identifying and addressing Members' adverse childhood experiences, which often result in co-morbid and co-occurring conditions. Our approach is supported by a growing body of research that demonstrates that individuals who experience trauma, particularly in childhood, have much higher incidences of chronic disease and BH issues.[2]

[1] National Council for Behavioral Health. Need for Trauma-Informed Care. Retrieved from https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/

[2] Davis, R. and Maul, A. Center for Health Care Strategies. Trauma-Informed Care: Opportunities for High-Need, High-Cost Medicaid Populations. March 2015. http://www.chcs.org/media/TIC-Brief-031915_final.pdf

Principle of Least Restrictive Environment

We support all opportunities for Members, including those with SPMI and other disabilities, to maximize their ability to seek and obtain treatment and to live, work, and learn in the communities of their choice with the appropriate level of clinical support. Our person-centered approach and practices facilitate Member- and family-driven services and supports that are responsive and meaningful to evolving preferences, health and functional support needs, and personal goals. Further, our integrated model aligns with SAMHSA's System of Care Model and Integration Approach, which is a best practice designed to make BH more accessible and connected to the broader health system.

Our successful cross-disciplinary care and service coordination model, honed over many years serving diverse and complex Medicaid and other populations across the U.S., emphasizes a Member-centric focus: ***No matter what we do, we will emphasize the Member, not the process.*** We will engage Members as active participants in their health care decisions and address their biopsychosocial strengths and needs through quality services and supports, Care Coordination and management, a recovery focus, and health promotion.

Our Care Coordinators will meet with Members in the communities they live in to develop individualized care plans that span the service delivery systems of PH, BH, and social supports, and as indicated, maximize Member independence and offer care in the least restrictive setting possible. This model includes coordinating waiver services to help Members remain in their communities. We designed our Level of Care (LOC) guidelines to make sure Members receive the most clinically effective, appropriate, and least restrictive services based on their unique needs, goals, and circumstances to support their recovery and community living. We recognize that the care continuum is fluid and Members may enter treatment at any level, moving to more or less intensive settings or LOCs. At each LOC, our goal is providing access to individualized treatment. Our BH Utilization Management (UM) guidelines reflect evidence-based treatment protocols for children, adolescents, and adults.

Rising Star Program

We will create programs and services that enable Members with SPMI, SED, or other disabilities to live in their community, in the least restrictive setting possible. For example, Anthem created its Rising Star program to improve health outcomes for Members with SPMI or SED – with a specific focus on those Members who are most resistant to care. Across 5 states, this program has helped provide continuity of care for Members with SPMI or SED through consistent collaboration with the Providers who are already engaged with them. Each Member is assigned a Home Hospital or Home Provider and a Care Coordinator to promote continuity. By giving Members a choice about how they will use services, Anthem encourages the process of self-managing their conditions. They build trust and help make sure the Member has a voice in the process, so that he or she becomes accountable for treatment compliance. Anthem also addresses barriers and needs such as homelessness, vocational interests/challenges, and transportation. ***The program has been a success because it offers consistent treatment, reduced readmissions, improved quality of life, and a consistent physician contact.*** Table 5.12-1 highlights individual successes in the program:

Table 5.12-1. The Individual Stories behind the Rising Star Program Numbers

Individual Before	Individual After the Rising Star Program
Female Participant: 18 psychiatric hospitalizations 17 ER visits in under 10 months Two failed interventions	**Female Participant after 29 months in Rising Star:** 5 hospitalizations 5 ER visits Actively involved with her child and has a healthy relationship with her husband
Male Participant 12 psychiatric hospitalizations Disabled, living in supervised housing	**Male Participant after 15 months in Rising Star:** No hospitalizations Regular attendance at outpatient facilities Receive an award for improvements in function from a Provider organization for SPMI clients.

Principle of Culturally Responsive Care

We support and implement culturally competent practices to assure effective engagement of Members in their health care with systems, services, and Providers. We incorporate our cultural competency practices across every part of our delivery system — such as honoring Members' beliefs, being sensitive to cultural diversity, and adopting attitudes and interpersonal communication styles that respect Members' cultural backgrounds including BH awareness campaigns to ensure sensitivity towards our members living with BH conditions For example, we include relevant questions during initial and comprehensive Member assessments; develop cultural supports in the Member's care plan; recruit qualified, multi-cultural practitioners; and partner with local, community-based organizations and cultural groups to provide additional support for Members.

Angela's Story: Eliminating Barriers to Communication

Angela is a seven-year-old Member with a hearing impairment. Her PCMP contacted our Care Coordinator for assistance after experiencing difficulties securing a face-to-face translator for Angela's appointments. Communication was particularly challenging as her mother is Spanish-speaking and does not know sign language.

We arranged for interpreter services to meet both Angela's and her mother's needs during provider appointments. We also located free sign language and English as a Second Language classes in the community for Angela and her mother. As a result, Angela received the care she needed, her mother participated in her treatment, and communication significantly improved with the PCMP and between Angela and her mother.

Anthem Member Centered

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We will identify and bridge gaps in care to make sure all of our Members receive equitable and effective care. We will provide access to Members with special health needs (such as video relay for the hearing impaired) and we will work with the Department and community partners to meet the needs of Members with intellectual and development disabilities. We know that the quality of the patient-provider interaction has a profound impact on Members' ability to communicate symptoms to their Provider and adhere to recommended treatment.

When developing our Provider Network, we will consider cultural competence, multi-lingual support, accessibility to the Provider's premises, and any special communication abilities, such as interpreter services. We will identify and recruit Providers with the cultural characteristics and experience to offer care compatible with our Members' cultural health beliefs and in their preferred languages, whenever possible. We will monitor Providers' racial and ethnic population mix to make sure the network reflects and meets the needs of our Members. We will also conduct on-site visits to verify compliance with our standards for physical accessibility, and establish policies and procedures to make sure we can appropriately respond and assist our Providers in responding to Member requests for interpreter services.

We will communicate with respect to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families, and communities. Our organization meets all Culturally and Linguistically Appropriate Services (CLAS) requirements defined by the State and complies with Title VI and the National CLAS standards for BH benefits. We have adopted all 15 CLAS standards to promote the equitable and effective treatment of all Members entering the health care system.

Through our Academy, we furnish information that Providers and their staff can use to remove cultural barriers between themselves and Members. We offer multi-modality training venues for all Network Providers, including in-person, online, tailored webinars, and written materials aligned with population-specific needs and requirements. We will also conduct CLAS training for Providers in our network as part of our new Provider orientation program, as well as on-demand through our Provider website, along with our Cultural Competency Toolkit.

Our Care Coordinators will help Members locate Network Providers who speak a specific language or are of a specific ethnicity. We will connect Members to telephonic language interpretation services through our language line as needed and as requested. We will review aggregate data from various sources, including Colorado Department of Public Health and Environment data, HEDIS® reports, U.S. Census reports, cultural needs and assessment reports, and State of Colorado Medicaid program data, to see that our network reflects our region's cultural diversity. We will update enrollment data daily; our language line usage report monthly; and CAHPS® Member surveys, Member complaint data, and Provider language and ethnicity annually.

Cultural competence is a dynamic process that involves continually learning and responding as our membership evolves. We will routinely analyze Member utilization and demographic information to identify the cultural groups and unique characteristics of the communities we serve, determine any communities or cultural groups that are not being reached or served, and identify solutions for reaching these communities or cultural groups. Through our Quality Management Committee, we will conduct an annual population analysis that assesses our Member population's characteristics and needs. The Committee will consider the Members' cultural, ethnic, and linguistic needs; their clinical characteristics; clinical programs; demographics; and quality improvement efforts. Based on the findings, we will review and update Member materials and our website.

Principle of Prevention and Early Intervention

We support community-focused prevention and early intervention to reduce the impact of mental health and substance use disorders on individuals and communities. The objective of our Early Treatment Program's (ETP),for members with first time psychosis episode, is to engage Members via a team based intervention focusing on shared decision making that is geared toward recovery. Research has indicated that implementing the ETP evidenced based interventions in a community setting will help to prevent potential admissions, readmissions and ER visits. Moreover, outcomes show decreases in behavioral and medical health care costs, and improved quality of care and quality of life for these Members.

Further, the ETP program is modeled after the national experimental intervention, NAVIGATE (Schooler, 2014) that employs a coordinated specialty care model that includes a comprehensive and integrated treatment intervention. The NAVIGATE components include the following core areas: psychopharmacological treatment, family treatment, individual resiliency training and supported employment/education. Providing members an Early Treatment Program with a specific focus on recovery from psychosis will assist in promoting improved Member functioning and empowerment,

health, recovery, and resiliency along with the appropriate use of treatment, interventions and social supports.

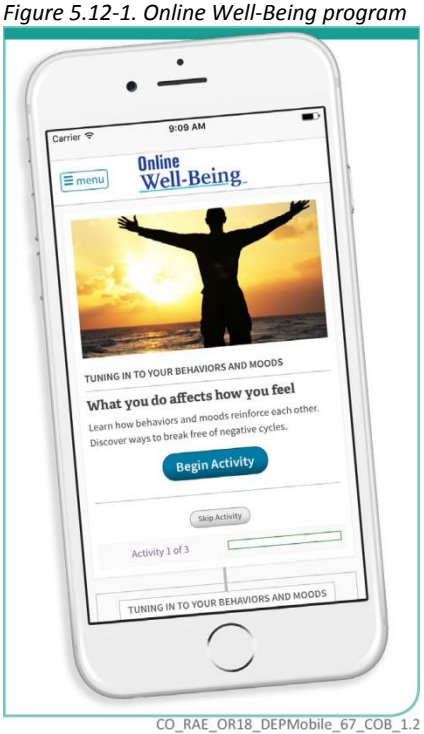
We know that stigma and misconceptions prevent many Members from getting the help they need. In fact, the Colorado Health Institute's Colorado Health Access Survey showed that stigma is one of the primary reasons people do not seek BH care. To help eliminate these barriers, we will focus on educating Members, Network Providers, and the communities we serve about mental health and recovery and resiliency, and collaborating with and training Providers and their staff on rephrasing mental health and substance use disorders as emotional health to help normalize these issues. ***For example, as a RCCO, CCHA is currently partnering with local public health agencies and Centura in the new Statewide Let's Talk campaign or Hablamos Colorado. The campaign was developed by a coalition of public health departments that received a grant to create a Mental Health Stigma campaign as part of the Statewide Innovation Model project.*** CCHA *Plus* will also partner with and support Mental Health First Aid Colorado (which promotes mental health education and wellness for Coloradans) to increase training and certification. We will partner with community organizations to host Mental Health First Aid training, bringing individuals together from community organizations.

To improve the public's understanding of mental health and substance use disorders, normalize these conditions as legitimate and treatable, and to actively promote emotion health, we will provide education and information via published materials, planned programs, and events, such as:

- General health education fact sheets
- Health education messages for callers on hold
- Community health education through classes, health fairs, and events
- Automated or live telephone scripts that promote knowledge and awareness of mental health and substance use disorders
- Content on our website

In addition to outreach and education, Members will also receive BH support through our value- added benefit, Online Well-Being. This benefit consists of an online community that promotes mental health and wellness through instruction, games, goal setting, and monitoring. ***Our program includes web and mobile resources to help strengthen mind, body and spirit and offers personalized resources to help Members take an active part in improving their health and well-being.*** Known as "the health club for your mind," our Online Well-Being program provides Members with health education and prevention information that encourages strong connections between Members and primary care, see Figure 5.12-1. Studies show individuals have greater short-and long-term success achieving a healthy lifestyle when they have access to a support network.

Figure 5.12-1. Online Well-Being program



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We will implement a comprehensive array of services that build on initiatives implemented by CCHA and Anthem in other states, which have demonstrated value in identifying Members who can benefit from preventive and early intervention services. ***Screening for emerging or unrecognized BH treatment needs is an important***

component of our program and key to achieving positive integrated health outcomes. We will work with Providers to help them incorporate BH screening tools into their workflow and use the results so that Members and their families receive preventive and early intervention.

We will partner with CMHCs and Colorado Crisis services to provide community education, and will also offer trainings for our Network Providers and staff to rephrase mental health and substance use disorders as emotional health to normalize BH needs. During interactions with Members and families, our Member Services Representatives (24/7 Call Center) and Care Coordinators will offer education around normalizing BH and assist Members in navigating resources to meet behavioral, physical, and social determinants of health needs. When we speak with Members, we discuss how stress impacts physical and emotional health. We also provide education on how physical and emotional health impact each other. We have found Members are responsive to this, given that almost everyone has experienced stress at some point in their lives. We will provide education related to BH diagnoses and symptoms and how BH services can help improve emotional health.

Principle of Member- and Family-Centered Care

We believe that there is not one definition of person-centered care — it is unique to each Member and his or her support system. Our person-centered philosophy aligns all services and supports based on the Member's choices, preferences, and desired outcomes, as well as the strengths and needs of Members, their families, and their communities. Our Care Coordinators will engage Members and their families in recovery and resiliency care planning that includes the Member, family members or representative, primary care and BH treating providers and other services providers, and others chosen by the Member or involved in the Member's daily living. We will work with Members and their families to identify services and supports, including informal supports and services reimbursed from other funding streams. Our approach includes the following:

- Putting Members at the center of care by helping them express their needs and goals, as well as respecting their strengths, preferences, values, and culture
- Assuring the delivery and continuity of timely integrated and well-coordinated care that is meaningful to Members' needs
- Supporting our Members in deciding who is involved in their health care decisions
- Supporting open, two-way communication, information, and education by collaborating with Members and their identified health homes (including their families and providers)
- Assuring Members are safe in the most appropriate environment for their needs
- Providing education to Members and their care team that will help them make informed decisions about their care

In addition, we will develop care plans with our Members that address social determinants and community resources needed to meet individual needs, proactive strategies to mitigate or manage crisis, and day-to-day flexibility to respond to ever-changing needs. We use a trauma-informed engagement approach and embrace solution-based strategies such as Motivational Interviewing. We will team with our Providers, local governmental resources, community resources, and faith-based partners to wrap supports around Members. ***These supports are delivered face-to-face by caring and qualified people building real relationships with Members.*** These supports are grounded in the community. We will also encourage collaboration between care team members to promote whole-person and integrated care, while also exchanging only the most essential areas of their care to protect Member autonomy and privacy.

b. Delivering Services in Multiple Community-based Settings

No matter where our Members reside, we will provide access to medically necessary BH services. Leveraging Anthem's extensive BH expertise, we will implement a comprehensive network that meets the needs of the ACC Program Members across access standards and includes all provider types outlined in the Statement of Work. With access to a range of BH providers across multiple, community-based settings, we can shift the burden from CMHCs (who currently receive the majority of referrals), increase accessibility, and improve outcomes. Our approach to facilitating the delivery of services in multiple community-based settings stems from years of experience serving Members who have specialized needs: expectant mothers, young children, Members receiving waiver services, individuals in the hospital or transitioning from a place of service, individuals in nursing homes, and individuals with complex or chronic needs, including individuals diagnosed with SPMI and SED.

To connect Members to the intensity of services they need to support recovery and to maximize access to community-based services, we will leverage our existing relationships and build upon these with Providers, facilities, and community-based organizations across the continuum of care, including:

- Community Mental Health Centers
- Substance Use Services Providers
- Federally Qualified Health Centers
- Independent Providers
- Single Entry Points
- Community Center Boards
- School-based health centers
- Food pantries, housing and transportation resources, financial and legal resources
- Human service organizations, peer-run organization, advocacy and faith-based organizations
- Local public health agencies

Our Care Coordination team is the lynchpin to assuring our Members have access to the right supports and services at the right time and in the right place. Care Coordinators integrate PH and BH coordination, consider a Member's social and functional risk factors, calibrate the intensity of Care Coordination to each individual, and deliver tailored, Member-driven care plans that incorporate community-based services to encourage independent and sustained recovery. Our Care Coordinators are knowledgeable about and will link Members and their families to Covered Services (including 1915(b)(3) supports) and additional community resources, supports, and systems they need (such as disability advocacy groups, for example).

In building our Provider Network, we will consider the full continuum of BH services that Members of all ages and genders will need. We will analyze expected populations to identify available Providers by type and specialty and will target all available Providers within the travel distance requirements, including contiguous counties. We will leverage Member-to-Provider ratios set forth by NCQA, MBHO, and State regulations, and where needed, enhance these standard measures by developing more stringent target ratios in regions or specific populations. We will establish target ratios of Members to Providers, by Provider type, to account for expected utilization of services. Our network development strategy does not stop at contracting. We will continue to collaborate with and support the provision of integrated services through:

- Enhancing capacity by contracting with PH and BH Providers who are clinically integrated
- Offering proactive Provider education and outreach that addresses contract requirements
- Expanding our efforts to simplify operations and minimize administrative burden

- Working with Providers to develop Lean workflows that will increase their service capacity while streamlining processes
- Using sound reimbursement practices, and prompt and accurate claims payment
- Expanding capacity of PCMPs and "non-traditional" BH providers in both urban and rural areas to address mental health and substance use conditions through education and reimbursement for BH screening and assessment

Facilitating "No Wrong Door" Referrals

To support Members in accessing care, we will employ a "no wrong door" policy for referrals, encouraging and accepting referrals of Members who need Care Coordination and support at any time from any source. In addition to Member self-referral, we will proactively use a multi-modal approach to identify Members who may benefit from interventions as discussed in OR 15. Through screening, direct referrals, and predictive modeling, we will identify Members, no matter where they live, who may benefit from any of our Care Coordination programs — including those targeting BH treatment needs. For Members living in the community or served in facilities, we will also work to improve PCMP participation in screening and identification of BH conditions to provide opportunities for early intervention with at-risk Members. ***We will work closely with PCMPs to share evidence-based practices and offer the tools and training they need to screen, treat, and coordinate care for BH conditions. We will also use Provider newsletters, bulletins, and alerts to keep Providers informed on BH tools and resources.***

We will also coordinate screenings and access to BH services for Members who are using residential supports, such as adult family homes, assisted living facilities, and skilled nursing facilities. We will contract with onsite physicians for assessment and required services to provide a seamless system of care. ***We will work with facilities to enable access to BH specialists through telepsychiatry or telepsychology services as appropriate, to enhance access for Members.*** We will also partner with Providers to either provide services in facilities, or work collaboratively with onsite physicians to accept and quickly respond to referrals.

Both Anthem and CCHA have long-standing relationships and collaborations with community groups to improve access to care in alternative settings. CCHA *Plus* has connected with the Colorado chapter of the National Alliance for Mental Illness (NAMI) to attend training with their teams and to discuss with their leadership ways we can improve access. In addition, we will work with the following:

- **Homeless Shelters or Temporary Housing Agencies.** Our Care Coordinators will identify and authorize covered services and refer Members for services that include finding housing, keeping individuals in their community, and providing peer supports. Our mobile technology facilitates Care Coordinator screening and use of standardized instruments and consultation with physicians using video connectivity. We will support temporary housing, short-term, until more stable housing can be secured. For example, we will work with shelters and provide a motel room for a brief stay and, as a value added benefit, also provide transition kits to our members that include items such as dental and first aid supplies, emergency blankets and other critical care items. ***In Washington State, Anthem partnered with homeless shelters and currently works with the More Love project and the Union Gospel Mission to provide a shower van that visits homeless camps to provide showers, clean clothing, and access to food and other needed services.***
- **Schools.** We partner with school-based health centers to increase the quality of life for Coloradans, particularly those living in underserved, ethnically diverse communities. Partnering with school-based health centers promotes EPSDT services, helps align with individualized education plan

services, and provides assessments and referrals useful in identifying students with physical health, mental health, or substance use issues, to facilitate early intervention.

- **Nursing Homes.** We will reach out and develop relationships with Colorado nursing homes to support the continuum of care for our Members and will work with them to enable telepsychiatry or telepsychology services, as appropriate, for Members. For those Members receiving Home- and Community-Based Services, we will collaborate with their assigned case managers.
- **Adult and Child Group Homes.** We will work with child and adult group homes to support services such as telemedicine and telepsychiatry that supplement SUD providers or address situations when a SUD provider does not offer services, and offer wraparound services that meet Members' needs.

As a RCCO, CCHA has already built solid relationships and coordinated care across systems of care. In fact, ***they worked closely with the Department to help Jefferson Center for Mental Health become the first CMHC in the State to have a clinic contracted as a PCMP.*** CCHA has also worked with other community BH Providers to improve the integration and coordination of PH and BH services for Members.

Facilitating Member Choice of Community-based Care Settings

First and foremost, as discussed in OR 16, we will assure Members have access to a multidisciplinary Care Coordination team. No matter the setting of care, we will ensure Members are receiving medically necessary community-based care across the continuum of care. Our multidisciplinary team will be co-located in the community and participate in shared rounds with PCMPs, BH provider clinics, and shared Care Coordination across physical, behavioral, and social supports. We support a culture of teamwork in which our employees work together to engage Members to define goals, provide access to activities that will help achieve those goals, and improve health outcomes. It is through this collaborative team approach that we ensure our Members' tenure in the community increases and they continue to receive the least restrictive care in the community. To support Providers, our Practice Transformation Coaches will meet them where they are and help determine their readiness for providing integrated, collaborative care. We will provide them with training on reporting and identifying screening tools to support transformation to an integrated care approach. Establishing a team approach with specialists to inform the care team may also include telemedicine options. ***By supporting Network Providers with these tools and training, Members have a choice of community-based health care settings that are, or are working toward, integrated care, including CMHCs or independent Providers with co-located primary care, primary care with co-located BH, or telemedicine access to BH in a primary care setting.***

Results & Successes

Our proactive and early identification of Members with potential or actual behavioral health needs and effective coordination with the CMHCs and independent, community-based behavioral health providers has established Region 6 as a leader in integration across the State, and will enable us to achieve the same success in other regions. Our successes include the following:

- **11 PCMP practices** have a fully-integrated behavioral health provider
- **30 PCMP practices** have a co-located behavioral health therapist
- **94%** of high volume PCMP practices screen Members regularly for depression
- **77%** of high volume PCMP practices have a reliable behavioral health referral process

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We have and will continue to invest in building capacity and increasing accessibility for the region through programs, strategies, and tools. As described below, a few of our strategies for helping Members connect to community-based services and prevent more restrictive levels of care include:

- Integrating PH and BH in community practices
- Offering a Post-Discharge Management program and co-location at hospitals to help keep Members in their communities

- Providing High Intensity Integrated Teams to provide more intensive Care Coordination (both telephonically and in-home visits when needed), so that Members can remain in their communities
- Using telemedicine to improve access

Integrating Primary Care and Behavioral Health in the Community

As a RAE, we bring our combined organization's long history of supporting integrated health care delivery solutions. We help Members get the care they need in the most effective and efficient way by supporting bi-directional, fully integrated PH and BH care in community practices.

PCMPs and OB/GYNs are often the first Providers to recognize a BH or substance use disorder. We will help by giving these Providers guidelines for substance use, depression, and other screening tools. Our Academy includes webinar training to strengthen PCP and OB/GYN skills related to screening and referrals for Members with BH conditions. ***As a RCCO, CCHA has helped integrate 34 BH providers into PCMPs, which enabled more than 15,000 CCHA Members and 34,000 ACC Program Members in accessing integrated services at their PCMP office. CCHA also partnered with Jefferson Center to co-locate a BH Provider in a primary care practice in the mountain communities of Gilpin and Clear Creek counties.***

As a RAE, we will offer resources and tools that support evidence-based integrated care in primary care settings. ***For example, in 8 states, Anthem has provided a BH Specialist or financial support for a co-located BH professional to help screen for BH conditions in primary care locations.*** A positive screen triggers a complete assessment, brief interventions, and follow-up. Members are also referred to specialists as needed, with ongoing Care Coordination. ***This initiative has received accolades, including a 2016 honor from the Institute of Medicaid Innovation for its creation of a framework for total-person care.***

We also support the integration of primary care into BH settings. CCHA *Plus* supports to facilitate integration of primary care into a mental health agency will draw on tools available through SAMHSA/Health Resources and Services Administration (HRSA) Resource Center for Integrated Care, such as the Behavioral Health Integration Capacity Assessment (BHICA), tools identified in the Bree Report, as well as tools developed by our organization. We will provide a matrix of roles and responsibilities for staff including for the nurse, PCMP, psychiatrists, social worker, and Care Coordinator. Workflows will describe such activities as screening for depression and substance use, developing shared care plans, and engaging Members in self-care. Training, consultation, and support may incorporate in-person training or consultation, online tailored webinars, and telephonic or telemedicine consultations.

Post Discharge Management and Co-Location in Hospital Settings

We will use our Post-Discharge Management Program (PDM), combined with co-located clinicians at hospitals to help keep Members in their communities. From Anthem's extensive Medicaid BH experience, we know the most efficient and effective way to coordinate discharge planning for Members is to co-locate registered nurses and licensed BH clinicians (who are assigned based on the Member's admission) within high volume hospitals and psychiatric facilities. This method supports early initiation of discharge planning with the Member, family or caregiver, hospital staff, and PCMP on the day of admission. Our Care Coordinators will collaborate with hospital discharge planners, Members and their families/caregivers, Providers, our co-located clinicians onsite where applicable, and our UM clinicians to develop a safe, sustainable discharge plan.

We recognize that the first 24 to 72 hours post-discharge represent the highest risk for Member readmissions. ***Our PDM Care Coordinators will reach out (telephonically or face-to-face, depending on the Member's needs) to the Member, family or caregiver, and facility discharge planner to begin the engagement process, discuss the conditions leading up to the admission, explain our discharge planning process, and assess the Member's risk for readmission.***

PDM Care Coordinators will support Members by engaging them in their health care decisions, educating them on available services and supports, helping them select the care that is important to them, and seeing that selected services are in place prior to the Member's discharge. Our Care Coordinators will also notify Members' PCMPs during the discharge planning process to schedule needed follow-up appointments.

By building close working relationships with facility staff, our Care Coordinators will become part of their discharge team, creating an environment of collaboration. They can participate in discharge planning meetings at the facility, make clinical recommendations for appropriate services upon discharge, conduct authorization reviews, and arrange for the Member to receive follow-up services and supports post-discharge. ***With appropriate permission from the State and our hospital partners, we will consider co-location of Care Coordinators in key regional hospitals with high volumes of admissions and discharges.***

High Intensity Integrated Team

Despite our best efforts and those of our Members to develop an appropriate care plan, there may be times that the care plan is unsuccessful, or the Member has challenges in adherence, resulting in ER or inpatient service use as alternatives to the proposed care plan. The needs of these Members will be

served using a combination of telephonic and in-home visits for high intensity Care Coordination interventions and clinical programs, based on each Member's individual assessed needs or services, where traditional disease management is ineffective.

The objective is to provide an integrated team approach, with a single point of contact for both BH and PH, based on individualized needs assessment. This team provides Members a higher intensity of services and LOC options. There is a specific focus on a Member's individual needs to improve functioning and control over their health care. Members are engaged in the program through the use of Motivational Interviewing, recovery and resilience, and person-centered assessment and care planning processes. With these techniques, the Member will actively manage their health care needs and improve their quality of life. Improving quality of care will reduce potential admissions, readmissions, and ER visits, and will result in a decrease in total health care costs.

Using Telemedicine to Improve Access to Behavioral Health Care

In other states, Anthem has established and improved upon existing telemedicine capabilities for Members who are in difficult-to-reach areas, in areas with limited providers, or who are unable to travel. ***For example, Anthem collaborated with the Global Partnership for Telehealth to provide funding for implementation of telemedicine services in school-based clinics throughout Georgia.***

Through telemedicine, we can improve the timeliness of Member care, supporting them in primary care as well as in home-based settings, by offering direct interaction with PH and BH professionals. We will expand education and awareness among our Members and Network Providers to maximize the opportunities presented by telemedicine, and improve access to care and Care Coordination. We will strategically invest in equipment and other costs associated with expansion of access points. We will continue to explore and familiarize ourselves on the growing pool of technological evidence-based supports and treatments, such as online programs, text therapy, and more.

For our Members with physical, functional, or behavioral disabilities who are unable to travel to providers, we offer alternate options including:

- Our **LiveHealth Online** program will provide Members with 24/7/365 on-demand access through video-enabled computer, tablet, or smart phone, for a live audio and video consultation with a Colorado-licensed, board-certified physician. The physician can diagnose, make medical recommendations, and prescribe medications when necessary for clinical conditions such as a cough, cold, fever, or flu. Our Care Coordinators will be trained in the use of LiveHealth Online as an option to facilitate access for Members in community settings. In addition, the LiveHealth Online capabilities are expanding to include BH consultations through licensed psychologists, social workers, counselors, and psychiatrists.
- Through our **Online Well-Being Program,** we will offer an online community promoting health and wellness through instruction, games, goal setting, and monitoring. This value-added benefit is available to all Members to help them manage their own BH issues. Studies show that individuals have greater short-and long-term success achieving a healthy lifestyle when they have access to a support network.

c. Ensuring Compliance with Federal Managed Care Regulations

We will provide covered BH services as required by the ACC and in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all other applicable State, federal, and Contract requirements. Our compliance with the mandates of the Federal Mental Health Parity Law and the Affordable Care Act includes:

- Confirming medical management techniques applied to BH benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits
- Assuring compliance with MHPAEA for any benefits offered to Members beyond those specified in the Medicaid State plan
- Making the criteria for medical necessity determinations for BH benefits available to any current or potential Member or contracting Provider, upon request
- Providing Members the reason for any denial of reimbursement or payment with respect to BH benefits
- Providing out-of-network coverage for BH benefits, when made available for medical and surgical benefits

Anthem's national multi-departmental and senior leadership work group evaluates and continuously monitors program compliance with the MHPAEA for each state, and we will leverage this for Colorado as well. The work group also provides ongoing guidance on parity between physical, mental health, and substance use disorder services for Members. The CCHA *Plus* Technology Services team will use well-established data exchange systems and protocols, in accordance with State and federal requirements, including HIPAA regulations and 42 CFR Part 2.

Transparency and Communication to Support Parity. We are committed to transparency in parity-related communications with Members and Providers. We will post our clinical criteria for all services including those for BH medical necessity determinations on our Provider portal. We will provide the reason for any denial of reimbursement or payment of BH benefits using a formal denial notice. Current or potential Members may also access this information through discussion with their Providers, our Care Coordinators, or upon request by calling the customer service line.

Non-Quantitative Treatment Limitations under Parity. We will comply with all non-quantitative treatment limitation requirements listed in the RFP and will immediately address additional requirements that may become effective in the future. We do not place annual, episode, or lifetime quantitative limits on benefits. We do not place prior authorization requirements on routine outpatient BH services, and we provide online tools for Providers to easily determine what requires authorization.

Finally, we do not impose a non-quantitative treatment limitation with respect to BH benefits in any classification that is more restrictive than the predominant treatment limitation of that type applied to substantially all medical and surgical benefits in the same classification furnished to Members. We will assure compliance for any benefits offered to Members beyond those otherwise specified by the Contract, and will make available out-of-network coverage for BH benefits when in-network coverage cannot meet the Member's needs. We are committed to working with the Department to review and revise practices, and provide requested information to support continued compliance with parity.

Assuring Confidentiality

We will require employees and Providers to comply with all relevant State and federal laws regarding protected health care information (PHI) privacy and confidentiality, including protecting and maintaining the confidentiality of SUD information. We will use stringent policies, processes, and systems to make sure we do not share sensitive information inappropriately. We will include privacy and confidentiality requirements in our Provider contracts and conduct annual privacy training for our employees on this topic. Our Provider agreements require compliance with HIPAA protocols, as well as 42 CFR Part 2 and other applicable State and federal requirements when coordinating Member care with other Providers (in- or out-of-network).

CCHA *Plus* Will Meet All Section 5.12 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 18, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.12 that are not detailed in our response.

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.**

As a RAE, CCHA *Plus* brings the experience, resources, programs, infrastructure, and a fully integrated model to help ensure Members have access to Covered Services, when and where they need them. We will facilitate the delivery of all medically necessary Covered Services in accordance with 10 CCR 2505-10 8.076.1.8, and as detailed in Section 5.12.5 of the Statement of Work. We understand the significant value community-based services (respite, clubhouse/drop-in services, assertive community treatment and other non-medical services) bring to Members and the system. We will provide Members with a comprehensive package of 1915(b)(3) services, delivering care in the least restrictive setting possible to make the best use of available funding and drive the best outcomes for Members. Additionally we will actively engage and work with our Network Providers to make sure Members are getting the level of care and services in the appropriate amount, scope, and duration that will drive the best outcomes and meet their needs.

Recognizing that behavioral health (BH) is a crucial component of total health, we assembled our programs and services around an integrated Care Coordination model that is Member- and family-centered, trauma-informed, and that promotes recovery and resiliency. Our goal is to build on the Department's Behavioral Health Program and the significant work done over the past 20 years to further evolve BH coordination, integration, and delivery. To achieve this, we will leverage the long-standing relationships CCHA *Plus* managing partner CCHA has built with Providers, community mental health centers (CMHCs), and community-based organizations and expand access to community-based services through a comprehensive, independent provider network.

We will promote recovery and resiliency in our provider network and in every interaction we have with Members and their families and caregivers. Our recovery philosophy is hope-based and focuses on Member self-determination; developing empowering relationships; having a meaningful, productive role in society; and eliminating stigma and discrimination. These philosophies provide the foundation for collaboration and integration of health services. We know that Members diagnosed with serious and persistent mental illness (SPMI) or serious emotional disturbance (SED) are typically those who have the greatest opportunity for integrated, coordinated, and recovery-focused health care. We will develop and implement strategies for Members with SPMI or SED to minimize hospitalizations and residential treatment, while increasing community tenure. ***By facilitating access to State Plan services in conjunction with 1915(b)(3) Waiver services, we will assist Members in maintaining an optimal level of functioning, residing in the community setting of their choice, and reaching their recovery goals.***

Coordinating care across health care and corrections systems helps homeless Member with SUD

Our Care Coordinator, Erin, identified 23 year-old Tessa as a homeless, high emergency department utilizer with PTSD, anxiety, and addicted to heroin and opioids. Erin worked with an addiction physician to evaluate her and a chemical dependency professional/peer support counselor to determine how best to help her as she moved in and out of the hospital and jail.

Together, they obtained an authorization for 30 days of residential treatment following her jail hospital discharge where they had started her on methadone. Their plan also included transitioning her to suboxone; doing a warm hand-off to the residential facility to get her stabilized and prevent relapses; setting up a monthly injection to help with cravings; and then doing a warm transfer to a PCMP in her aunt's Indiana community where Tessa would live. But Tessa was arrested again, so their plans will have to wait 28 days to be implemented. ***Meanwhile, Tessa said she is grateful to be on suboxone and wants to rely on her strengths, go back to school, and get her life back on track.***

Anthem Member Centered

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Arranging for the Provision of Covered Services

Our strong provider network will include hospitals, psychiatrists, psychologists, private and small group practices, BH hospitals, substance use Providers, school-based centers, CMHCs, FQHCs and others so Members have access to the range of BH providers who deliver medically necessary Covered Services, including the full array of State Plan and 1915(b)(3) Waiver services. We will help make sure Members receive the most appropriate care for the duration and frequency best suited to aid their recovery, so they can live successfully in the community of their choice. ***Our programs and services will work in conjunction with State Plan and 1915(b)(3) Waiver services to offer a comprehensive, complementary array of supports for Members and their families and caregivers.***

State Plan Outpatient Services

To promote easy access to care, we will use a "No Wrong Door" approach, so that Members can access the full range of services from a variety of entry points. We will receive referrals from sources, including self-referral, families/caregivers, Providers, utilization management staff, or 24/7 Call Center (Member Services) Representatives (based on information from calls). In addition to referrals, we will work with our PCMPs and other Providers to offer BH screenings. We will use the statewide stratification framework in tandem with our CI3 predictive modeling and continuous case findings tools (described in OR 15) to identify Members who may be in need of BH services, so our Care Coordinators can proactively reach out to them. We will make sure our Network Providers and community partners have the information needed to connect Members to us easily for services. Through our provider network, all of our Members will have access to Outpatient Covered Services across a variety of settings, including BH clinicians working in BH clinics, those in independent practice, small and large group Network

Providers, hospital-based outpatient programs, and PCMPs offering BH treatment or BH clinicians practicing in PCMP offices.

Emergency and Post-Stabilization Care

Members will have access to emergency services 24 hours a day, 7 days a week, 365 days a year. CCHA *Plus* will cover and pay for emergency services and post-stabilization care services as specified in 42 CFR 438.114(b) and 42 CFR 422.113(c), and as outlined in the Statement of Work.

To promote unimpeded access to emergency and post-stabilization services, we will cover emergency services delivered by any appropriately licensed Provider, in- or out-of-network, without any requirement for prior authorization. We will have programs and interventions in place to assist Members who frequently seek care for non-emergent conditions in an emergency room (ER) while covering a medical screening examination any time a Member presents to an ER for services. We will promote appropriate use of the ER to preserve funding and timely access for people with health care emergencies. We will also coordinate closely with Colorado Crisis Services and work with community-based BH Providers, CMHCs, and the MSOs to align strategies and resources so Members are aware of crisis walk-in centers and 24/7 crisis line services.

To help ensure the Members who access crisis services receive the appropriate follow up, we will seek to build a formal agreement and data exchange process with Colorado Crisis Services so that we are notified when our Members request their assistance or are discharged from crisis services. Upon crisis resolution, we will support the discharge plans and collaborate with the Crisis Center by assigning a Care Coordinator to stay in contact with the Member for a minimum of 72 hours, or longer as indicated by the Member's condition and compliance with the prescribed discharge plan. Our goal is to make sure the Member is engaging with the aftercare treatment plan provided, as well as reconnecting to their circle of supports. The Care Coordinator will also reconnect the Member to his or her PCMP and other services and supports needed.

State Plan Inpatient Services

CCHA *Plus* will work with a range of Network hospitals across Colorado to provide inpatient care for Members of all ages who have a covered behavioral health diagnosis. We understand and acknowledge our responsibilities for covering Inpatient Psychiatric Hospital Services, as outlined in Section 5.12.5.7.17.

We understand that when hospitalized, Members can often be overwhelmed from thinking about returning home, or by too many Providers involved in their care. To avoid this overwhelming situation for the Member, we will provide a single point of contact responsible for seeing that the Member has what is needed to return to the environment of his or her choosing. We will initiate Care Coordination activities immediately upon notification or identification of an inpatient psychiatric admission.

We know that a Member's highest risk of readmission to an inpatient setting is within the first 48 hours following hospital discharge. We will begin discharge planning when a Member is admitted to an inpatient facility by coordinating with hospital employees upon Member admission. We will identify and address Member needs and confirm the ongoing medical necessity of the continued stay to reduce the risk of re-admission or of an acute episode. Our UM clinicians are the eyes, ears, and feet on the ground at the hospital and the primary liaison with hospital employees. They will arrange services necessary to transition a Member back home or to a more appropriate level of care based on the Member's needs in tandem with our Care Coordinators. They will also assist in scheduling follow up BH appointments within 7 days of discharge and connect Members to services such as transportation, housing, medications, and physical health (PH) appointments. The clinicians have direct knowledge of the care provided in the

hospital, and have access to the medical team serving the Member as well as near real-time information from the medical record. As a result, Members and their families/caregivers will have information and support for interventions both during the Member's hospital stay and ongoing as part of his or her transition.

a. Comprehensive List of 1915(b)(3) Waiver Services

We understand the value of 1915(b)(3) waiver services in supporting Members to live successfully in the community. Community-based services such as intensive Care Coordination, Assertive Community Treatment (ACT), clubhouses and drop-in center services, educational and skills training courses, and prevention/early intervention can positively impact Members' health and well-being while making the best use of available BH funding in the least restrictive settings possible. Further, proactively providing these types of services in the community and customizing them to each Member's needs will reduce other high-cost services, like ER visits, pharmacy, or psychiatric hospitalizations.

CCHA *Plus* will facilitate access to all of the 1915(b)(3) waiver services outlined in the Statement of Work. Table 5.12-3 provides the list of 1915(b)(3) waiver services Members will have access to in conjunction with State Plan Covered Services. We will recruit, develop, and maintain a robust provider network and will establish the partnerships needed with community-based organizations to make sure Members have access to the full scope of these waiver services. We will base our Network on our knowledge of Colorado's health care landscape; collaboration with Providers, community leaders, and advocates; and by listening to our Members and their families/caregivers describe the challenges they face as they navigate the health care system. Building our network development strategies around this feedback will create a strong foundation for the success and sustainability of our provider network. For more information on our provider network, see OR 11 and OR 12.

We will continuously monitor the effectiveness of Covered Services, including the use and quality of waiver services. We will analyze authorization, claims, and encounter data to identify trends and opportunities to improve access to and quality of the care and services delivered. We will also look at Member satisfaction surveys as well as grievance and appeals data to help inform the delivery of services and improve Member experience and outcomes. Where we identify opportunities to evolve and improve the waiver services offered to Members, we will work with the Department to propose these changes. CCHA *Plus* will also submit a quarterly 1915(b)(3) Services Report to the Department that lists waiver services and expenditure amounts associated with each service, in accordance with Statement of Work requirements. Our list of 1915(b)(3) Waiver Services using the table in RFP Appendix S is included as Table 5.12-2.

Table 5.12-2: 1915(b)(3) Waiver Services, Availability, Locations, Member Capacity, and Special Populations

Service	Service Description	Availability	Locations	Member Capacity*	Special Populations
Vocational Services	Services to help those ineligible for state vocational rehabilitation services to gain the employment skills, tools, resources, and supports needed to search for and obtain competitive, community-based employment. Services may include skill and support development interventions, educational services, vocational assessment, and job coaching.	Monday – Friday 8 am – 6 pm	Services throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties	Open Access	Adults, young adults, and adolescents
Intensive Care Coordination	Community-based services averaging more than 1 hour per week, aimed at reducing the risk for 24-hour placement. Services include assessment, care plan development, multi-system referrals, and assistance with Wraparound and supportive living services, monitoring and follow-up.	Normal business hours Monday through Friday, flexible based on Member and family needs	Community-based services throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties	Open Access	Adults (children and youth in extended EPSDT)
Prevention/Early Intervention Activities	Proactive efforts to help Members choose healthy behaviors and lifestyles that promote positive BH Services include BH screenings; educational programs promoting safe and stable families; senior workshops on aging disorders; and parenting skills classes.	24 hours a day, 7 days a week, 365 days a year (services are flexible according to Member and family needs)	Online, community-based locations, clinics, schools, nursing homes, and other sites based on needs of Members and their families	Open Access	Adults (children and youth served as part of State Plan Expanded EPSDT)
Clubhouse/Drop In Centers	Peer support services for those with BH disorders. Clubhouse participants may use their skills for clerical work, data input, meal preparation, providing resource information and patient outreach. Drop-in Centers offer activities for individuals to interact socially, promoting recovery by building meaningful relationships.	Normal business hours, Monday through Friday; also includes some after-hours, weekends, and holiday programs	Locations throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties	225 – 250	Adults

Service	Service Description	Availability	Locations	Member Capacity*	Special Populations
Residential Services	Programs and services that help Members gain the skills to live in the housing situation of their choice. These services include 24-hour care, excluding room and board, provided in a non-hospital, non-nursing home setting. Services are provided in the setting where the Member is living, in real-time, with immediate interventions available as needed. Clinical interventions include assessments and support for: mental and physical health status; safety; the Member's motivation for treatment; the Member's ability to provide for daily living needs; group interactions; individual, group or family therapy; medication management; and behavioral interventions. Residential services may be provided to children/youth under Expanded EPSDT.	24 hours a day, 7 days a week, 365 days a year	Locations throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson	65 – 80	Adults Female Department of Corrections Male Department of Corrections Veterans
Assertive Community Treatment (ACT)	Provides comprehensive, local treatment to adults with serious BH disorders. Services are highly individualized and person-centered for Members who need significant assistance and support to address and overcome barriers and obstacles as a result of mental illness. Services include Care Coordination, initial and ongoing BH assessments, psychiatric services, employment and housing assistance, family support and education, and SUD services.	Flexible, according to needs of Members and families; emergency response 24 hours a day, 7 days a week	Community-based services throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties	Open Access	Adults
Recovery Services	Promotes self-management of BH symptoms, relapse prevention, treatment choices, mutual support, enrichment, rights protection, and social supports. Services include peer counseling and support services; peer-run drop-in centers; peer-run employment services; peer mentoring; consumer and family support groups; warm lines; and advocacy services.	Flexible, according to needs of Members and their families	Office and community-based services throughout Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties	Open Access	Adults diagnosed with MH or SUD

Service	Service Description	Availability	Locations	Member Capacity*	Special Populations
Respite Services	Temporary or short-term care of a child, youth, or adult Member by adults other than the birth parents, foster/adoptive parents, or family members. Provides temporary relief for family caregivers from the ongoing responsibility of caring for an individual of any age with special needs or who may be at risk of abuse or neglect.	24 hours a day, 7days a week, 365 days a year	Member or Respite Provider home, or community-based location	Open Access	Adolescents and children

*Member Capacity numbers are estimates. As a RAE, we will seek to contract with these entities to ensure access to 1915(b)(3) services.

b. Utilization Management Program and Procedures

Utilization management (UM) will be a central component of our integrated care model. We will maintain a well-structured UM program to coordinate Members' receipt of the most appropriate, medically necessary care, benefits, and services using an impartial, evidence-based, and consistent approach. Our mission is to make sure each Member receives the right care, at the right place, at the right time, every time. To achieve the best outcomes and most efficient use of resources and benefits for our Members, ***we will not separate the management and delivery of acute and primary care services from BH and social services and supports, nor will we subcontract any key part of our program to either internal or external entities.*** We will perform all UM activities in-house, including authorization, concurrent review, discharge planning, and other activities. As part of our commitment to transparency, we will make our UM criteria available in writing by mail, fax, and online.

Anthem brings a National Committee for Quality Assurance (NCQA)-accredited UM program designed with more than **26 years of experience** coordinating Medicaid, the Children's Health Insurance Program (CHIP), and other state-sponsored programs across 20 states and now serving more than **6.5 million** Members.

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CCHA *Plus* will operate and maintain a documented, **annual UM Program Description** that clearly defines our UM scope and processes, established program objectives, structure and accountability of staff responsible at each level of UM decision-making, and well-developed policies and procedures that support timely decision-making and standards for the use and periodic review of clinical criteria. Our UM Director, a Colorado-licensed, qualified licensed professional, will spearhead our UM Program, which includes managing the authorization and review process, analyzing utilization trends and recommending improvement initiatives where needed, and overseeing that services are medically necessary, appropriate, and accessible to Members.

Our UM Program will in no way impede timely access to services. Rather, we will use our UM processes and activities to address Members' health challenges creatively, and to help them access the most appropriate services. The scope of UM includes eligibility and coverage review, prospective review, prior authorization, concurrent review, and discharge planning in conjunction with our Care Coordination model. Our UM staff will work closely with community health care practitioners and Network Providers to support quality outcomes for Members and their families. As a crucial component of our UM Program, we will maintain a feedback loop as part of working collaboratively with our Network Providers. We will involve Network Providers in our UM program development and implementation through our Behavioral Health Advisory Committee, which provides a platform for BH Providers and advocates to communicate directly with CCHA *Plus* staff. The group will convene Providers from CMHCs and private sector BH Providers, as well as organizations such as substance abuse Providers, ER representatives, crisis centers, and other organizations serving our Members' BH needs.

Our Chief Clinical Officer and Quality Management Committee will approve all aspects of our UM program annually. We will submit all details of the program to the Department for 30 days after the contract effective date and 30 days after any significant change.

As part of our UM program, we will establish an **annual UM Work Plan,** a working document that specifies our UM program objectives, required internal and external reporting, responsible staff, activities, status, and outcomes. The Work Plan tracks all UM activities, including quarterly and annual key service utilization indicators in areas such as service request volume, determination turnaround times and compliance rates, Member inpatient admission and readmission rates, and interventions designed to impact our internal staff and Network Provider performance. Other areas of focus include Member and Provider satisfaction with UM and over- and under-utilization.

Routine monitoring and evaluating target metrics represents a key component of UM. We will monitor trends and use their findings to share insights about care. Our UM program will detail mechanisms to monitor over- and under-utilization in the region including initiatives aimed toward reducing the use of unnecessary emergency room (ER) visits or inpatient admissions, length of stay, and readmissions.

We will also analyze Network Provider utilization practices and trends for both over- and underutilization. The UM program will give relevant UM information to the QM program for quality improvement activities. This information will include identifying quality of care concerns, disproportionate utilization trends, adverse access patterns, and lack of continuity and Care Coordination processes.

We will conduct an **annual UM Evaluation** consistent with NCQA MBHO requirements to be reviewed and approved by our QM Committee. We will build on existing UM experience and processes to develop our annual evaluation. We will annually review our UM Program Description, including the Work Plan and Evaluation, and submit it to the Department for approval.

Utilization Management Decision-Making

We have the infrastructure, technology, resources, and processes in place to manage covered BH services in a truly integrated manner and to comply with all Department UM requirements. We will use the UM process to make service authorization decisions that support each Member's recovery. We acknowledge the Member's unique needs and circumstances, including co-morbidities or co-occurring disorders, age, culture, psychosocial needs, personal goals, availability of supports within the local community, and other available supports. This assures Members receive the most effective services and supports in the least restrictive setting. We will continuously monitor all medical necessity determinations to make sure they are completed as fast as the Member's condition requires and in accordance with Contract requirements.

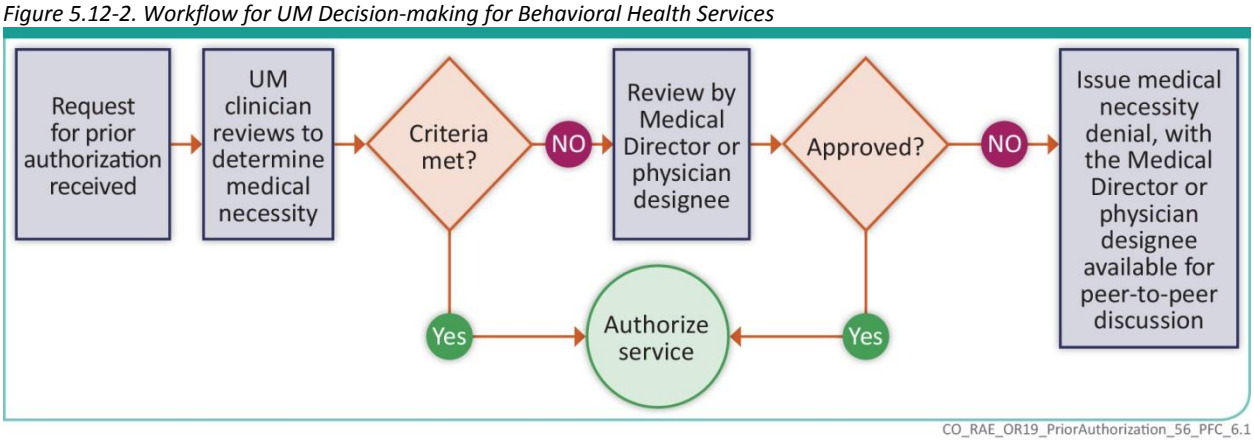
Our UM policies, procedures, and processes aim to improve both Members' experience of care and to boost overall population health cost effectively. Through UM, we will make certain that eligible Members receive the most clinically appropriate care and services in the most efficient manner possible, and will enhance case review consistency by providing a framework for clinical decision-making.

Utilization Management Decision-Making Workflow

Our workflow for initial authorization, displayed in Figure 5.12-2, includes prior authorization or concurrent authorization. As all of our BH services will be provided internally within our organization, the workflow is the same for any BH service requiring authorization. We will require prior authorization for higher levels of care, such as residential and inpatient treatment services that are scheduled/non-emergent or concurrent review for urgent/emergent admissions when prior authorization is not feasible. Each service must be determined to be medically necessary based on Colorado-specific medical necessity criteria. Our UM and Care Coordination teams will work together to make sure Members' services are well-coordinated, support recovery, and are the most effective services available.

In making clinical determinations, we will provide covered BH services in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all other applicable State, federal, and contract requirements, as outlined in OR 18.

Figure 5.12-2. Workflow for UM Decision-making for Behavioral Health Services



Our workflow process for inpatient or intensive services includes a determination of whether the Member's needs can be met at a lower level of care. This promotes diversion to the least restrictive setting when clinically appropriate and feasible. In addition, our workflow for inpatient services includes transition planning and support activities, such as arranging aftercare appointments within 7 days of discharge and coordinating access to prescribed medications on discharge. We will also team with Network Providers and social service agencies to coordinate the Member's access to housing, food, transportation, medical appointments, and other necessary services to support a safe transition. We will adhere to NCQA MBHO and State guidelines regarding BH authorization timelines.

As part of an integrated program, we will have specially trained and qualified UM clinicians who will review clinical information using established clinical criteria and guidelines that comply with State requirements. During the initial review, if the UM clinician is unable to approve services, he or she will forward the service request to the Medical Director or physician designee for review and determination. The Medical Director or physician designee will be board-certified or board-eligible in general psychiatry or child psychiatry, as applicable to the requested service. The reviewer may look at additional criteria or contact the requesting Provider for more information before making a final determination.

Processing Service Authorization Requests

Collaboration with Providers is critical to establishing more efficient patterns of utilization. We will facilitate Provider access to data, information, and systems that ease the administrative burden of review and approval processes to support the most effective delivery

Autism Spectrum Disorders program provides intensive case management for family with new special health care needs diagnosis

Nala, three-year-old Damian's Nigerian mother, needed appropriate therapy for her son after a recent diagnosis of autism and help finding a more stable and affordable living environment for herself and her two young sons. Our Care Coordinator, Robin, worked with Nala intensely for three months, helping her deal with the stress of the diagnosis; educating her about our Autism Spectrum Disorders program; participating in three-way calls to local autism providers, child care, and support groups; and helping her access additional funding through Children Special Health Care Services. She also resolved a transportation issue that impacted Nala's ability to access services and helped with language issues.

Robin educated her about using the About Special Kids website as an excellent resource for children with autism. She gave Nala some tips on what to ask for and how to keep track of contacts and resources. And she educated her about how to locate and apply for public and subsidized housing in Indianapolis. Robin walked her through the website and secured a live person and phone number in case she had follow-up questions. Robin's relationship with Nala empowered her with the knowledge and tools to take the initiative to secure what she needs for herself and her family.

Anthem **Member Centered**

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of services. We will offer Provider-friendly options for service authorization submission and related activities:

- Providers may request service authorization by telephone, fax, or online.
- Providers may look up a requested service by CPT code on our website and receive notification whether the service requires authorization.
- Providers may view authorization status on our website.
- We comply with NCQA's or Colorado's review, authorization, and notification turnaround times, whichever are the most restrictive.

Assuring the Integrity of Clinical Decision Making

We will make medical necessity determinations using BH UM criteria and guidelines, which reflect evidence-based treatment protocols for children, adolescents, and adults. We will assess the Member's need for inpatient hospital admissions, continued stays, and retrospective reviews using our criteria, which promotes consistency and integrity in guiding our clinical staff to make appropriate determinations. We will follow specific protocols, summarized in Table 5.12-3, to support integrity of coverage determinations. Any decisions that the Member or Provider is not satisfied with can be appealed and will be reviewed by our professionals skilled with the appropriate clinical expertise of the Member's condition.

Table 5.12-3. A Comprehensive Strategy to Promote Integrity of UM Decisions

Protocol	Summary
Clinical Criteria	Our medical necessity criteria are evidence-based and include nationally recognized sources (such as the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry). These criteria will be coupled with local and best practices to make sure Members receive the most clinically effective, appropriate, and least restrictive services based on their unique needs, goals, and circumstances to support recovery and community living. We develop our medical policies and clinical guidelines through a rigorous process, with input and approval from external Providers in the community and academic settings. We also incorporate clinical best practice guidelines from nationally recognized professional organizations, up-to-date clinical research, and input from practicing licensed and board-certified physicians.
Local Clinical Leadership	When the medical necessity criteria are not met, we will refer requests to the Medical Director or physician designee who may engage a Peer Reviewer for further evaluation. We foster a Provider-friendly prior authorization approach. We strive to engage Network Providers in collegial discussions to negotiate a treatment plan that is mutually satisfactory and appropriate, based on the Member's unique case history. Only a Medical Director or physician designee will have the authority to issue a denial if we are unable to collaborate to develop an alternative plan.
Inter-Rater Reliability (IRR) Audits	We will evaluate all clinical employees annually to verify consistency and accuracy in application of the criteria. We apply mechanisms, such as hypothetical UM test cases or a sample of Utilization Review determination files, using an NCQA-approved auditing method, to evaluate the consistency of criteria application. IRRs help us pinpoint those UM clinicians who need additional training, which may include a formal review of criteria application and oversight of all reviews for those falling below our IRR threshold. We will report IRR results and aggregate national results to our QM Committee, which will determine opportunities for improvement and develop action plans.

Both Members and Network Providers will have access to our UM decision making criteria upon request. Through our Colorado Medicaid Training Academy, we will train BH Providers on the use of our level of care guidelines and UM protocols. We will disseminate all new or revised guidelines to Network Providers within 60 days of adoption and/or revision. Our guidelines will be accessible on our Network Provider website or by contacting our toll-free number. We will also provide Quick Reference Tools and tips to assist Network Providers in using our guidelines and protocols. In addition, our Practice Transformation Coaches will conduct one-on-one training. We will hold scheduled webinars to educate BH Providers on the use of our guidelines and UM protocols. In addition, our Medical Director will review level of care guidelines one-on-one with our Providers, during discussions related to missed opportunities for providing recommended services. Our Medical Director will also share best practices related to improving performance measures.

Inter-Rater Results 2016

Our Behavioral Health clinical reviewer average scores were:
- **94%** for Anthem Behavioral Health Guidelines
- **95%** for American Society of Addiction Medicine assessment

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Prohibiting Incentives for Medically Necessary Services

We will base UM decisions on evidence-based criteria and appropriateness of care or service and benefit coverage. We will not provide incentives to any individuals or entities that conduct UM activities to deny, limit, or discontinue medically necessary services for any Member. We will require all staff to take the annual Ethics and Compliance training that includes a program on Living with Integrity. An attestation regarding compensation is part of this program; we will inform UM staff of their responsibility to review the compensation statement. By completing the full Ethics and Compliance training, our employees agree to the terms of this statement. Our policies and procedures require termination for any clinical reviewer perceived to have a conflict of interest or to have received incentives that may affect review decisions.

If our UM staff determine that a Member does not meet medical necessity standards for MH and SUD services, our Care Coordinators will inform and assist the Member on how other appropriate services may be obtained and will coordinate with the Member's system of care and Health Neighborhood to connect them to the appropriate Network Providers (such as an MSO, Community Centered Board, or Single Entry Point agency).

c. Meeting Care Planning, Care Coordination, and Transition of Care Requirements

CCHA *Plus* Care Coordinators will work with the Member to develop an individualized, person-centered care plan that reflects the Member's strengths, needs, preferences, and goals. ***Our coordinated care planning approach places the Member in the center to make sure all resource needs are integrated. This approach results in better services and resource allocation; it enhances self-direction and improves health status with no duplication.*** Our organization is experienced in coordinating the full spectrum of services regardless of whether we or other entities are responsible for payment.

We will engage our Members from the start to drive their individual care planning. Our Care Coordinators support Member involvement and promote continuity of care through close

Member Testimonial

The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come. I have been working with CCHA since 04/2017 and have first-hand experience of the person-centered, comprehensive services their Care Coordinators provide. The CCHA care team has helped me with respite care, searching for supportive services and ABA therapy for my autistic son. This has made a huge impact on my overall health and well-being.
Christine

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coordination with the Member, family, Network Providers, specialists, community organizations, and system partners. Care Coordinators will work with the Member to:

- Identify the Member's desired outcomes, health goals, and support needs, including his or her desired living arrangement, educational or employment goals, and other community living requirements
- Determine the services and supports from all sources, covered and non-covered, required to meet the Member's identified needs and support achievement of desired outcomes, considering the Member's health and wellness needs as well as availability and appropriateness of services, including:
  - State Plan services
  - 1915(b)(3) waivers services
  - Services from other programs or agencies, such as school-based services
  - Community-based resources, such as housing, independent living, and social support services
  - Additional benefits such as health education and disease management
  - Unpaid natural and caregiver supports, family supports, and cost-effective supplemental services for Members who would otherwise require a higher level of care

The Members' Care Coordinator will continuously assess the effectiveness of the care plan and work with the Member and his or her support system, as applicable, to revise the plan when desired outcomes are not achieved or when a Member's needs or goals change. The Care Coordinator will make referrals, coordinate care, verify services are not duplicative, address any known gaps, and follow-up on engagement and retention with planned services and supports to make sure Members continue on their recovery paths.

***The care plan represents a dynamic roadmap that changes as Members' needs evolve*.** We will work with Members and their families to determine their lifestyle goals and to locate supports and services to achieve those goals. During conversations with Members, we will evaluate their readiness to change, encourage them to identify their strengths and needs, and help develop their care plan. This evidence-based and person-centered engagement methodology enhances the probability that Members develop self-directed care plans with achievable goals. Our fully integrated program will take every aspect of a Member's life into account. We will work with Members to address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and other factors that can compromise sustained recovery.

Our care planning approach promotes recovery and resiliency by:

- Incorporating care and services across all Network Providers, programs, and systems in the Member's integrated, overall care plan
- Encouraging Members and their families to participate in care planning and making sure services are individualized to the Member and his or her needs and goals
- Facilitating and promoting natural supports, such as peer specialists and friends and family
- Making sure Members have choice and access to a range of services (including prevention) and maintaining a diverse Network of Providers who can meet the cultural, linguistic, and specialized needs of Members

Transition of Care

We will make sure Members involved in multiple systems, who experience service transitions from other Medicaid programs and delivery systems, including other RAEs, have continuity of care. Care Coordinators will support Member transitions of care through an approach that includes Member engagement, bridge supports and peer services, Care Coordination, and proactive linkage to supports and services. Our approach will be customized to specific settings and circumstances. Our transition planning program will provide enhanced support to Members and their families during transitions, including changes in Provider, setting, or level of care. When transition planning is needed, ***Care Coordinators trained in the Coleman Transitions Model will use a phased approach of identification, engagement, stabilization, and maintenance to work with Members, their families, and the Providers involved in their care.*** Care Coordinators will connect Members to appropriate follow-up services for PH and BH services. Transition planning will target a reduction in overall 30-day readmission rates for Members discharged home or to lower levels of care, and improved 7- and 30- day follow-up after discharge appointment adherence.

Helping a Member transition home to live her best life, her way

After a leg amputation below the knee due to vascular disease, Sandra needed help with all the changes in her life. Sherry, our Care Coordinator, knowing that navigating the system of services and supports can be confusing, listened to her concerns; created a person-centered care plan; helped her transition home from a skilled nursing facility with a personal care attendant; and coordinated PT, OT, skilled nursing visits, home health physician visits, and a prosthetist. She also arranged for a home modification grant and labor from Habitat for Humanity to make her home wheelchair accessible.

But while they were talking, Sandra became tearful and shared that she was struggling with all the physical and emotional changes. She said she wanted to regain her confidence and independence and that her personal goal was to go outside and care for her African Violets in her greenhouse – which she hadn't been able to do for a year.

So Sherry connected her with behavioral health support, and four weeks later, ***Sandra reported that the home modifications had been made; her mood was 100% improved; and she was sitting in her greenhouse as Sherry spoke to her, planting African Violets.***

Anthem **Member Centered**

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Transition from Higher Levels of Care. We support the philosophy that admissions, discharge, and transfers should be well coordinated, with planning beginning from the time a Member is admitted to care and continuing throughout the treatment process. When a Member enters any type of institutional setting, whether a hospital, rehabilitation facility, nursing home, or psychiatric facility, we will initiate outreach to the Member and institutional Network Provider to assess the Member's reason for admission, the planned or prescribed length of stay, and to begin transition planning. We will provide a designated clinician (a registered nurse or BH clinician) who will go onsite to coordinate the Member's transition from the facility to follow-up appointments and community services. The clinician will include the Member, current treating practitioner and/or facility transition planner, practitioner or facility admission coordinator at the next level of care, and, as applicable, the Member's family or friends. He or she will communicate with Providers, such as ACT Providers, and offer information to the Member, family/caregivers, and community-based Providers (with appropriate Member consent) about the Member's follow-up care plan. On the day of discharge, the clinician will remind the facility of the transition session as applicable, and meet with the Member and family as needed, and provide a warm handoff to a Care Coordinator, supporting transition into the community.

Supporting Members Post-Discharge. On the day of discharge, our Care Coordinator will confirm that the Member and family/caregiver has all necessary medications, a copy of the discharge plan, a list of scheduled follow-up appointments, and transportation to those appointments. Following the Member's discharge, the Care Coordinator will contact the Member to confirm the safe transition, verify that any in-home services and PH services are in place and satisfactory to the Member, remind the Member and

family of upcoming appointments, and identify any barriers to attending those appointments. Following transition, the Care Coordinator will continue close communication with the Member and family or caregiver at a level based on the Member's needs. During this close communication, the Care Coordinator will be able to identify and address barriers to participation in the discharge plan.

Members with Criminal Justice Involvement. Our Criminal Justice (CJ) program will provides Care Coordination Wraparound support for justice-involved Members, including Department of Corrections (DOC) prison systems, parolees, statutorily discharged but not on parole, involved with local county jails and judicial districts, on probation, involved in Pre-trial and Diversion programs, or living in Community Corrections and Halfway/Transitional Housing programs. We will work with these entities to make sure we are notified as soon as possible following a Member's entry into the system. We will also have opportunities to co-locate employees at facilities to support early engagement and coordination. Probation and parole officers will be welcome to participate on the Member's care team. Through our jail-in-reach, we will address Members upon entry to the system, develop a plan of care, introduce them to the Network Providers they will be continuing with after discharge, and identify the appropriate services, including BH, as applicable. Through this program, we will facilitate access to non-Medicaid funds for Members who lose eligibility while in jail, but who are ready for reentry with access to services and funding.

Transitions to and from Other Regional Accountable Entities. We will be flexible in our approach to Members who move between regions while adhering to all applicable requirements in 42 C.F.R. § 438.62. We will support transitions to and from other RAEs as both a payer and coordinator of care, using our existing experience and established protocols. Transition support includes obtaining and exchanging existing records, care information, and authorizations to assure continuity of care. For Members transitioning in from another RAE, we will obtain all health information and care plans, complete a screening, and arrange continued services without restriction, including those that require prior authorization. We will identify Network Providers within the RAE, perform an assessment and develop a new care plan, and authorize our services within 90 days.

Our team will support identification and referral to appropriate supports and Network Providers based on a review and assessment of clinical information for Members transitioning into the RAE, considering the Member's needs, preferences, and geographic proximity to services. We will support ongoing care relationships by helping non-participating Providers gain access to the Network.

For Members transitioning out of the RAE, we will provide Care Coordination supports and information and work together with the Member's new RAE. We will encourage Members with complex needs to accept a warm handoff to Network Providers in the new region, to support a seamless transition in care. We will maintain a transitions policy between RAEs in our surrounding areas.

d. Leveraging and Coordinating with Other Community-based Organizations and State Agencies

We know that Members often need assistance navigating the continuum of care as they transition to varying treatment and service levels. As part of our integrated Care Coordination model, we will work with Members, Network Providers, and the multiple agencies comprising the systems of care to align strategies and prevent obstacles for Members. Our Care Coordinators will help unify and bring resources together, addressing Member needs across agencies and systems to reduce duplication, maximize resources, improve Member experience, and achieve the best outcomes. Our Care Coordination team will work to build relationships and identify opportunities to collaborate with stakeholders (including other RAEs, community organizations, Colorado Crisis Services, schools, and others).

Colorado Crisis Services System

We look forward to expanding our partnership with Colorado Crisis Services to align with other agencies within the Health Neighborhood and Community. We will continue to focus on promoting Colorado Crisis Services to Members and Network Providers to emphasize health literacy, medical Providers, BH entities, and substance use Providers, as well as data sharing and development of bi-directional workflows for Care Coordination and transitions. We will use our partnerships with community-based BH health Providers, CMHCs, and Managed Service Organizations (MSOs) to further overall strategic alignment to make sure Members are receiving the care they need and know how to use the crisis walk-in centers and 24/7 crisis line appropriately.

As a RCCO, CCHA has already laid the groundwork for this alignment through ongoing outreach and community-based efforts with Colorado Crisis Services, and CCHA *Plus* will leverage that experience as a RAE. Colorado Crisis Services conducted training for CCHA Care Coordinators to see that Members receive timely access to BH interventions during a crisis. We look forward to the opportunity to formalize our relationship with Colorado Crisis Services by coordinating follow-up care for ACC Members. We also want to infuse these efforts with population health approaches to decrease stigma and promote the importance of emotional well-being. We recognize that the Colorado Crisis System provides access to critical BH crisis services, and we have worked to integrate the system into our BH solution for Members.

We will leverage CCHA's long-established partnerships with the Region's CMHCs, Jefferson Center for Mental Health and Mental Health Partners, who serve as Region 6 crisis system Providers. Our partnerships include established arrangements with the CMHCs to coordinate follow-up care for Members that access the crisis system. As a RAE, we will work to expand BH options available to our Members, particularly in Clear Creek and Gilpin counties, by building a stronger independent provider network to provide services in addition to the two CMHCs in the region.

Managed Service Organizations

We understand the importance of substance use services for our Members' health and well-being. As a RCCO, CCHA has demonstrated a commitment to assuring access to substance use services in Region 6. ***Last year when the Region's largest substance use Provider was no longer able to provide detox services, CCHA provided financial support to see that Members did not go without these critical services. CCHA gave funding to Jefferson Center for Mental Health to take over administration of detox services and worked with them to connect Members to available services.***

CCHA already coordinates and connects Members to substance use services available through the MSOs, Signal Behavioral Health Network, and Mental Health Partners. As a RAE, CCHA *Plus* will continue to connect Members with substance use services. Our Care Coordinators will tour the facilities, learn about their programs and intake processes, and share information about our Care Coordination services. We will maintain a targeted list of substance use treatment community resources and a program directory that spans the whole continuum of care for adults and youth, including detox, residential, transitional sober living, medication-assisted treatment, intensive outpatient, outpatient, and community peer support groups.

As a RAE, we bring organizational experience coordinating with MSOs and will continue working with Region 6 MSOs to make sure Members receive the services related to SUDs. When a Member requires substance use services not covered under Medicaid, such as residential treatment, we will consult with community organizations and Providers as part of the Member's integrated care team. To work in conjunction with the MSOs, we will include them on our BH committees and develop partnerships to

establish a notification system for Members using their services, referrals, and to maximize Care Coordination.

Colorado Department of Human Services

We will work with the Department of Human Services to meet the needs of our Members who are involved with the foster care system. We know that children, youth, and young adults in the foster care system have diverse and unique needs. These Members have experienced traumatic events, and have frequent changes in living environments. We are well versed in and support the Department's efforts to minimize placement disruption and achieve permanency. Recognizing that Colorado has a shortage of caseworkers, we will serve families at the intake level, emancipation, and post-adoption level. We can assist the Department by providing Care Coordination services to these families with a goal of minimizing re-referrals and placement disruptions.

CCHA currently serves as a RCCO and external consultant in Permanency Roundtable Meetings hosted by the Department of Human Services. These meetings aim to expedite permanency for children who have been out of the home for 1 year and who have a goal of enrolling in an Other Planned Permanency Living Arrangement. These meetings help to expedite legal permanency for the child, discover new ways to accelerate permanency, and address systematic barriers to successful permanency. CCHA *Plus* is committed to serving the region's emancipating foster youth. By providing comprehensive Care Coordination to our emancipating youth and acting as a static factor and available resource, we will be able to reduce these negative outcomes. In 2015, it was estimated that 28.7% of foster youth will graduate from high school on time, but at least 38% will have been incarcerated between the ages of 16 and 19 and enhance the quality of these children's lives.

We will especially focus on transition for children entering the program and for those aging out of the system. We understand the unique needs that adoptive families face. In roundtable discussions held by CCHA, adoptive parents often report on their struggles to navigate multiple systems after their case is closed due to adoption finalization. CCHA *Plus* will continue to coordinate care for these families, and by doing so early on, we will continue to minimize ER use, residential child care facility placement, and adoption disruption.

CCHA *Plus* Will Meet All Section 5.12 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 19, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.12 that are not detailed in our response.

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 C delivered in primary care settings and how the Offeror will work with PCMPs when a Member requires more than six (6) sessions.

We know that physical health (PH) and behavioral health (BH) go hand in hand, and that the best outcomes for Members occur when Providers work together on well-informed treatment decisions. As a RAE, CCHA *Plus* will offer a fully integrated model with resources, tools, and strategies to support Primary Care Medical Provider (PCMP) practices in delivering primary-care-based BH services. We also support the Colorado State Innovation Model (SIM) and its goals of helping practices integrate BH and primary care using value-based payment (VPB) structures. Currently, managing partner CCHA is a Practice Transformation Organization offering assistance to Providers in improving PH and BH practice transformation, physician incentive plans supporting SIM's payment reform goals, population health education and engagement, and education and technical assistance promoting efficiency.

Tracking Use of Fee-For-Service, Short-Term Behavioral Health

We believe the 6 Fee-For-Service (FFS) short-term BH sessions will help open up access. We will support PCMPs by closely working with them to identify Members in need of and receiving these short-term BH sessions, track and monitor use, and coordinate additional services so that Members continuously receive the services and support they need.

We will collaborate with the Department and Network Providers to develop a process to track FFS short-term BH sessions, which will include evaluation as well as individual, group, and/or family psychotherapy (as outlined in Appendix P of the RFP). Using our monitoring and tracking tools, we will access the Business Intelligence and Data Management (BIDM) System claims data to track use of the short-term BH services, while also working closely with PCMPs so that we are notified in near real-time when a Member reaches the maximum 6 FFS sessions. CCHA *Plus* managing partner Anthem tracks FFS in every state where they serve Medicaid Members and will bring this expertise to Colorado.

Supporting Behavioral Health in Primary Care Settings

We will help make sure PCMPs are informed about the process and enable them to set up systems and processes to conduct, document, and bill for the 6 FFS short-term BH sessions. We will offer face-to-face and online trainings to address this topic, as well as information on BH screenings and the referral and prior authorization processes, when a Member would benefit from additional services. We will build policy and authorization protocols with our partners and Network Providers in the community.

As a RCCO, CCHA has extensive experience supporting PCMPs in delivering BH services in their practices. CCHA has collaborated closely with Community Mental Health Centers (CMHCs) and independent Providers to identify BH practitioners who deliver short-term BH services within primary care settings. ***As a result,***

Provider Testimonial

Having behavioral health co-location at Focus on Kids has been wonderful! Lynn, the therapist chosen for our practice, is great. Our patients love her, and our staff loves her. She is easy to work with, and it is so convenient that she is here. It really has improved the process of referring our patients for therapy. They are much more willing to go see a therapist after they realize how convenient it is for them, just having to come to our office.
Jolene Reini, Focus on Kids Pediatric

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more than 34,000 CCHA Members in Region 6 receive medical home services from a Network Provider that offers BH services.

In addition, Anthem has provided a BH Specialist or financial support for a co-located BH professional to help screen for BH conditions in primary care locations across 8 states. A positive screen triggers a complete assessment, brief interventions, and follow-up. Members are also referred to specialists as needed, with ongoing Care Coordination. This initiative has received accolades, including a recent (2016) honor from the Institute of Medicaid Innovation for its creation of a framework for total person care. Leveraging Anthem's experience supporting primary-care-based BH services, coupled with their vast experience building BH networks will help CCHA *Plus* support PCMPs in locating and integrating a BH provider in the PCMP's practice.

Through our **Provider Support program,** we will use a multi-pronged approach to make it easier to deliver primary-care-based BH services, including:

- Conducting a readiness assessment (to meet PCMPs where they are)
- Connecting PCMPs to licensed BH Providers who can deliver primary-care-based BH services to integrate into their setting
- Helping PCMP practices modify and integrate their workflows
- Providing Team-based Care Coordination support to assist with PH and BH service delivery
- Offering tools, training, and webinars targeted to providing the 6 FFS short-term BH sessions and to help PCMPs incorporate BH screening tools into their workflow
- Implementing quality improvement activities and measures
- Offering practice transformation coaching as well as technology and data sharing support
- Supporting practices in adopting a value-based payment approach, similar to the Department's Primary Care Alternative Payment Model

CCHA has already helped Network Providers lead the State's BH integration efforts in primary care:

- **11 practices** have a fully-integrated BH Network Provider
- **30 practices** have a co-located BH therapist
- **94%** of high-volume practices report regularly screening for depression
- **77%** of high-volume practices report having a reliable BH referral process

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We know that change can be difficult, and we will strive to collaborate with PCMPs to help them become comfortable with integrated care delivery and move them along the continuum of integration. As a RCCO, CCHA already supports PMCPs to locate BH Providers in primary care settings through partnerships with CMHCs, including Jefferson Center for Mental Health, Mental Health Center Denver, Arapahoe Douglas Mental Health Network, Mental Health Partners, and Community Reach.

Referring Members for Additional Sessions

Our primary goal in tracking and monitoring the 6 FFS short-term BH sessions will be to make sure our Members continue to receive the services they need in the setting of their choice**,** which may include continuing care with their PCMPs or referring them to another Provider for care beyond the 6 sessions. We will always focus on the Members and their families or caregivers and make sure they are receiving the most appropriate care to address their needs. We know that integrating BH clinicians into primary care will help destigmatize and make it easier for Members to access BH services. Our Care Coordinators will work in conjunction with Providers and Members and their families to authorize the Member's continued treatment in the primary care setting, refer them to a BH specialist in the community for more intensive services, and connect Members diagnosed with complex conditions to additional supports that may be needed. As a RAE, CCHA *Plus* brings a fully integrated model, which will help assure a smooth and seamless transition to more intensive BH services, should the Member need them.

CCHA *Plus* Will Meet All Section 5.12 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 20, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.12 that are not detailed in our response.

Section 5.13

COLORADO COMMUNITY HEALTH ALLIANCE

Data, Analytics and Claims Processing Systems

5.13 DATA, ANALYTICS AND CLAIMS PROCESSING SYSTEMS

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

Data is a critical component of every aspect of truly integrated physical health (PH) and behavioral health (BH) care delivery. Because of this, CCHA *Plus* has designed an innovative technology platform to provide advanced data analytic capabilities that drive operational improvements and population health strategies. Our Member-focused, whole-person data platform will enable effective data sharing between Care Coordinators, Network Providers, Health Neighborhoods, and internal quality committees to see that we provide the right care at the right time and in the right setting.

Leveraging the best of CCHA and Anthem systems, our analytic expertise will be central in supporting efforts to address the delivery system's performance, outcomes, and overall costs. CCHA *Plus* has already invested in sophisticated systems that aggregate and analyze data to make data-driven recommendations that support quality improvement and population health efforts. The combination of CCHA's experience as a current Region 6 RCCO and Anthem's national expertise managing health care data and reporting and working with state-required exchanges is unmatched. Together, as CCHA *Plus*, we will deliver actionable data and reports that support Department initiatives and improve Network Provider performance.

Our understanding of key cost drivers and clinical outcomes will guide development of reports to make certain we track trends that impact quality of care and financial impact, as well as support transparency with the Department. In our response below, we describe how we will use data to drive outcomes and manage performance.

How We Will Receive, Process, and Manage Data

CCHA *Plus* will use data and analytics to operate the ACC Program. Our data and analytics systems will drive our management, coordination, and care activities, including process improvement and population health management. As a Region 6 RCCO, CCHA built its data and analytics program to complement the Department's tools and resources, including the Statewide Data and Analytics Contractor (SDAC) — now the BIDM System. They have supplemented the Department's tools with innovative analytics systems that build upon the BIDM System and enable them to establish performance benchmarks and monitor Network Provider performance across key cost and utilization metrics. Combined with Anthem's advanced predictive modeling capabilities and reporting dashboards, as a RAE, CCHA *Plus* will leverage the power of integrated PH and BH data to build upon the overall health and wellness of Region 6 Members and communities.

Central Role of Data and Analytics

As we implement many new and innovative approaches to population health, Care Coordination, and practice support, we will have a comprehensive evaluation strategy that uses data and analytics to monitor outcomes and costs and enable us to engage in continuous quality improvement. We will support Network Providers in the delivery of quality health care by providing information, guidance, meaningful and actionable data, and tools to help their patients make personal health choices and decisions. As the State evolves its data practices, CCHA *Plus* will also evolve our analytics to incorporate community data/public health trends in evaluation of ACC program performance.

Receiving, Processing, and Managing Data

Leveraging best practices from CCHA and Anthem, CCHA *Plus* will have secure and automated processes that retrieve and process data from a multitude of sources and senders to facilitate accurate, timely reporting. For example, in 2016 CCHA partnered with the Colorado Community Managed Care Network (CCMCN), the data arm of the FQHC association, in a data sharing project to improve FQHC performance on ACC Program KPIs. CCHA provided CCMCN with all Members' Medicaid claims attributed to an FQHC (about 19% of the population in Region 6). CCHA provided $20,000 to CCMCN to compare Medicaid claims and each electronic health record to get a more complete picture of each Member and identify gaps in care (such as preventive screenings and well-child checks). CCMCN produced a dashboard for each FQHC to evaluate progress on reaching KPIs and identify opportunities to improve performance. CCMCN also provided practice transformation support to help the FQHCs make changes and improve scores. In the next phase of this project, as a RAE, CCHA *Plus* plans to expand on the work to include a common BH integration measure — depression screenings.

Using Data and Analytics to Successfully Operate the Accountable Care Collaborative Program

As a RAE, we look forward to interfacing with Colorado interChange and the BIDM System to create direct file exchanges with the Department. We will load, process, and manage data to produce meaningful reports that promote better health outcomes for Members and the Network Providers. This synergistic integration will improve the accuracy and usefulness of our reports.

Through our data warehouses, we will make a comprehensive source of Member health information available to both internal (for example, Care Coordinators) and external parties (for example, Network Providers and the Department) to drive care decisions. This information will include claims and encounter data for PH and BH, pharmacy, and dental information that we receive from the Department to provide a holistic picture of each Member's health needs. To make sure we deliver accurate reports, CCHA *Plus* will use a rigorous data validation process to verify data accuracy. For example, when CCHA first started receiving admission, discharge and transfer (ADT) data, they wanted to make sure they were receiving all admissions and discharges for Region 6. Before creating and sharing reports using the ADT data feeds, they compared the data with other data sources they were receiving from some hospital systems. This comparison showed that the ADT data did not identify most of their Region 6 Members. They worked closely with the Department to modify the algorithm to align with their PCMPs and Members and improve data accuracy.

Data warehouses support operational processes, analytics, and reporting, and receive data directly from the system of record to promote data quality, control, and consistency. The data warehouses will support access to:

- Member health data to support whole-person care
- Advanced data analytics, such as predictive modeling, to identify Members for Care Coordination
- Operational, management, regulatory, and ad hoc reporting to drive business decisions

Creating Meaningful and Actionable Data

Our reporting process will support the collection and reporting of relevant data to the Department, as well as Network Providers and Community stakeholders, through both regulatory/contractual and ad hoc reports. Together, CCHA, as one of the highest performing RCCOs, and Anthem, as a high-performing national Medicaid administrator, know that quality controls are a critical part of their outstanding results. As detailed in OR 17 and 23, CCHA *Plus* will use dashboards to monitor and report results to enable our leadership team to make informed decisions. We will track and trend our HEDIS® and State-specified measures through monthly reports to identify opportunities for performance improvement, assess the impact of interventions, and monitor our performance relative to the Department Performance Measures. Simultaneously, internal teams responsible for reviewing trended KPI data, nationally recognized quality and utilization measures, and cost data to generate reports, will use a variety of methods to confirm report accuracy and quality. When a variance is flagged, CCHA *Plus* will document it to make sure we understand the reason for it and track trends over time.

For example, when CCHA flagged a variance in their work on the well-child check (WCC) KPI, they evaluated it in an organized way — with clear action items and evaluation processes. Based on their findings, over the past several months, CCHA has worked with PCMPs, Safety Net Providers, and Members to improve their performance on this measure and achieve positive results.

We have well-developed policies and procedures to confirm the quality of information we submit to the Department or share with Network Providers or the BIDM System. Keys to our success will include:

- Leadership accountability and oversight of query design and interpretation of required reporting, as well as approval of actions needed to improve performance on targeted efforts or areas of concern
- A system that collects, captures, and maintains a comprehensive set of data necessary for report generation and analysis
- Documented procedures to communicate reporting changes to business owners who work with our Reporting team to verify that programmatic modifications reflect accurate output

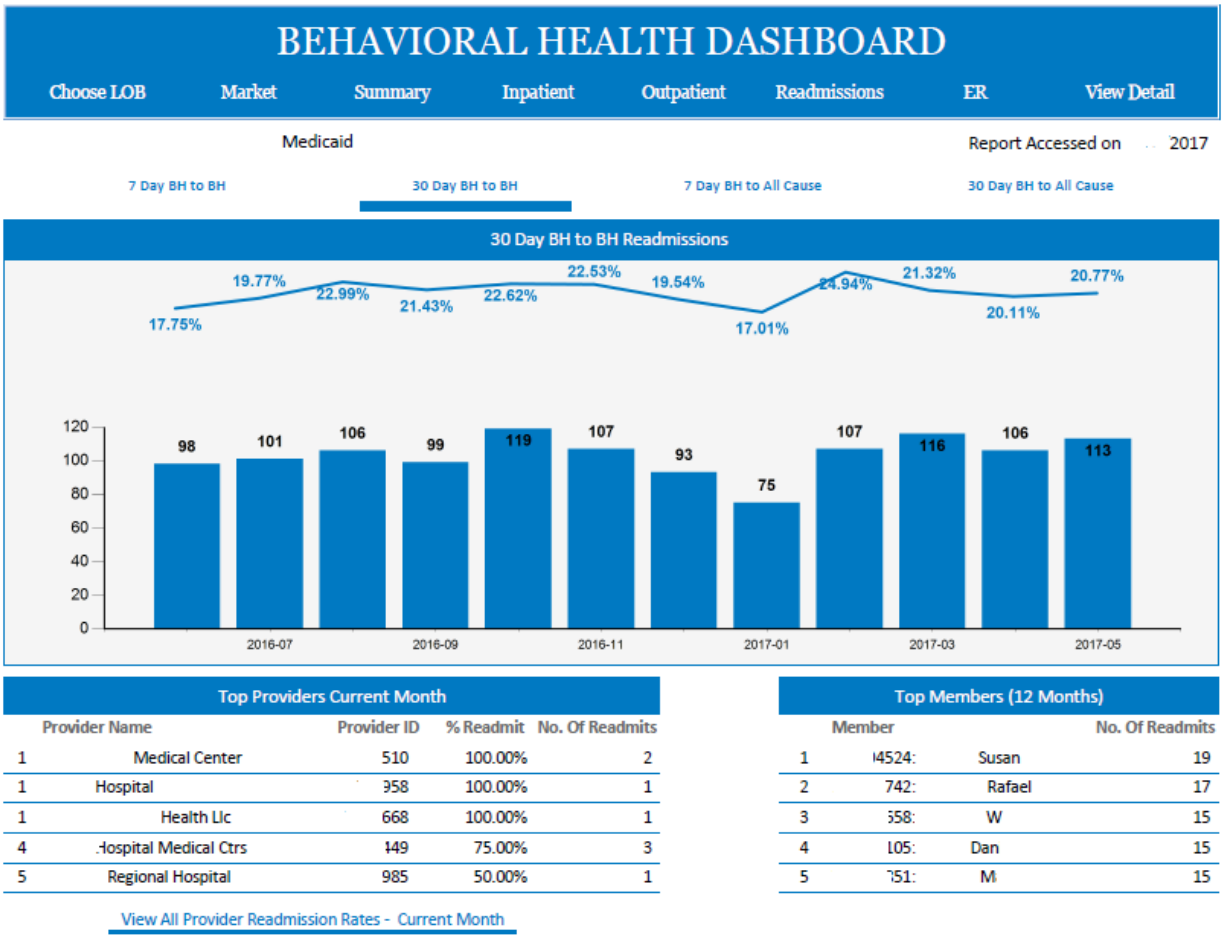
Using Data Tools to Drive Performance Improvement

With a wealth of reliable data and sophisticated analytic tools at our fingertips, our Quality Improvement (QI) team will track and trend performance over time and drive quality improvements, such as regularly monitoring changes in performance measures. Our tools include:

- **Analytics.** We will use our analytics platform to share practice-, Network Provider-, and Member-level detail, including performance trends, target goals, gaps in care, and utilization. Our platform includes quality measure performance trended over time with benchmarks and comparable data from regions across Colorado we obtain from the Department. ***This will facilitate best practice sharing across the RAEs and will be a great tool for the Operational Learning Collaborative*** and work on statewide initiatives like the State Innovation Model (SIM), Comprehensive Primary Care (CPC+), and the Colorado Opportunity Project; and support identification of strategies most likely to achieve gains for Colorado quality initiatives.
- **KPI Reporting.** We will facilitate KPI and HEDIS®-like measure reporting using our measure development tool. We will track and trend these measures through monthly reports to identify opportunities for performance improvement, assess the impact of interventions, and monitor our performance relative to Department performance measures. Reports will include the following:
  - **Gaps in Care Report** —identifies Members who need specific services to close gaps in care
  - **Benchmark Report** — shows monthly trends by specific measure
  - **Provider Quality Report Card** (generated quarterly with KPI rates by Network Providers) — identifies actionable data that drives rates, as well as opportunities for quality improvement

- **Member Management Dashboard and Reporting Tool.** To support integration, the CCHA *Plus* monthly Behavioral Health Dashboard (see example in Figure 5.13-1) and daily Customized Authorization Reporting Tool (CART) will produce reports that include Members experiencing a BH condition to drive transparency and support management and care. Daily CART reports will provide insight into metrics, such as Members awaiting approvals, data needed to complete approvals, how long Members have been in care, how long they have been at a certain level of care, the number engaged in intensive outpatient care, those receiving outpatient hospital services, and the number of Members in inpatient care. Data from these reports will inform Utilization Management Representatives and Care Coordinators and confirm Members are receiving the right care, as well as see that we are meeting our fiduciary responsibilities to the Department and stakeholders. Depending on the type and format of pharmacy data the Department shares with CCHA *Plus*, we can also include data regarding Network Provider prescribing patterns and script fulfillment.
- **Predictive Modeling Tools.** Our proprietary predictive modeling tool will supplement the information we receive from the Department's to enable us to identify Members with the highest risk levels and coordinate their services and supports to achieve optimal outcomes. With this data, we will hone in on Members with the greatest risk levels and tailor Care Coordination programs. It will also enable us to track changes in Member risk levels over time. Other predictive modeling tools we will use include **Likelihood of Inpatient Admission** (LIPA), an index that prioritizes Members for outreach by predicting the probability of an inpatient admission; and **Behavioral Health "First-Time Admitter,"** which spots Members who have not had a BH admission in the past 6 months, but are likely to have one in the next 60 days.
- **Care Coordination System.** This innovative system of tools will consolidate Member data and information from multiple sources into a single record that delivers a holistic dashboard of demographic, utilization, care plan, and gaps in care to appropriate staff. For example, Care Coordinators will be able to readily identify gaps in primary and preventive care and close them as part of their planning process.
- **Provider Profile Tools.** CCHA *Plus* profiling tools will support identification of Network Providers whose quality results need improvement and tailor outreach and engagement with them directly. Our Provider Support team will help Network Providers use the dashboard to engage in quality improvement efforts explained in OR 17. Both CCHA and Anthem currently produce similar reports that are used by their respective QI teams to monitor the results of their improvement efforts.

Figure 5.13-1. Behavioral Health Dashboard: Our BH Dashboard Delivers Critical Information to Support the Management of Members



Sharing Data with Network Providers

Our Provider Support team and Practice Transformation Coaches will analyze Network Provider performance and provide feedback continuously through our Network Provider Dashboard. The Dashboard presents Network Provider performance benchmarked to the entire network, practice, and peers. We stratify aggregated data by Provider for comparison purposes and help each engage in improvement efforts. Building on the experiences of both CCHA and Anthem, CCHA *Plus* will produce population- and condition-specific reports to share with Network Providers (for example, maternity list, well-child checkups list, SMI) to support whole-person care. Below is a sample listing of our Medicaid Network Provider data sharing and performance reports that support transparency as a RAE.

Table 5.13-1. CCHA Plus Will Promote Data Sharing and Transparency through a Variety of Reports

Report	Purpose	Recipients
Gaps in Care	Provides PCMPs with a list of assigned Members who have gaps in recommended care, such as missed preventive health services. We use the reports to engage PCMPs to improve targeted clinical quality results, promote safe and effective patient care, and increase preventive health services for Members.	Available to all PCMPs with a Member with gaps in recommended care

Report	Purpose	Recipients
Right Care, Place, Time (RCPT) Report	Enables analysis of ER use and frequency. Through a drill-down analysis, we gain insight into utilization by region, date, presenting condition, urgent versus non-urgent, PCMP, and more. The RCPT program goal is to reduce non-emergency ER use by educating Members and helping them access appropriate alternatives, such as their PCMPs or urgent care services.	Available to all PCMPs with a Member with high ER utilization
Integrated Member Dashboard	Through our Care Coordination Tool, all Network Providers can access our easy-to-navigate Integrated Member Dashboard that gives them access to a single view that displays Member-specific data, including HEDIS® care alerts, authorizations, prescriptions, and claims organized by type, such as inpatient, ER, and office visits.	Available to all Network Providers

Data Driven Practice Support and Transformation

CCHA *Plus* will have a staff of Business Analysts (Clinical Informaticists) dedicated to supporting Network Providers in managing and using data. We use multiple sources of data, as listed in Table 5.13-1, to achieve the Quadruple Aim outcome. Please see our response to Offeror's Response 17 and 23 for more information about our use of data and reports to help drive improvement at the practice level.

Key Cost Drivers

As part of understanding key cost drivers within the region and identifying variations, CCHA *Plus* will monitor overall utilization (for example, ER utilization, co-morbid conditions, prescriber practices) to understand trends and identify opportunities for both operational and Network Provider practice improvement. Review of utilization data generated by claims, as well as other data resources provided by the Department, will be used to monitor and identify those cost categories growing faster than would be expected. Once those low-value services and cost categories have been identified, we will review the information to truly understand drivers. We will then initiate mitigation efforts to help lower utilization and facilitate steerage to more cost-effective therapies and treatments with better outcomes.

Cost and Utilization Monitoring

Our Quality Management Committee will include CCHA *Plus* employees representing cross-functional experts, as well as key leaders of the health system (PCMPs, hospitals, and BH Providers) to analyze our cost and financial reports and develop strategies for implementation across major cost centers of the health system. Based on our managing partners' experience, we expect this level of review and collaboration across CCHA *Plus* and the health system to help reduce costs through elimination of duplicated or unnecessary services.

Additionally, this committee will review historical cost trends and monitor current trends. Members of the committee and internal employees will meet regularly and communicate with Network Providers about identified outlier cost trends, unnecessary testing, or procedures. ***In collaboration with the Department, Network Providers, and stakeholders, we will incorporate practice-level costs for Network Providers into our value-based PMPM methodology, creating a new lever to reward physicians and BH Providers for delivering high-value services.***

Colorado interChange (MMIS)

CCHA *Plus* will receive Medicaid raw claims data via X.12 EDI 837 batch transactions, as well as extract claims and encounters data from State systems. Regardless of source, we will process data through our integrated framework and store it in our master data environment, which will be the "source of truth" shared with down-stream systems, Network Providers, and Community partners.

As we evolve our ability to normalize extracted comprehensive data from EHR systems, we will reconcile clinical with claims data received from the Department and share reports with our Care Coordinators, Network Providers, and management team, providing a unique view of each Member's longitudinal health record.

Business Intelligence and Data Management System (BIDM System)

Over the past 6 years, CCHA has used SDAC data, analytics, and reporting to drive RCCO operations and support PCMPs' quality improvement efforts. As BIDM replaces the SDAC, CCHA *Plus* will be at the forefront of providing technical assistance and training to Care Coordinators and Network Providers.

We will access standard analytics and reports from the BIDM. We are excited to see what the new system will bring and look forward to receiving new sources beyond claims data. As an example, the Pharmacy Benefit Management System will enable PCMPs to identify and report on suspect conditions based on medications prescribed across the continuum of Member care. This data will also provide insight into unnecessary ER utilization and enable community providers to identify trends and deploy the appropriate resources.

For instance, the BIDM tool uses Diagnostic Cost Group (DCG) algorithms to indicate Members with a high risk of future costs. Our analytic tool will be able to use the Hierarchical Condition Category (HCC) and Johns Hopkins ACG® System models to indicate condition-driven risk and offer a comparison of claims and clinical (EHR) data to identify gaps in care and opportunities to rectify both coding errors and care gaps.

Compliance with State and Federal Regulations Regarding

Our data management system meets all federal regulations regarding privacy, security, electronic health care transactions, and individually identifiable health information. The privacy regulations comprise 42 C.F.R. Part 2, 45 C.F.R. § 160, 162 and 164; the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 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.

We understand the sensitive nature of the health and enrollment information we will collect and maintain to operate CCHA *Plus*. We also understand the importance of securing this information to protect the privacy of our Members and Network Providers. We will require all team members to take HIPAA, HITECH, and Fraud and Abuse certification training annually. Active monitoring of HIPAA, HITECH, and other federal and State requirements will identify the possible impact any changes will have on our systems and operations.

Compliance with HIPAA Business Associate Agreement

To protect confidentiality, integrity, and availability of data, Technology Services will employ a defense-in-depth security strategy that incorporates administrative, technical, and physical controls at the facility, network, operating system, application, and data store levels. Information security standards are consistent with industry best practices, standard frameworks, and the regulatory requirements of HIPAA. Some of the many controls will include:

- **Facility Access** controlled by proximity-based electronic security badges
- **Access to Workstations or Systems** that requires the use of a unique user identifier and password (complex and changed at regular intervals)
- **Role-Based Security** limits that update capabilities and access to application functionality
- **Network Security** managed and monitored using a number of technologies and security management systems providing 24/7 real-time security event monitoring and reporting capabilities

Data Governance Policy

CCHA *Plus* will maintain a Data Governance policy for sharing data with other entities, including Network Providers and Community organizations. We will build upon CCHA's and Anthem's comprehensive set of privacy policies and procedures, as well as current Colorado-specific policies and procedures that make up the Data Governance Policy, to develop a comprehensive approach to maintaining the privacy, security, and confidentiality of each Member's information and its use and disclosure to Network Providers and other authorized entities. We will share different levels of access with different entities, depending on the purpose of the data sharing project.

We will submit these policies for review and approval by the Department. Our privacy policies will address how BH data will be shared, as well as circumstances where other entities, including providers and community organizations, will be granted full access to Member-level data.

We will submit our Data Governance Policy to the Department no later than July 1, 2018, and an updated policy annually thereafter. Additionally, we will report on the status and results of these governance activities, as well as our review and update timelines and activities, annually.

CCHA *Plus* Will Meet All Section 5.13 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR Questions 21. We also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.13 that are not detailed in our response.

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.

CCHA *Plus* will operate a sophisticated data management system as a key component for achieving improved health care access and outcomes for Coloradans while demonstrating sound stewardship of financial resources. We understand that a critical component of our system will be the ability to process claims accurately and quickly, and provide encounter data to the Department in a timely manner.

Through the integration of physical health (PH) and behavioral health (BH) data with other data sources, including the Colorado Interchange and BIDM system, we will use the data internally to inform our daily practices and share it with Network Providers and Health Neighborhood and Community partners to increase transparency, drive access and quality improvements, and steer PH and BH integration at the point of care.

CCHA *Plus* Data Management System

Since 2011, CCHA has served more than 135,000 Colorado Medicaid Members in Region 6 effectively through their advanced systems that enable them to provide actionable data to those who serve Members. For more than 26 years, Anthem has evolved their mature systems to integrate data across the health care system, fine-tuning their processes based on state, provider, and member needs. CCHA *Plus* will leverage the best practices of CCHA and Anthem to deliver a highly configurable and customizable system, enabling us to meet the Department requirements now and in the future.

The CCHA *Plus* Management Information System (MIS) will be built on a Medicaid model that integrates Member, Network Provider, Department, and population health-specific needs and innovations that will enable our RAE operations to benefit from the best practice enhancements of CCHA and Anthem. The modular design of our MIS will provide a flexible, configurable, and scalable system that will deliver the required functionality, including, benefits, business rules, and reports, to support RAE operations.

Our plan for completion of required MIS setup will see that capabilities are successfully implemented, including all required testing and documentation, by readiness review. While we will leverage CCHA's experience and existing systems setup as a RCCO, we understand that the ACC Program will require additional setup as it brings together the administration of both PH and BH under a single RAE. To confirm that our systems perform as expected, we will conduct a more formal and meticulous review of system requirements, connection points (for example, with the BIDM), and expected outputs, developing a requirements matrix and work plan that will guide our implementation.

Structure

Our IT department is composed of an elite team of IT professionals highly skilled and experienced in developing application interfaces and integration technologies using large data systems containing all types of medical information systems data, including systems managing Provider Network, membership/enrollment, authorization, Care Coordination, claims, encounter, and supporting reference data.

As a Region 6 RCCO, CCHA has received and processed proprietary multi-segment HL7-compliant and proprietary flat files that contain lab battery/test results from the 2 major lab companies in the region. They have successfully consumed and distributed analytics data report feeds to PCMPs and Care Coordinators in HL7 formats containing large sets of admission, discharge and transfer (ADT) events.

MIS Integrated Components

The CCHA *Plus* MIS includes 5 main integrated components that deliver all key business processing functions and features required by the Department:

- **Public Member and Provider Websites and Secure Portals.** The CCHA *Plus* website will deliver publicly available information and tools to Members, Network Providers, Health Neighborhood, and Community. Our secure Network Provider portals will require users to enter their login credentials to access information for that specific user (for example, PHI, provider practice information). Our websites will use industry-standard Web services and content management system technologies. For more information on our interactive Website see OR 9.
- **Care Coordination System.** Our electronic Care Coordination System is the foundation of our Care Coordination program. It can be configured to evolve with the health care system, adding new, customized functionality to support the ACC Program and meet Members' and Network Providers' needs. The Care Coordination System will facilitate collaboration between Network Providers, Health Neighborhood Providers, the Community, and Care Coordinators to support each Member's goals, selection of a care team lead, and an individualized care plan. We will feed raw eligibility and claims data files we receive from the Department into the system, as well as additional data feeds (such as ADT feeds and the Health First Colorado Nurse Advice line data). We will control secure access to this data using role-based security.
- **Core Operations System.** The Core Operations System (COS) will be the authoritative host, or system of record, for data about Network Providers, Members (including demographics, enrollment, and other insurance coverage), claims and encounters, and authorizations. It will collect and track data on utilization, grievances and appeals, Network Provider contracts, Member benefits, finance, and more in support of ACC Program operations and quality assessment and improvement activities. Our system will identify an individual across a range of different programs. For instance, an individual covered under the Medicaid program but incarcerated in a Colorado Department of Corrections facility resolves to a single individual associated with Member identifiers and eligibility in both systems. The same is true for Members covered under Medicaid who may have additional coverage in a commercial plan.
- **Data Warehouse.** Our data warehouse will support operational processes, analytics, and reporting for both PH and BH, while receiving data directly from the COS to promote data quality, control, and consistency across the health care system. The data warehouse will deliver comprehensive health information, including claims/encounter data for PH, BH, and other services, as well as certain lab results and immunizations. The data warehouse supports access to:
  - Health service data for both PH and BH
  - Advanced data analytics, including predictive modeling to identify Members for Care Coordination
  - Operational, management, regulatory, and reporting data
- **Supplemental Applications.** Our MIS will include integrated supplemental applications that support the overall functionality of CCHA *Plus*. This includes identification cards, call center efficiency, Network Provider payment, extra services, HEDIS®, key performance indicators (KPIs), and document imaging and workflow. Business intelligence dashboards, analytical reporting, and other supplemental applications will maximize functionality, efficiency, security, and data analytics.

Claims Processing System for Capitated Behavioral Health

We will leverage Anthem's experience to administer the claims processing system for the capitated BH benefit. ***Anthem provides experience processing and paying BH claims in 18 states for more than 5.6M lives as of Q1 2017.***

As a RAE, CCHA *Plus* will implement Anthem's system that achieved Common Security Framework (CSF) certification from HITRUST in August 2016. The CSF is a comprehensive framework that incorporates and leverages existing security requirements on health care organizations, including those from federal (such as HIPAA and HITECH), state, third-party (such as Control Objectives for Information and Related Technology [COBIT]), and other government agencies (such as CMS).

We will use the BIDM System to access current and historical Medicaid claims and encounter data for BH services and load that into our COS. Claims processing is a critical function that will be performed by our COS, with claims intake and payment support delivered by the supplemental applications component of our MIS. Our MIS will accept and process paper and electronic claims for the capitated BH benefit using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. We will scan paper claims into our document management system and transform them into HIPAA-compliant electronic claim transactions. We will accept electronic claims from three clearinghouses and our Provider portal — all at no cost to the Network Provider.

We will use effective technology and experienced employees to consistently deliver prompt and accurate claims payment. Through Anthem, we have proven ability to process large volumes of claims timely.

Claims Edits

Our system will perform extensive edits that identify and resolve issues prior to submission to the adjudication system to maximize throughput and conduct balancing to verify that all received claims are accounted for, regardless of the submission methodology.

- In 2016, we processed almost **700,000 BH claims** with an average turnaround time of approximately **8 days** and **97%** paid within 30 days.
- Both payment (number of claims) and financial (claim dollars) accuracy across all markets and claim types was **99%** or better.

CO_RAE_CO22_Claims2_16_COB_DP_4.2

The claims editing and adjudication processes will access data stored in our COS, including Member enrollment, Network Provider data, prior authorizations, other health insurance information, and other claims history data.

We will extract processed claims data from the COS as input to our claims payment process for Network Provider reimbursement (via check or electronic funds transfer) and remittance advice generation (with multiple options for delivery, including paper, website, or HIPAA-compliant ASC X12 835 data file). Network Providers will be able to access claims status information 24/7 directly through the CCHA *Plus* secure Provider portal and our IVR system. Claims status will also be available to our Network Provider services call center to enable Provider Relations team members to help resolve any claims questions.

Claims Adjudication

Claims adjudication accuracy will be vital to our role as stewards of the Department's funds and as true partners to Network Providers. Given Anthem's experience serving Members with BH conditions across the nation, CCHA *Plus* recognizes and understands the complexities and challenges associated with system configuration for BH services.

Anthem has successfully managed payments for mental health and SUD Network Providers, including individual Network Providers, outpatient individual and group services, inpatient facilities for mental health and SUD, and medical detoxification services. This multi-level process will begin with contracting

and credentialing licensed BH clinicians who render independent services, outpatient- and facility-based clinicians, and the locations where licensed professionals can provide services.

During this process, CCHA *Plus* will require Network Providers to complete a ***Behavioral Health Areas of Expertise Profile*** that reflects their licensing, credentialing, and areas of expertise for serving Members with mental health and SUD.

We will configure our MIS with Network Provider licensing information upon verification, as well as level of care criteria published by the ASAM, for placement, continued stay, and discharge of Members with addiction and co-occurring conditions.

We will use an experienced team of CCHA *Plus* employees to configure claims processing and adjudication system that deliver prompt and accurate BH Provider payment. We will comply with the Department's requirements and configure our encounter extract according to requirements specified in Section 5.13.2.2.3 of the RFP.

We will conduct frequent, ongoing outreach and education on proper claims submission and billing practices to guide mental health and SUD Network Providers. ***In 2016, Anthem's claims payment accuracy (number of claims) averaged 99.39% and financial accuracy (claim dollars) averaged 98.99%.***

Behavioral Health Encounter Data Reporting

We understand the importance of transmitting accurate, timely encounter data securely and efficiently. Leveraging the experience of our managing partners, CCHA *Plus* employees have extensive experience generating Medicaid encounter data. In 2016, these employees assisted in the submission of more than 233.5 million encounters. They also have experience with multiple transmission standards and working with state-designated fiscal agents (like DXC) to submit Medicaid encounters following the state's preferences. CCHA *Plus* will continue the long history of success supporting transparency in reporting for which CCHA and Anthem are known.

Encounter Data Process

We will manage submission of encounter data through a robust Encounter Management System (EMS), dedicated staffing, and a tightly managed submission schedule. The EMS is highly customizable and includes controls that will enable us to closely monitor compliance with Colorado Medical Assistance Program policy rules to make sure that the quality and timeliness of BH encounter data meets the Department's standards.

Encounter Management employees will follow a strict submission schedule, extracting claims data from our processing system. They will maintain a comprehensive schedule of system processes, review tasks, and submission dates necessary to deliver complete, accurate, and timely encounter data to the Department.

Monthly, our Encounter Management staff will deliver to the Department's fiscal agent a certified ANSI ASC X12N 837 formatted file containing encounter claims that are paid, adjusted, or denied. When requested by the Department, we will modify the format. Our staff will review data and files to confirm that we:

- Determine the acceptability of all encounter data within 90 days of an adjudicated claim or have notified the Department of the reason for any delay and expected submission date
- Make adjustments to encounter claims within 14 calendar days of notification by the Department or when we discover the data is incorrect, invalid, or some element of the claim requires revision
- Submit accurate encounter data no later than 120 days following the date when we adjudicated a Network Provider claim

- Submit monthly data certifications for all encounter data used for rate setting, in compliance with 42 C.F.R. § 438.604 and 438.606
- Submit raw encounter data, excluding that protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD) according to guidelines in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide

Export Capability

Our data warehouse will support complex analytical and ad hoc queries using business intelligence tools. The warehouse is an integrated repository fed directly from the COS to deliver data quality, control, and consistency. The data warehouse will also house data from external sources, including encounter data from other programs, such as pharmacy and vision. The warehouse will maximize our capacity for data analytics and afford us the flexibility to produce targeted reporting that supports Department customers, business processes, Network Providers, and Members. We can accommodate any industry standard or mutually agreed upon format. We leverage Secure File Transport Protocol (SFTP) and can export files via our Electronic Data Interchange (EDI) gateway.

Integration with Other Systems

CCHA *Plus* will use existing tools provided by the Department, and other available resources, to establish performance benchmarks and monitor Provider performance across key cost, utilization, and clinical outcomes metrics — including the Colorado interChange and the BIDM (described above).

As a RCCO, CCHA has created secure, automated processes to retrieve and process data from a multitude of sources and senders. They currently receive Medicaid raw claims data as well daily/monthly eligibility via the 834 and 820 EDI transactions, as well as the ACC Program monthly snapshot report.

Health Information Exchange (HIE) data will be received and processed daily from the State HIE system. We will also work with Network Providers to access their EHR data to obtain that most complete picture of the Members we will serve. We will incorporate this ADT data into our data warehouse for reporting and analytics and ER program evaluation. Using this data, we will produce reports daily as part of our ER Reduction and Transitions of Care programs.

We will use all tools and available resources provided by the Department to establish benchmarks and monitor Network Provider performance across key cost and utilization metrics.

Colorado interChange

We see the value that access to timely clinical data can deliver to Network Providers, Members, and employees. CCHA *Plus* will build upon CCHA's experience interfacing with the Colorado interChange and Anthem's experience interfacing with many state-run MMIS and Health Information Networks to enable us to retrieve eligibility, enrollment, and attribution information for Members.

Leveraging the existing interface application developed by CCHA software engineers that provides an end-to-end solution for file and data management, CCHA *Plus* will use this process going forward to send and receive BH claims and encounter data. This integration framework is an automated application that retrieves, processes, and supplies data for direct use or consumption by downstream applications.

The application is highly flexible and easily configured to support management and integration of data in any structured form from internal and external sources. CCHA currently uses this system to access data from various State sites, including the State's interchange MoveIT. Additionally, through our partnership with Correctional Health Partners (CHP), the integration framework application will manage Member

eligibility and Provider Networks for the Colorado Department of Corrections, Colorado Division of Youth Services, and various jail and prison systems in the state of Colorado and across the country.

BIDM

CCHA *Plus* will employ current CCHA training practices and leverage their workflows to request BIDM access for Network Providers as they contract with us. We are proud of CCHA's track record on KPI improvements, and CCHA *Plus* will similarly dedicate resources and efforts using BIDM information when it is implemented.

CCHA has been actively engaged with the Department and DXC (previously Hewlett Packard Enterprise Systems) since November 2016. They have attended every interChange work group and discussion and engaged with the Department staff independently since then, providing detailed information on eligibility, portal operations, and more to help identify and resolve challenges in bringing the new interChange system online. When the new Truven raw claims test data was released February 2017, they were the first RCCO to load and analyze that data. They have provided continuous feedback on data structure, design, and content to the Department and Truven, resulting in modifications and enhancements to the management of raw claims data.

Integration among Components

Based on Service Oriented Architecture (SOA), integration among components is a key design premise of our MIS. We have based our systems on the principle that all data originates from a single system of record; all changes to the data are made in the system of record, though other systems may access and use the information as consumers through the interfaces. This approach will protect data integrity and prevent inconsistencies between systems for the same piece of information.

Examples of MIS Integration to Support Internal and External Clients. Across our MIS, there are many examples of how data from multiple sources and system components is integrated to support operational processes. Table 5.13-2 highlights two applications that integrate data from different sources to support day-to-day operations.

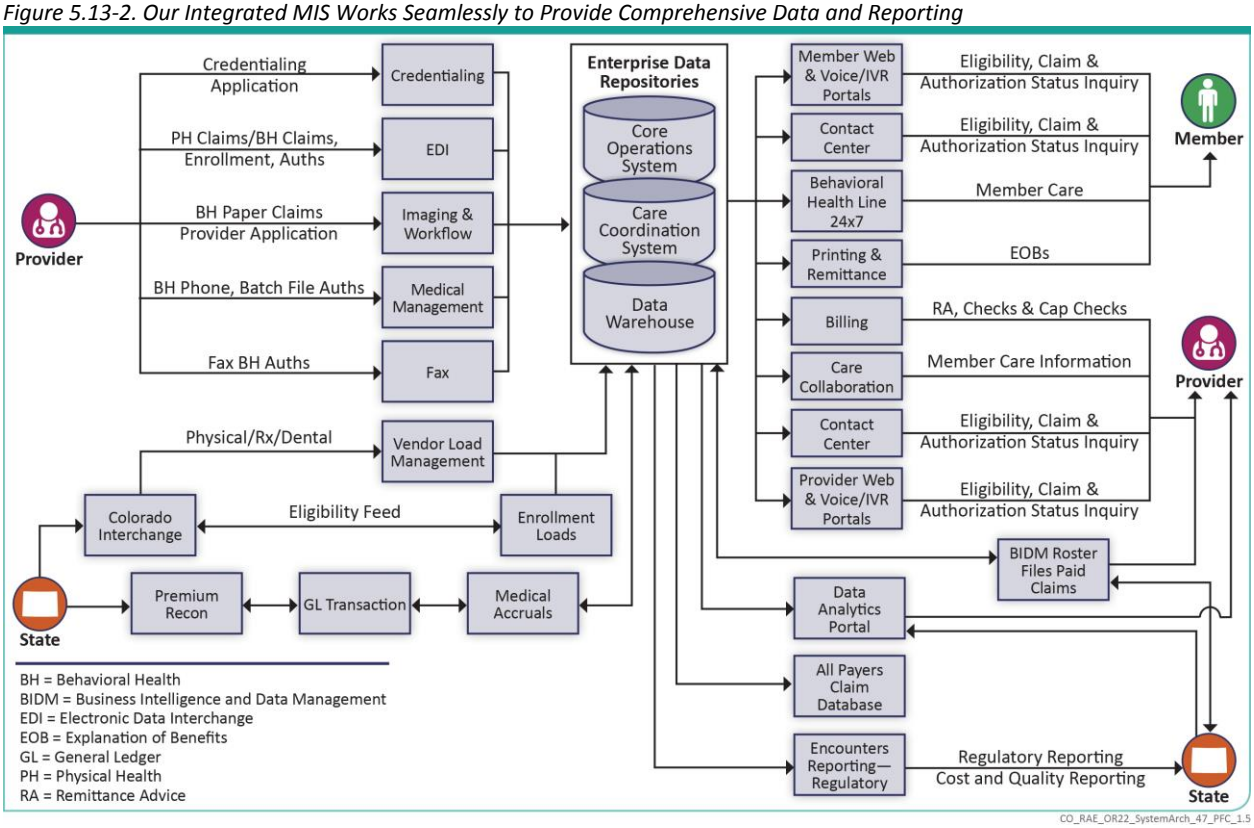
Table 5.13-2. Our MIS Integrates Data to Serve Internal and External Clients (When Available)

Application	Example of System Data Integration
Care Coordination System **Serves: Internal and External (Department, Network Providers) Members**	Our Care Coordination System will integrate data from multiple sources, when available, and afford Care Coordination staff and Network Providers access to a single view that displays Member data in an easy-to-navigate dashboard. For example, the System will integrate data from our COS (including demographics, enrollment, claims, and authorizations), plans of care, and data warehouse (including encounters, immunization data, and lab results). The Care Coordination System will display care alerts, authorizations, prescriptions, lab results, and claims organized by type (such as inpatient, ER, and office visit). It will organize information into a timeline of clinical events representing a longitudinal Member record across a number of domains, including diagnosis, Network Providers, and medication history. Integrating data from a number of sources into a single system will enable Network Providers and Care Coordinators to better support the health and well-being of Colorado Medicaid Members.

System Architecture Diagram

Figure 5.13-2 displays our system architecture diagram.

Figure 5.13-2. Our Integrated MIS Works Seamlessly to Provide Comprehensive Data and Reporting



Care Coordination Tool

Our integrated, electronic Care Coordination Tool is the cornerstone of our Care Coordination model. Our Care Coordination Tool houses Member assessments and care plans and provides information about Member conditions, medications, and chronologically ordered progress notes. This tool promotes comprehensive Care Coordination of Member needs and issues, whether the driver is PH, BH, pharmacy, or other. All of our clinical staff involved in Member care will work in our Care Coordination Tool, enhancing clinical oversight, facilitating communication across departments, and reducing Member risk of fragmented care.

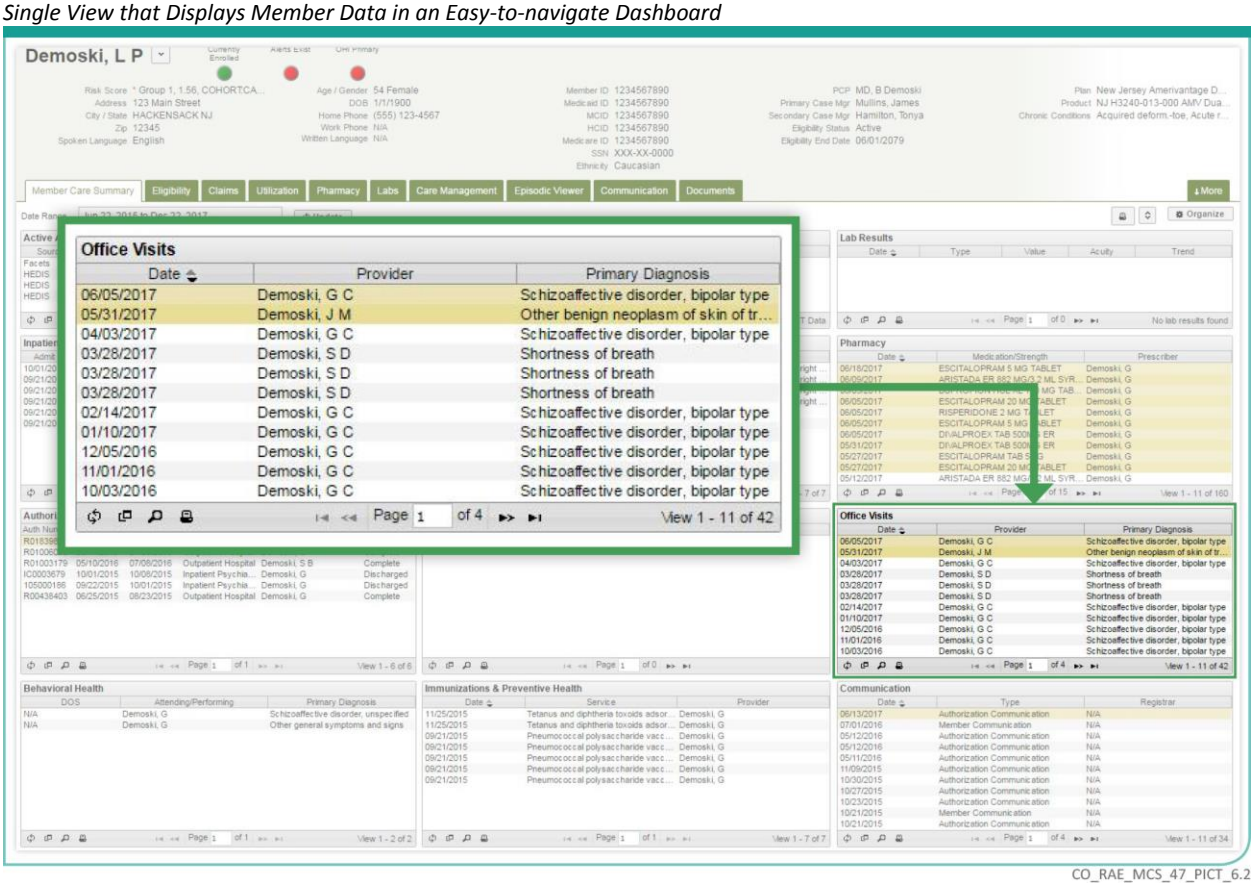
Our Care Coordination Tool collects and aggregates the following:

- Name and Medicaid ID of Member receiving interventions
- Age
- Gender identity
- Race/ethnicity
- Name of entity or entities providing Care Coordination, including the Member's choice of lead Care Coordinator, if there is more than one
- Care Coordination notes, activities, and Members' needs
- Stratification level

The screenshot below (Figure 5.13-3) was taken from our Care Coordination System solution. It illustrates how we will integrate data from multiple sources to afford our Care Coordination staff and Network Providers a single view that displays Member data in an easy-to-navigate dashboard. It

integrates data from our COS (demographics, claims, authorizations), Care Coordination System (assessments, plans of care), and data warehouses (subcontractor encounters, immunizations, and lab results). It displays care alerts, labs, authorizations, prescriptions, and claims organized by type (such as inpatient, ER, and office visit) and a timeline of clinical events across domains, including Network Providers, diagnosis, services, and medications. Integrating data into a single system will help Network Providers and Care Coordinators better support Colorado Members.

Figure 5.13-3. We Integrate Data from Multiple Sources so that Our Care Coordination Staff and Network Providers Have a Single View that Displays Member Data in an Easy-to-navigate Dashboard



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Based on Anthem's proven Care Coordination Tool, CCHA *Plus* will use the Tool to seamlessly integrate with our COS, gathering and organizing information for management and coordination of Member care and services. Member utilization data, such as claims history, authorization, immunization records, lab results, and care data, will be readily available in an organized format with tools for Care Coordinators to identify and manage Members' needs. The tool will capture assessment completion, care planning, and ongoing interventions, including telephonic, face-to-face, or home visits, email, text, and mail contact between the Care Coordinator, the Member, and the Network Provider. It also will include online and mobile access to related attachments such as Power of Attorney documents, clinical records, or consent documents with significant relevance to the Member's care.

Our Care Coordination Tool will capture all Member assessment information, including results from the initial health needs screening and any completed comprehensive assessments. We will use that information to drive care plan development, maintenance, and monitoring. The system will prompt Care Coordinators on critical items and tasks to be addressed during the assessment and Care Coordination process. These tools will enable Care Coordinators to track both Care Coordination activities and barriers to care identified through discussions with the Member to verify that we are providing the care and

services needed. The CCHA *Plus* library of reports will enable us to use data to monitor Care Coordinator caseloads, compliance with accreditation requirements, and compliance with required time frames (such as timely completion of health needs screenings). In collaboration with the Department, Network Providers, and stakeholders, we will include this data as part of the CCHA *Plus* value-based payment approach for PCMP PMPM payments.

CCHA *Plus* Will Meet All Section 5.13 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR Questions 22. We also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.13 that are not detailed in our response.

Section 5.14

COLORADO COMMUNITY HEALTH ALLIANCE

Outcomes, Quality Assessment and Performance Improvement Program

5.14 OUTCOMES, QUALITY ASSESSMENT, AND PERFORMANCE IMPROVEMENT PROGRAM

OFFEROR'S RESPONSE 23

Describe how the Offeror will implement and maintain an ongoing Quality Improvement Program, in accordance with the requirements of Section 5.14, and how the Offeror will address quality throughout the administration of the program.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

As a RAE, CCHA *Plus* will bring extensive experience implementing and maintaining a comprehensive Quality Improvement program. We are excited to offer the combined expertise of CCHA as the current Regional Care Collaborative Organization (RCCO) for Region 6 and Anthem's long, successful history with quality improvement initiatives for behavioral health.

CCHA is currently participating in various programs with the Department to improve quality of care for Colorado Medicaid Members. The Department provides RCCOs with reports on a regular basis to help them monitor their performance. As demonstrated in the most recent report, CCHA is one of the top performing RCCOs in the ACC Program (Figure 5.14-1). The CCHA Quality Improvement team continuously assesses performance on all key performance indicators (KPIs) and other key ACC measures. CCHA has been nimble and quick in addressing performance problems. They use data to evaluate all of their programs and engage in rapid-cycle feedback processes that allow for refinement and innovation on the spot.

Figure 5.14-1. CCHA Achieves Consistently Strong Performance in RCCO 6

Key	Best Performance	Better than Standards	Worse than Standards	Worst Performance

		RCCO 1	RCCO 2	RCCO 3	RCCO 4	RCCO 5	RCCO 6	RCCO 7
Current Program KPIs	ER KPI PKPY	616.54	721.85	704.07	711.05	762.35	662.02	749.37
	Post-Partum KPI Rate	80.36%	73.13%	66.49%	77.73%	61.54%	76.13%	78.56%
	WCC 3 - 9 KPI Rate	47.33%	44.10%	51.53%	41.93%	56.91%	51.64%	41.06%
Member Experience	30 Day Follow-Up Rate	44.80%	44.93%	43.81%	46.13%	42.52%	44.64%	44.17%
	PCMP Attribution % Rate	75.59%	81.30%	73.26%	82.67%	80.06%	76.70%	73.77%
Cost	TCC (3M Calculated) PMPM	$220.73	$224.57	$225.66	$217.41	$219.79	$221.82	$228.04
Retired KPIs	30-Day Readmissions PKPY	4.27	4.24	4.97	4.48	6.28	4.95	4.60
	High Cost Imaging PKPY	256.99	264.77	234.53	271.31	257.56	222.24	240.37
	Well-Child Check 0 - 21	46.47%	45.15%	50.10%	41.98%	55.40%	47.50%	42.02%

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CCHA and Anthem participate in local and national quality improvement programs and bring sophisticated quality improvement processes and resources to the CCHA *Plus* RAE. As a RAE, our

integrated physical health (PH) and behavioral health (BH) Quality Improvement program will align with the Centers for Medicare and Medicaid Services (CMS) definition of quality and meets all federal requirements for both the Primary Care Case Management (PCCM) and Prepaid Inpatient Health Plan (PIHP). Further, our Quality Improvement program aligns with the Department's Quality Strategy and will drive value in the health care system, improving Member outcomes and experience, provider performance, and cost-effectiveness.

Continuous Quality Improvement

Quality improvement will be embedded in every aspect of our operations, every interaction with Members, and every touch point with Network Providers. We will use data to drive continuous quality improvement to achieve better health outcomes for Members. As an important part of our commitment to quality, we recognize that person- and family-centered care requires integrated PH and BH services. This approach is reflected at all organizational levels, and each employee will work to achieve the best outcome for Members. Through a fully integrated Quality Improvement program that complies with 42 C.F.R. §438.310-370 and that aligns with the Department's Quality Strategy, we will objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable PH and BH services.

Quality Improvement Program

The CCHA *Plus* Quality Improvement program will be designed to monitor and ensure the delivery of consistent, reliable, and integrated PH and BH services to Members so we can collectively achieve the Quadruple Aim goals that focus on population health, patient experience, per capita costs, and provider satisfaction. The program will provide a structure that describes how our quality programs will be planned, managed, and monitored to assure an integrated, holistic, person-centered model for continuous improvement. Establishing these processes and quality standards will help us ensure that all activities follow an organizational standard that will ultimately result in better health and quality outcome for Members.

CCHA *Plus* will comply with the deliverables and timetables identified in the RFP for the Quality Improvement Plan, the Quality Improvement Plan Update, and the Annual Quality Report. Additionally, we will post our Annual Quality Report on the CCHA *Plus* website, CCHAcares.com.

Program Structure

The CCHA *Plus* Quality Improvement program will be comprised of a three-part structure as follows:

Program Plan: Our program plan will detail programs and performance outcomes from the previous year and ensures that quality goals and plans for the upcoming year are integrated into the overall strategic plan of the organization. These programs will be evaluated annually and will be designed to meet the service and cultural needs of our population as well as address any performance shortfalls in the previous year and extend all program performance successes. Program descriptions will be documented and shared with employees. New programs and goals will primarily be identified through the following:

- Feedback from current programs, the Department, and provider and community subcommittees
- Issues identified by tracking and trending data over time
- Issues and outcomes identified in the previous year's Quality Management (QM) Program Evaluation
- Issues identified by employees, Network Providers, BH providers, Members and their family members and caregivers, and community partners
- Contractual requirements

Work Plan: Annually, the Quality Improvement team will identify specific activities, data points, and strategies to drive continuous quality improvement and the performance measures to be evaluated throughout the year. We will then develop corresponding policies and procedures, train our staff, and collect data to track improvement.

Program Evaluation: Programs will be evaluated based on how performance improved for quality and safety of PH and BH clinical care, quality services, reducing waste in the system, increasing efficiency, and increasing internal and external satisfaction.

As mentioned above, part of the process is reviewing past and upcoming program outcomes and requirements. The following requirements will be included in the Quality Improvement program:

- Creation and implementation of internal and external performance improvement projects
- Collection and submission of performance improvement data, including Member experience data collected both internally and externally
- Creation of a mechanism to detect and manage underutilization and over-utilization of services
- Creation of a mechanism to assess the quality and appropriateness of care furnished to Members with special health care needs
- Creation of a mechanism to identify and address quality of care concerns raised by the Department, providers, or internal staff
- Participation in an annual External Quality Site Review
- Participation in external Program Improvement Advisory Committees (PIAC)
- Creation of a Regional PIAC

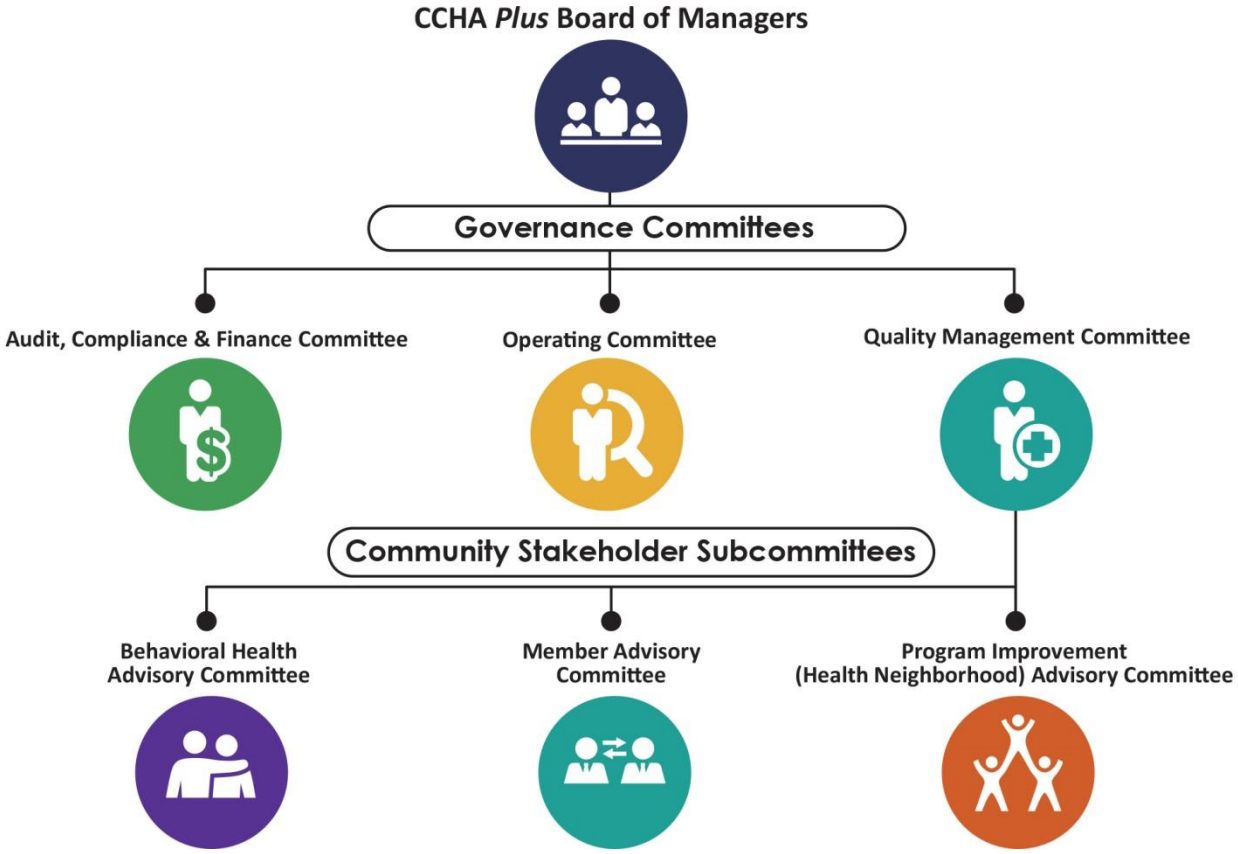
The CCHA *Plus* Annual Quality Report will be produced from the results of our program evaluation work. This report will help inform strategies for the following year and will be publicly available on our website.

Program Governance

The CCHA *Plus* board of managers will have the ultimate authority and responsibility for quality of care and services provided to Members and the approval of the Quality Improvement Program, Quality Improvement Work Plan, and Annual Evaluation. The board will welcome feedback from the Department, as well as other external committees like the Program Improvement Advisory Committees (PIAC), and may delegate operations and monitoring to other subcommittees. However, the board of managers will ultimately be responsible for ensuring that adequate resources are allocated for implementation of the Quality Improvement Program and Work Plan.

In OR 8, you will find our governance structure including detailed information about our governance and community stakeholder committees. This structure is as follows:

Figure 5.14-2. Governance of CCHA Plus Provides Robust Oversight and Community Stakeholder Voice



Our Quality Management Committee (QMC) structure reinforces clear local accountability, fosters inclusive participation by a wide range of constituents, and blends local and national resources. The QMC will monitor practice and RAE performance while developing, recommending, and overseeing clinical education, policies, and procedures that help drive improved quality of care and experience for Colorado Medicaid Members. We will draw from guidance and input from three subcommittees.

Our regional Program Improvement (Health Neighborhood) Advisory Committee is similar to the statewide PIAC and includes representatives from Members and caregivers, PCMPs, BH providers, county and public health agencies, CMHCs, FQHCs, schools, hospitals, dental, LTSS, advocacy groups, and community resource partners. This committee will be open to the public and the minutes will be posted to our website, CCHAcares.com. This regional committee will help drive quality improvement and community investment throughout our programs.

The Behavioral Health Advisory Committee includes providers from CMHCs and private sector mental health providers, PCMPs, and organizations such as substance use disorder providers, emergency room representatives, Colorado Crisis Services, National Alliance on Mental Illness (NAMI), Federation of Families for Children's Mental Health, and other organizations serving BH needs of Members. We will also seek to include Members who use BH services and representatives from key state agencies so that diverse stakeholder perspectives are present. To support Member participation, we will help arrange for transportation and childcare if needed. This committee will take a deeper dive into BH challenges and help shape the overall CCHA *Plus* BH program by providing direction and ideas to drive innovations that improve access to quality BH care for Colorado Medicaid Members.

The Member Advisory Committee will be open to any Member enrolled in the ACC Program in our region. Members will represent a diverse population that brings feedback and input from varying perspectives to help drive things such as pilot program ideas, engagement efforts, and communications. As a RCCO, CCHA has found great value in this committee structure and Anthem brings a rich history of committee engagement. CCHA *Plus* looks forward to continuing this forum to gain insights from our Members.

Performance Improvement Projects

CCHA brings extensive experience designing and conducting Performance Improvement Projects (PIPs) to achieve significant and sustainable improvement over time in clinical and nonclinical care areas. They have a successful track record of achieving results, and CCHA *Plus* will build upon these successes in the next iteration of the ACC Program. We will add at least two new PIP initiatives that will address pertinent PH and BH issues for our Members. Additionally, we have the capabilities, expertise, and resources to implement up to two more PIPs as requested by CMS or the Department.

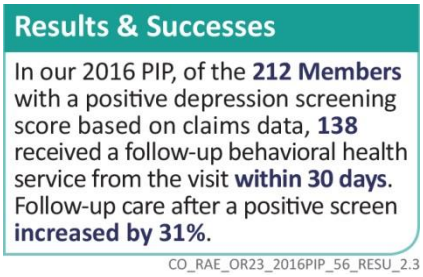
Our PIPs will start with a specific statement of the problem we will address and goals we hope to achieve as a result of our work, including the following:

- Clearly defined performance measures
- A comprehensive plan to intervene
- Evaluation methodologies
- Continuous improvement plans to sustain or improve future outcomes

Performance Improvement Project Examples

Timely Treatment for Members with Depression

A good example of our approach and the successful results of CCHA is the ***Timely Treatment for Members with Depression***, which was implemented in November 2014. For this PIP, CCHA merged PH and BH claims data for four PCMP providers. The goal of the PIP was to answer the question, "Do targeted interventions increase the percentage of Members who screened positive for depression with a PCMP and completed a follow-up visit with a BH specialist within 30 days?"



The Department's contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), validated the 2016 PIP submission with a "met" status and a score of 100 percent. By October 2016, as a RCCO, CCHA had achieved statistically significant improvement (Stouffer's Z value of .000000000000540) in the number of Members receiving a follow-up visit with a BH provider following a positive depression screen in the primary care setting. Of the 212 Members who had a positive depression screening score based on claims data, 138 received a follow-up BH service within 30 days. The percentage of those who had follow-up care after a positive screen increased from 24.1% in September 2015 to 65.1% in September 2016, which significantly exceeded the pre-determined goal of 30%.

The PIP focused on 4 different primary care practices: Milestone Medical Group at Longmont United Hospital, Hall Medical, Peak Pediatrics, and Boulder Valley Women's Health. These practices represent a good cross-section of the Member population. Each of the providers participated in a barrier analysis to identify areas of opportunity and design interventions. CCHA will submit for re-measurement for year 2 in September 2017 with a goal of 75%. The successful outcomes of ***Timely Treatment for Members with***

Depression are an excellent example of our ability as a RAE to use BH and PH data to achieve meaningful results.

Through this partnership, CCHA learned there are some barriers to managing the whole person at the right place and right time. Although data and HIPAA agreements are in place, the CCHA Care Coordination team and the providers have had to wait for BH and PH data to be merged to act on the information. The process has been manual and resource heavy. In the next phase of the ACC Program, CCHA *Plus* looks forward to having both BH and PH claims data available for more focused PIPs that show positive health outcomes for Members and working collaboratively with the Department and the EQRO. By having all the data integrated in-house, we will have timelier, streamlined access to broader data that will give us a comprehensive picture to better address the overall health of Members with serious PH and BH issues.

CCHA *Plus* is committed to implementing programs and strategies that are centered on yielding better outcomes for Members. As mentioned in our Quality Improvement Plan and in our Member Experience below, health outcomes and satisfaction will always be weaved into our strategies. As such, our PIP initiatives will not be any different. We will take into account feedback from our Members and the Network Providers so we can enhance our programs and strategies. The results of the feedback will be evaluated and included in our Quality Improvement Plan for the following year.

We will make sure that the Performance Improvement Projects are reviewed annually and submitted to the Department within 30 days of the Department's request. Additionally, we will work with the Department's EQRO to make sure the PIPs are in line with the requirements for the EQRO Protocol for Validating Performance Improvement Projects.

CCHA currently participates in annual learning collaboratives held by the Department for sharing best practices with other RCCOs. As a RAE, CCHA *Plus* will continue to be an active participant in these collaboratives.

Reducing Emergency Room and Inpatient Costs and Utilization

Anthem launched innovative strategies to improve emergency room (ER) and inpatient utilization and costs in Nevada by analyzing, targeting, and addressing root causes. The successful program used an integrated approach that combined the following strategies:

- Community-based Care Coordinators met with Members at the ER or where they lived and provided transportation to and from their providers to reduce missed appointments, and provided assistance with social services and other community resources as needed
- A Behavioral Health/Medical/Injection Clinic that provided primary care and telemedicine exams, intensive hands-on Care Coordination, BH therapy, and long-acting injectable medication therapy
- Psychiatric urgent care facility provided short-term respite care for up to 12 hours
- Pharmacy provided medication therapy management, as well as bedside delivery of medications to Members in the hospital
- Anthem assisted with placement in transitional medical and short-term housing
- Anthem assisted with long-term housing in group home or other supported living
- Anthem coordinated supported employment in collaboration with Nevada Partners

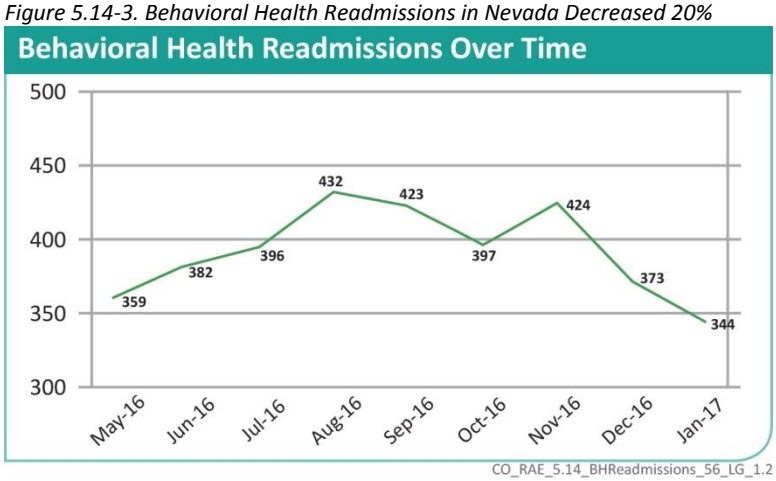
To reduce unnecessary ER services, the Rapid Response team is notified when Members with BH needs go to the ER but do not meet criteria for admission. The Rapid Response team goes to the ER, assesses the Member's needs, and triages the Member to the appropriate setting, including a psychiatric urgent care facility, if appropriate. Onsite Care Coordinators perform needs assessments and work with

Members to identify and address clinical and social factors that interfere with management of their health, such as lack of personal identification, transportation, or stable housing.

Recognizing that a lack of housing often contributes to frequent hospital stays, Members with more than 12 inpatient bed days have access to a short-term housing program. This alternative approach provides significant cost savings compared to repeated hospitalizations, as well as the opportunity for improved quality of life and outcomes.

This initiative has shown positive results. ***Anthem saw a 25% decrease in BH ER visits from the peak in 2016 to January 2017, 1,600 diversions from the ER, and more than 1,000 psychiatric urgent facility assessments.*** They also ***observed a 20% decrease in BH readmissions from the peak in 2016 to January 2017 and a decrease in average length of stay from 7 to 6 days*** (Figure 5.14-3). Through identifying the problem and implementing effective strategies, the rate is the lowest they have observed over this time period.

Figure 5.14-3. Behavioral Health Readmissions in Nevada Decreased 20%



Performance Measurement

As a RCCO, CCHA actively works with the Department, providers, and the Health Neighborhood to improve performance by monitoring and acting upon performance measures. As described in other sections of our response, CCHA has invested heavily in talent and technology to leverage the power of data and achieve demonstrable results in our performance. These investments are a strategic priority and influence their programs and employees at all levels.

We believe that what gets measured gets improved. The right performance measures help focus activities so resources can be directed to improve the quality and safety of care provided to Members in both clinical and non-clinical areas. CCHA *Plus* is committed to the success of the RAE, and will commit to having the KPIs in place for new performance and pay-for-performance measures and make sure the CCHA *Plus* team and provider network is aware and has the support to achieve the identified outcome.

As a RCCO, CCHA currently measures and reports performance for several local and national programs that are publically reported and fully supports transparency in making performance measures publically available. CCHA *Plus* is committed to providing data as requested to enable the Department or its designee to calculate the performance measures. As a RAE, we will bring more data and analytics capabilities and have the ability to utilize internal resources such as the Interactive Analytic Insights tool to support our Quality Improvement program.

Below is a brief summary of the steps we will take to manage our performance:

1. Work with the Department to provide feedback on newly proposed criteria, reporting frequency, and other performance measurement components, as needed or asked

2. Review measure and ensure that goals are aligned with organizational plan
3. Review the measure definition and target goals and ensure staff is trained to support the Member and provider
4. Depending on the measure, create reports at a RAE, practice/provider, and Member level
5. Take action: implement interventions within the RAE, with Members, with Network Providers, or in partnership with the Health Neighborhood or Community to improve performance
6. Create a process to track data and interventions over time
7. Regularly monitor data and determine impact of the interventions and adjust as necessary
8. Provide continued education on measures, reports, and interventions to employees, providers and Members
9. Report to the Department as needed or required by the RFP

CCHA *Plus* Technology Solutions

Our custom-built Interactive Analytic Insights tool, a dynamic and scalable tool, provides comprehensive information about quality performance to support the Quality Improvement (QI) Program. It includes quality measure performance trended over time, with performance benchmarks and comparable data from other state health programs. This tool is used to improve QI Program effectiveness and support the QI team with data visualization and targeting interventions through:

- **Population monitoring** – viewing the efficacy of interventions throughout the community
- **Tracking disparities** – identifying populations and clinical areas where we should provide additional support and tailored interventions to close gaps
- **Tailoring outreach** – using data analysis to identify member, provider, and community needs, and to develop outreach and education strategies to address these needs

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CCHA has put these improvement processes in place for all of the ACC Key Performance Indicator (KPI) measures. These KPI measures are currently tracked at the RCCO level and PCMP level (including Safety Net Providers and Advanced PCMPs). CCHA also supports PCMPs with collecting data from their EHRs and using data from the Statewide Data Analytics Contractor (SDAC), soon to be the Data Analytics Portal (DAP), or CCHA reports for real-time clinical data. The CCHA QI team uses these reports as a tool at the practice level or with CCHA leadership as they evaluate performance at the RCCO level. As discussed in OR 17, CCHA currently has a robust Provider Support program that provides all Network Providers, including Safety Net Providers and Advanced PCMPs like Clinica Family Health, Metro Community Provider Network (MCPN), Salud Family Health Centers, Rocky Mountain Youth Clinics, and Denver Health, with data and expertise on QI activities and opportunities. Because some interventions may be more effective than others, they deploy multiple interventions to achieve the goals of the KPIs. Below are some examples of the different interventions CCHA has in place with PCMPs, Members, and Community partners to achieve the current KPI measures.

Monitoring Performance at RCCO Level

CCHA strives to be a peak performer in everything they do. Over the course of the current RCCO contract, their Quality Improvement Program has resulted in achievement of 2 out of 3 current KPIs and maintaining top performer status on retired KPIs. Currently, the CCHA Quality Improvement team is focused on the final KPI that no RCCO has yet to achieve: well-child checks (WCC). CCHA is improving their performance more than most other RCCOs. Examples of these Quality Improvement Program efforts are provided below.

CCHA Leadership Engagement

Increasing WCC visits has been a top priority for CCHA's leadership team, as part of achieving ACC Program and performance goals. The team, including the CCHA Chief Clinical Officer, meets monthly with the multidisciplinary Quality Improvement team to review WCC performance and discuss evaluations and innovative interventions. They continuously evaluate new ideas and opportunities to

engage the families or guardians of the Member in their health, encourage them to access preventive services, and avoid inappropriate utilization of the health care system. CCHA's work with PCMPs is also evaluated to determine how the CCHA Practice Transformation Coaches and co-located Care Coordinators can work with PCMPs to change their WCC workflows, reach out to Members, and engage in continuous quality improvement. Organization-wide, CCHA experiments with innovative new programs like AmeriCorps, DispatchHealth, or Member incentive programs to leverage the Health Neighborhood and Community to improve quality performance.

Member Engagement

To increase WCC visits, CCHA's Care Coordination program engaged in targeted outreach, using data provided by the Department, to determine which Members needed WCC visits. The data was used to leverage an Interactive Voice Response (IVR) technology campaign to remind parents of WCC visit. Additionally, CCHA partnered with AmeriCorps to create an outreach program to engage and educate families in the community and in elementary schools using a financial incentive to encourage families to complete WCC visits.

Network Providers

CCHA has worked with their provider network to understand the challenges with WCC visit performance goals. CCHA Practice Transformation Coaches asked the PCMPs to identify barriers to meeting the WCC KPI. Some of the responses were:

- Inaccurate attribution
- No-shows for WCC appointments
- Outreach attempts go unanswered
- No Member incentives available
- Providers who are not Vaccines for Children (VFC) designated lose Members to other practices or walk-in clinics, which may not file a claim to close the WCC gap

CCHA used this feedback to develop new interventions to support PCMPs, including helping them improve their Member outreach strategies and reduce no-show appointments. They also increased the number of Care Coordinators that are co-located in PCMP offices. Care Coordinators attend weekly quality improvement meetings and support CCHA Practice Transformation Coaches in work on KPI improvements. The Chief Clinical Officer has been an excellent resource to inspire physicians to focus on practice transformation efforts that ultimately will improve financial performance and Member outcomes.

Provider Testimonial

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by helping our practices to improve our KPIs especially our ED utilization and Well-Child checks.
Kim Taylor, Manager, NextCare Urgent Care

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Safety Net Providers

As described in OR 17, CCHA designated a staff member who works with Safety Net Providers like MCPN, Clinica, and Salud to help them with quality improvement. CCHA has provided targeted assistance through a data-sharing project that compares Medicaid claims with EHR data to identify areas for improvement on WCC. By matching the Medicaid claims data with the FQHC EHR, the FQHCs can see a complete picture of what is happening with the Member. CCHA also provided funding to the data arm of the FQHC association, Colorado Community Health Networks (CCHN), so they can provide analytics and practice transformation coaching to individual FQHCs. In 2018, CCHA *Plus* looks forward to expanding this work to depression screening, a key measure for the State Innovation Model and BH integration efforts overall.

CCHA Incentive Program

The CCHA Incentive program, which provides up to $10,000 to PCMPs for achieving ACC KPI performance goals, integrating BH and Care Coordination, using data, and increasing access has proven an excellent motivator for PCMPs to engage in continuous quality improvement. The CCHA Incentive Plan is detailed in OR 17.

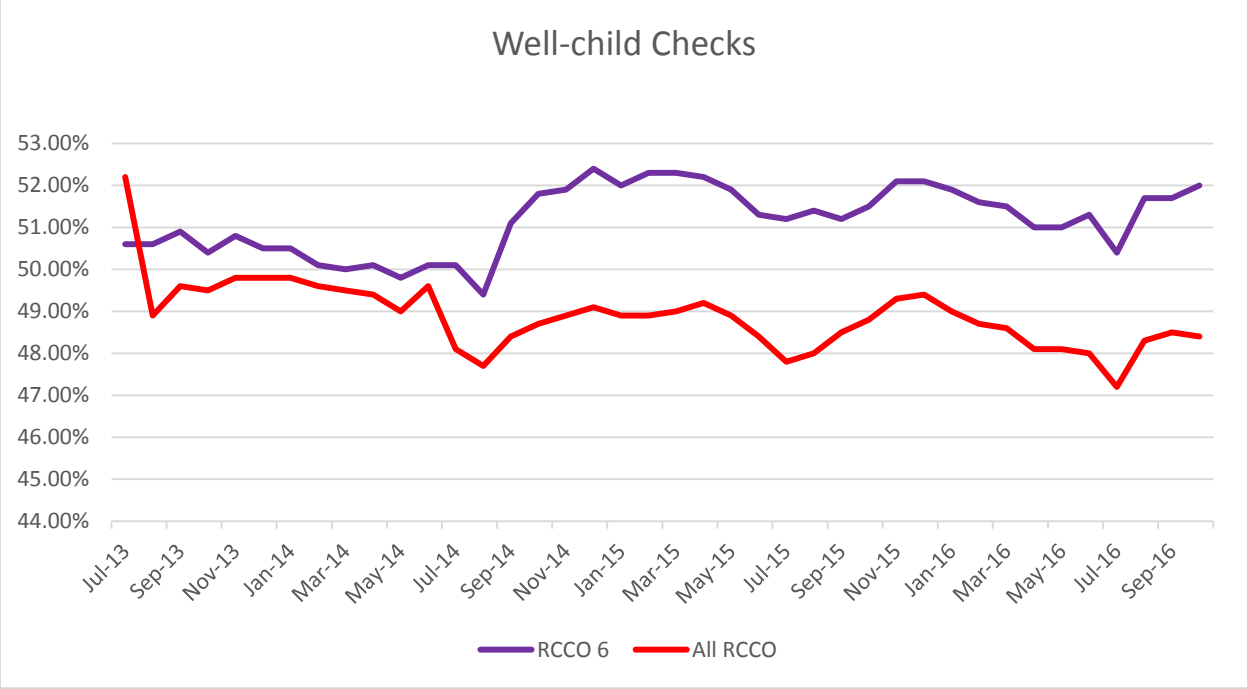
Table 5.14-1 shows all the interventions CCHA put in place to achieve the WCC KPI.

Table 5.14-1. CCHA Deploys a Range of Creative Interventions for Key Performance Indicators

Date	Description
07/01/13	WCC KPI begins
07/01/14	WCC IVR start date (all 0-21)
01/01/15	Birthday IVR Campaign start (0-21)
07/01/15	Peak Pediatrics Care Coordination co-location begins (largest pediatric group for CCHA)
07/01/15	KPI narrowed to 3-9 year olds
07/01/15	AmeriCorps program starts
08/01/15	Birthday IVR Campaign policy change (3-9 regardless of claim status)
11/02/15	Assigning CCHA Practice Transformation Coaches to all high-volume practices
01/01/16	Signed agreement with CCMCN, data arm of the FQHC association, to support FQHC work on KPI
07/21/16	Delegated Partners Liaison increases efforts with FQHCs
01/01/17	Birthday IVR Policy change (3-9 without WC in past year)
02/01/17	Emerald Elementary in-class training
04/01/17	Emerald Elementary Spring dance

As explained earlier, CCHA used their Quality Improvement program structure: program plan, work plan, and evaluation to ensure they approached the work with the WCC measure in an organized way, with clear action items and evaluation processes. Over the past several months, they have worked tirelessly with PCMPs, Safety Net Providers, and Members to increase performance on this measure, and they have seen results. The graph below shows changes in WCC performance over time. It should be noted that prior to July 2015, this KPI metric included ages 0 – 21 years. Effective July 2015, the Department changed the focus to ages 3 -9 years. CCHA is waiting to receive data from the Department for the period October 2016 forward and will better be able to evaluate performance over time.

Figure 5.14-4. CCHA Consistently Outperforms Other RCCOs on Well-child Checks



Monitoring Performance at the PCMP Level

CCHA strives to remove barriers for Network Providers to improve quality performance, especially when it comes to accessing performance data. They provide data to PCMPs in the format they request so they can use it easily in their existing workflows to serve Members better. CCHA can create reports, provide raw claims data, and support them with their data system. Their ability to provide data and reports is discussed in detail in OR 17 and 21.

Provider Performance Dashboards

CCHA produces quarterly performance dashboards to help PCMPs track their performance on a myriad of indicators. They can also use it to track their progress on financial incentives from the CCHA Incentive Program. The CCHA Provider Support team helps PCMPs use the dashboard to engage in quality improvement efforts explained in OR 17. These reports are used by the Quality Improvement (QI) teams to monitor the results of their improvement efforts and identify new areas when goals are met. Below is an example of the dashboard that is shared with PCMPs that includes all of the key performance indicators for the ACC Program.

Figure 5.14-5. CCHA Supports Providers in Quality Improvement with Detailed Dashboards

Practice Operations

Patient Panel:	7,680
% of Medicaid Patients to Total Patient Panel	4.51%

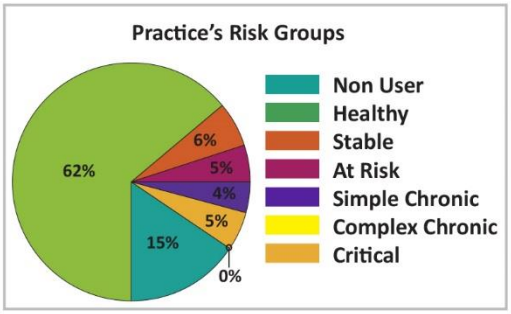
Practices Services:	
Cultural & Linguistic Appropriate Services	No

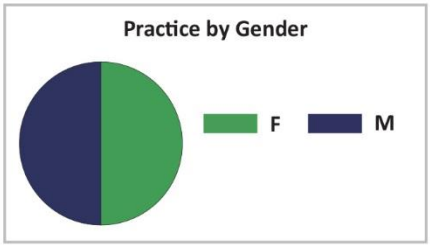
Support Team:		
Network/Contract Manager	Practice Transformation Coach	Health Partner
Josie Dostie	Rasheed Lawal	Amanda Mrkvicka

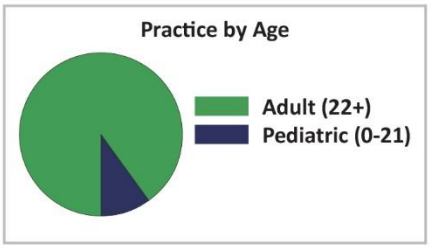
Population Health Management

Practice's % of ACC Medicaid Population *(as of April 2016)*	0.04%
Practice's % of CCHA Medicaid Population	0.26%

Demographic	CCHA	Practice
Total	131,036	346
FBMME	3,195	1
Foster	2,534	16







Safety Net Provider Performance Dashboards

CCHA also uses dashboards for Safety Net Providers and Advanced PCMPs like MCPN, Clinica, Salud, Denver Health, and Kaiser. The designated CCHA liaison meets with each FQHC monthly to review their performance using this dashboard to discuss quality improvement strategies.

New KPI Measures

CCHA has attended several Department subcommittee meetings to provide input on the 8 newly proposed KPI measures. CCHA *Plus* is eager to support the Department in establishing the 9th KPI metric. CCHA and Anthem have extensive expertise working with public and private payers to set up new performance measures. This combined experience gives us the ability to understand the

State Auditor Testimonial

CCHA has established a dedicated delegate partner liaison position to meet individually with delegates (safety net providers) monthly, review their performance data, discuss upcoming programs or project opportunities, maintain Department deliverable requirements, and generally consult with delegates to assist them with needs and improvements.

Health Services Advisory Group Auditor for the Department

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strengths and limitations of not only clinical and pay-for-performance measures, but also the limitations of administrative versus clinical data.

Most health plans use HEDIS® or similar standardized measures for the key performance indicators. We have reviewed the measures that are included in Appendix U and V of the RFP that may be included as performance measures. We have experience with most of the proposed measures and look forward to working with the Department to further define and align these measures. We will work closely with the PCMPs, who we will encourage to use a global population health strategy to improving outcomes.

Anthem's Vice President of Behavioral Health and Physical Health Integration is a member of the National Quality Forum's committee to endorse behavioral health performance measures that improve outcomes, particularly for mental health and substance use disorders.

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For example, as mentioned in OR 17, Practice Transformation Coaches support practices in local and national programs that use performance measures for pay for performance (P4P) or public reporting such as the State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+). Practices enrolled in these programs engage with the Provider Support program to achieve goals of improving clinical quality outcomes, reducing unnecessary utilization and cost, and improving the patient experience. In fact, Anthem employees have played an integral role in reviewing national BH performance measures. Anthem regularly uses more than 140 non-standard measures for complex support and service needs, demonstrating that we can apply quality metrics that address Colorado priorities.

As a RAE, CCHA *Plus* will welcome the invitation to work with the Department to determine the final measurement and pay for performance criteria, and help develop methodology calculations. We have the ability to track and report on additional performance measures by creating internal reports with our population management software or the SDAC or BIDM system. CCHA already supports the improvement of the KPIs set out by the Department and CCHA *Plus* is able to leverage this process to encourage Network Providers to work on additional measures.

Performance Management Tools

We will use analytic tools to collect, analyze, report, and act on data, including the Department's required Performance Measures. As a RCCO, CCHA already participates in training on the new BIDM system and is preparing providers for the new Data Analytics portal. As mentioned in OR 17, as each PCMP is contracted with the RCCO, they are enrolled in the CCHA Provider Support program, which includes a face-to-face orientation within 30 days of receiving Member attribution in the ACC Program. During the orientation, information is shared about the Department's contractors and their responsibilities, and an overview of tools available to providers such as the SDAC (soon to be BIDM). For Providers with high Medicaid attribution, the assigned CCHA Practice Transformation Coach performs an annual assessment and provides training on the SDAC and attribution process. If the provider is not familiar with the system, the coach will provide a one-on-one or group training. This assessment is conducted annually because turnover rates are high and information changes regularly. CCHA anticipates following the same process with the BIDM system, and CCHA *Plus* will continue with this process.

The CCHA *Plus* Population Management Tool will also be available to the PCMPs. This tool can merge claims and electronic health data, and is outlined in OR 17 and 21. We are fully capable of providing the Department with data for performance calculations, and our sophisticated data systems will easily allow data sharing with partners.

Our Solutions for Members Strengthen Performance Results

CCHA *Plus* will use a mix of interventions to address Member needs and to avoid fragmented care, provide prompt access, integrate PH and BH services, and address social determinants of health. Our person-centered approach will support improved Member outcomes and has been tailored to balance a range of complex Member needs. ***We propose the following interventions that emphasize innovative ways to create prompt and effective access to care:***

- Introducing LiveHealth Online for telemedicine and tele psychiatry
- Building self-care capacity with health education and coaching by Care Coordinators
- Partnering with the Health Neighborhood and Community to promote health, including preventive services and helping Members access non-medical services to address social determinants of health
- Implementing a web-based, mobile-friendly tool to help Members get better and stay mentally strong; our Online Well-Being Program is safe and secure and offers personalized resources to help Members actively improve their health and well-being in an online environment
- Offering a Virtual Reality Pain Management program as an alternative to narcotics for pain management
- Assisting Members in selecting a provider and making medical appointments
- Actively supporting providers' transition to increased levels of integration by teaming with the Department, PH and BH providers, and other stakeholders (For example, we can leverage the ECHO® program to offer remote case review with clinical case management for PCMPs who care for Members experiencing addictions, chronic conditions, and other BH concerns.)

Flexible Funding Pool

As a RCCO, CCHA has experience with tracking performance and focusing on program goals that are tied to the flexible funding pool. They have been successful with their participation in the existing pool, achieving the performance target, and receiving the incentive payout. CCHA strives to achieve performance targets because they use the funding payout to invest in Region 6 to improve performance. ***As a RCCO, CCHA has reinvested incentive payments in programs benefiting Members, Network Providers, the Health Neighborhood, and the Community that are designed to improve outcomes and make the best use of State resources to continue achieving performance targets.*** For example, incentive payments from meeting the current ACC Flexible Funding Pool goal provided funding for the CCHA Incentive Program.

CCHA *Plus* is excited to continue participation in the Flexible Funding Pool. We are agile enough to adapt to meet the needs of the Department and improve performance in areas beyond what is defined by the KPIs. We are comfortable using all data sources available to assess our performance and implement strategies for improvement. We look forward to collaborating with the Department to design the strategy, payment methodology, and distribution plan for the Flexible Funding Pool.

Public Reporting

We welcome public reporting of data to support a fully transparent system of care, track health outcomes over time, and prioritize resources to achieve Colorado's public health goals. CCHA *Plus* managing partners Physician Health Partners (PHP) and Anthem currently provide publicly reported data across other lines of business, such as the following:

- PHP provides reports for the CMS Medicare Shaved Savings Program (MSSP), which publishes cost, quality, and utilization results.
- Anthem programs across the nation participate in public reporting through NCQA's quality rating system, a major source of health plan quality information for stakeholders, including Members. The

annual online ratings incorporate measures of clinical outcomes and processes, accreditation results, and Member experience.

- Anthem programs are also rated by state-specific report cards in California, New York, and Washington. ***In 2016, the New York program earned 5 out of 5 stars from the New York State Department of Health,*** making it 1 of only 2 plans in the New York City region to earn the state's highest ranking. Ratings are based on a number of criteria, including preventive care, quality of life, satisfaction with care, and stability or improvement.

CCHA *Plus* has experience with most of the proposed Public Reporting measures included in Appendix U. We look forward to working with the Department to further define and align these measures to improve network performance on core health and utilization measures.

Behavioral Health Base Standards

CCHA *Plus* will be using best-in-class quality standards based on Anthem Medicaid Behavioral Health's national recognition as an accredited Managed Behavioral Health Organization by the National Committee for Quality Assurance (NCQA). This demonstrates adherence to evidence-based practices for providing high-quality care, access, and consumer protections, and underscores Anthem's success in administering a BH quality management program. Organizations earn their NCQA accreditation by proving their proficiency across five standards: Quality Management and Improvement, Care Coordination, Utilization Management and Credentialing, and Members' Rights and Responsibilities. ***Anthem Medicaid scored 100 percent on the associated standards.***

Anthem has extensive experience adopting BH HEDIS® measures as performance indicators for clinical improvement. They develop and implement quality initiatives as a result of data analysis for process improvement, and reassess initiatives annually to evaluate intervention effectiveness and to compare year-over-year performance.

Identifying Best Practices for Base Standards Interventions:
Anthem completed a study on best practices for follow-up care within seven days after an admission for mental health. We contacted Members to emphasize the importance of these appointments and incentivized them with a gift card for keeping the appointment. We found members receiving **$50 gift cards** are more likely to complete the appointment, and will use this data to inform our incentive programs in Colorado.

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Anthem is accustomed to using the Behavioral Health Base and Enhanced Standards outlined in the RFP. They use these measures today in state-sponsored programs and employ multi-pronged Member and provider interventions as well as systemic and data-driven management processes to address each of these standards. For example, they offer Member incentives through their Healthy Rewards program to encourage engagement in BH services. They also use strategies like Member outreach to close important gaps in care, texting capabilities to reach Members with follow-up appointment reminders, and other value-added benefits. As a RAE, CCHA *Plus* may also be able to leverage interventions such as the Behavioral Health Medication Management program, which focuses on improving prescriber practices and Member adherence to appropriate medication treatment to improve performance on related key measures.

To illustrate the experience and capabilities we will bring using the Behavioral Health Base Standards measures and developing effective interventions, Table 5.14-2 represents a sample of our improvement strategies for Colorado:

Table 5.14-2. CCHA Plus Will Meet BH Base Standards with Multiple Programs and Interventions

Selected Sample/Measure	Intervention
Sample Behavioral Health Base Standards	
Suicide risk assessment for major depressive disorder in children, adolescents, and adults	•Member assessment includes PHQ-9 and Columbia Suicide Severity Rating Scale •Suicide literacy training •Mental health first aid training for providers
Adherence to antipsychotic medications for individuals with schizophrenia	•$15 Healthy Reward incentive for medication management •Pharmacy claims analysis •Outreach to prescribers •Provider Behavioral Health Quality Incentive program (BHQIP)
Hospital readmissions at 7, 30, and 90 days	•Analytics and predictive modeling •Member outreach by peer support team •Online Well-Being Program value added benefit •Care Coordination •BHQIP

Suicide Risk Prevention

According to The Colorado Health Institute (CHI), the suicide rate in Colorado has increased 79% from 2000 to 2015 and is one of the highest in the country. Two of the counties with the highest rate of suicide are Gilpin and Clear Creek in the current CCHA Region 6. Similar to the Base Standards for suicide risk assessments, the following example illustrates a project Anthem implemented that will help address the barriers in Colorado and help decrease these suicide rates:

In 2017, Anthem implemented a Suicide Literacy project in collaboration with the Zero Suicide Institute to improve their employees' ability to identify people at elevated risk for suicide and provide them with care and support.

Screening: Their general health assessment features the PHQ-9, which includes a question about suicide. The BH module of the health assessment includes the Columbia Suicide Severity Rating Scale.

Training: In collaboration with the Zero Suicide Institute and the National Action Alliance on Suicide Prevention, Anthem is developing training for employees (including all clinical staff and clinical support staff) on how to listen to Members for any suicide risk factors or early warning signs, and ensure they know how to take appropriate action. This will help employees recognize warning signs that could otherwise be missed. Clinical supervisors will receive monthly follow-up consultation sessions to help them create an environment so that employees feel comfortable asking for support if needed, acknowledging that talking openly with Members about suicide may be challenging. The training will be required for the CCHA *Plus* Care Coordination team and eventually offered to all employees who come into contact with Members.

Best practices and outreach to people after discharge and ER visit: The Zero Suicide Institute is helping Anthem identify and implement best practices for reaching out to Members promptly after discharge from an inpatient, ER, or crisis visit for a suicide attempt. Clinical literature has demonstrated that Members are at high risk of suicide attempts, death, and readmissions immediately following discharge. CCHA *Plus* will implement these best practices by making a caring connection and helping the Member engage in follow-up care after a BH hospitalization. The outreach may be by telephone, text message, or a combination, and the goal is to assess the Member's risk, revise their safety plan if needed, help them make and attend an outpatient appointment, and make plans for the next touch-base. We will also offer the member a $50 gift card as an incentive for successfully completing an outpatient visit within 7 days following their discharge.

CCHA *Plus* will also implement Anthem's Crisis Center Follow Up program. To be effective, we will build a formal agreement and a data exchange process with the Crisis Centers so that we know when our Members have requested their assistance and when they are discharged. Upon the crisis resolution, our efforts will support the discharge plans created by the Crisis Center. We will collaborate with the Crisis Center by assigning a Care Coordinator to facilitate the connection between each Crisis Center to a Care Coordinator appropriate to the Member's needs and geographic region. This Care Coordinator will be in contact with the member over at least a 72-hour period and longer as indicated by the Member's condition and compliance with the prescribed discharge plan. The goal of this intervention is to ensure the Member is engaging with the aftercare treatment plan provider as well as reconnecting to their circle of supports. The Care Coordinator will also reconnect the Member to their PCMP to facilitate getting all gaps in care filled.

Monitoring and Measuring Outcomes

CCHA *Plus* brings the combined experience of CCHA and Anthem in measuring outcomes of clinical care and services by analyzing clinical and service performance indicators and health care outcomes to identify opportunities for improvement. ***Based on 2016 national benchmarks provided by NCQA, several Anthem Medicaid programs across the nation are outperforming 75% of other Medicaid health plans on several key BH measures.***

We are confident about our ability to improve quality in Colorado because Anthem has 12 or more programs with HEDIS® scores above the Colorado Medicaid average for key BH measures (Table 5.14-3). These measures focus on the pediatric population, reflecting an opportunity to improve care for our younger Members and realize lifelong health improvements.

Table 5.14-3. More than a Dozen Anthem Medicaid Programs Outperform Colorado's Current Average on Pediatric Behavioral Health Measures

Measure	2016 Colorado Medicaid Averages	Number of Anthem Contracts Surpassing Colorado Average
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	35.03%	12
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance	34.95%	15
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	6.43%	15

Behavioral Health Enhanced Standards

Table 5.14-4 represents a sample of Behavioral Health Enhanced Standard measures Anthem has used and corresponding targeted interventions for Colorado.

Table 5.14-4. CCHA Plus Will Meet BH Enhanced Standards with Multiple Programs and Interventions

Selected Sample/Measure	Intervention
Sample Behavioral Health Enhanced Standards	
Follow up for hospitalization for mental illness, 7 and 30 days	•Timely notification of hospitalizations •Aftercare appointment made before discharge •Telephonic follow up with Member •$50 Healthy Reward incentive for follow up after 7 and 30 days
Mental Health Engagement	•Telephonic follow up with Member •LiveHealth Online •Online Well-Being Program •BHQIP

Behavioral Health Quality Incentive Program (BHQIP)

As a RAE, CCHA *Plus* looks forward to participating in the Department's Behavioral Health Incentive program. We will offer our own incentive programs to BH providers to improve the quality of care. We recognize that Members with BH needs often have complex or co-morbid conditions that impact their engagement in health care services. Offering financial incentives has helped CMHCs and high-volume BH professional groups improve coordination across Members' PH and BH care, and improved the quality of care they provide. We will offer incentive payments to BH providers and facilities when they achieve specific goals that are important to the health of Members and in alignment with Department goals, such as:

- Reducing BH inpatient readmission rates
- Decreasing BH-related ER visits
- Increasing PCMP visits
- Following up after inpatient hospitalization for mental illness
- Increasing Member engagement in alcohol or other drug dependence treatment programs
- Adhering to anti-depressant medication for adults diagnosed with major depression

We look forward to working closely with the Department to bring our experience in developing BH quality measures for providers and aligning these with the Department's goal. We believe in full transparency and will frequently communicate and share BH data with the Department to improve the delivery of outcomes-based, cost-effective health care services.

Provider Testimonial

Our Practice Coach supports us by coordinating a streamlined referral process for our patients to receive mental health services. She navigated the systems of two separate not-for-profit health clinics to help us develop an internal system of communication that has helped us provide improved patient navigation services. She also is crucial in helping us navigate the changing reporting and quality requirements that Medicaid is developing. We could not maintain our Medicaid compliance without her assistance, and she is transparent, patient and excellent at her job.
Heather Goodchild, Clinical Director, Boulder Valley Women's Health

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Member Experience

To improve the experience for Members enrolled in the ACC Program, the current CCHA Care Coordination and Provider Support teams are trained to identify and work with Members to make sure that their needs are met. They monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by CCHA and the providers. CCHA also uses other data sources such as Member Advisory Committee feedback, enrollment information, Member surveys, call center data, claims, encounters, authorizations, appeals, grievances, adverse events, and stakeholder feedback. All of these sources provide actionable information about Members' satisfaction and opportunities to improve their experience and improve CCHA services.

When the data is available, the Practice Transformation Coach provides the report to the provider's quality improvement team and reviews the data and comments. The team then identifies areas for improvement.

As a RAE, CCHA *Plus* will leverage this experience and use similar processes to measure Member satisfaction with Network Providers. CCHA has used the ACC survey data to identify opportunities for improvement, and in the next phase of the ACC, CCHA *Plus* looks forward to supporting the Department with administering the CG-CAHPS and ECHO® surveys. Additionally, CCHA and Anthem have worked with Member Experience surveys, and we can provide additional support if needed.

Mechanisms to Detect Overutilization and Underutilization of Services

Through the CCHA *Plus* Quality Management Committee, we will identify and address over- and under-utilization of services on an ongoing basis through a combination of data analytics, focused leadership attention to trends, and improvement initiatives. We will proactively mine data and develop utilization reports using local and national analytics tools and our Care Coordination system to identify Members with low and high rates of utilization and to drive Member and provider interventions and education. We will monitor utilization reports to review, analyze, and resolve utilization patterns outside the norm, including Colorado benchmarks and indicators that allow for identification of regional and local practice variations and comparison to national benchmarks.

Key leaders of the health system including PCMPs, hospitals, and BH, will use cost analytics and financial reports to develop strategies to reduce costs through elimination of duplicated and unnecessary services or costs.

The committee will review cost trends by specialty, discuss specialty network development and partnerships, identify negative and positive cost and volume trend variances, and develop action plans based on findings. Frequently, this will involve committee member outreach to Health Neighborhood partners to discuss the observed trend and ensure good communication between the partners. As a RAE, this outreach could result in a corrective action plan, with continued oversight for a period of time, depending on the remediation plan. We will also leverage Health Neighborhood relationships by meeting with groups to gain additional insight into specialty trends, new procedures, or new payment methodologies.

Under- and over-utilization monitoring identifies opportunities to intervene with Members to improve access to appropriate care, educate on appropriate use of the ER, identify Members who need extra help including Care Coordination, and implement personalized interventions so Members receive necessary services at the right intensity and level of care. ***Rather than simply prevent over-utilization, we will make sure Members receive the services and care they need.*** The following are examples of the combined success of CCHA and Anthem in addressing over-utilization:

Reducing ER Use: Both CCHA and Anthem utilize a report that enables them to analyze ER use and frequency. Through a drilldown analysis, they are able to gain insight into utilization by region, date, presenting condition, urgent versus non-urgent, PMCP, and more. The goal is to reduce ER use for non-emergency reasons by educating Members and helping them access ER alternatives, when appropriate, such as their PCMP or urgent care services. To support this program, admission, discharge, and transfer (ADT) and claims data is used for targeted outreach and on-call resources. Network capacity is enhanced by encouraging providers to offer extended office hours and availability on weekends. CCHA *Plus* will have one program designed to reduce ER visits among all Members, and we will use these tools in efforts to reduce unnecessary ER utilization. The program will include many different interventions

based on the unique needs and circumstances of individual Members. As detailed in OR 11, CCHA *Plus* will offer a Rapid Response Team for the next iteration of the ACC Program to reduce unnecessary ER services for Members with BH needs. This service will be available for Members with BH needs that present at the ER but do not meet criteria for admission. The Rapid Response team will go to the ER, assess the Member's needs, and triage the Member to the appropriate setting, including a psychiatric urgent care facility, if appropriate.

Behavioral Health Medication Management Program: This program improves prescriber practices and Member adherence to appropriate medication treatment. The program promotes age-appropriate use of medications in children and older adults receiving anti-psychotic medications as well as reducing polypharmacy of antipsychotics by multiple prescribers. Using analysis of pharmacy claims data, the faxes are sent to prescribers and followed up by phone calls. Launched by Anthem in September 2016 in 18 states, the program has demonstrated rates of positive prescriber behavior change of 50% and has achieved meaningful cost savings that were 43% more than anticipated. This program has resulted in more informed prescribers and Members and increased the safety and effectiveness of medication therapies, leading to improved health outcomes. CCHA *Plus* is interested in offering this strategy in Colorado if the necessary pharmacy data can be made available.

We recognize that gaps in care likely indicate under-utilization of care and services. Our Practice Transformation and Care Coordination teams will implement a comprehensive gaps-in-care process that will identify and address service gaps such as PCMP visits; annual well checks; immunizations; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); prenatal and postpartum appointments; unfilled pharmacy prescriptions; 7- and 30-day follow up appointments; and dental and vision checkups. Our online Care Coordination System will provide a holistic picture of the Member's utilization by combining Member information into a single record for review by our clinical teams. Details about how care gaps will be addressed through our Practice Transformation team can be found in OR 17 and our strategy for population management can be found in OR 15. We will address gaps through interventions such as:

- Providing Member education and outreach such as Healthy Reward incentives, health events in the community, portable technologies for primary care screenings and immunizations, and targeted mailings for gaps or missed appointments
- Working with providers and their QI teams to identify gaps in care through their EHR system online clinical alerts, by providing monthly gaps in care reports, and through our population management tool that displays care alerts, prescriptions, lab results, and more to help identify barriers to accessing care and services (We may also offer providers additional incentives for their efforts to close important gaps in care for Members.)
- Alerting Members to needed services by referrals to Care Coordination and scheduling well care visits, postpartum follow-up visits, and other preventive visits, making reminder calls, identifying barriers, and arranging for transportation through our Care Coordinators
- Conducting outreach through our Care Coordinators, who will call Members with specialized health care needs who have gaps in care, such as women with high-risk pregnancies with gaps in prenatal visits, Members with asthma who have unfilled inhaler prescriptions, and Members with diabetes with gaps for A1C blood testing

We will also report results of our utilization analyses to the Quality Management Committee. Together, they will identify root causes and determine if the issue is specific to a provider or provider type, limited to a specific Member or Member subset, or limited to specific procedure codes or diagnosis categories, and whether further analysis is required. Findings may lead to specific actions that will enhance appropriate service utilization, such as additional procedures requiring prior authorization; resolution of claims payment or processing issues; new medical policy or code billing edits; and evaluation of

providers or provider subsets for potential fraud, abuse, and waste. We will complete these utilization analyses regularly, which will also support required reporting to the Department.

Other types of analytics and reporting that will be used to assist decision-making include practice level reporting on preventive services such as annual wellness visits, immunizations, and mammograms. Hospital utilization trends will be reviewed and monthly and quarterly reports provided on inpatient metrics by hospital, ER visits, avoidable ER visits, and observation admits, as well as Skilled Nursing Facility (SNF) utilization metrics. These components will be tracked and measured against annual targets and reported to medical directors and Care Coordination teams. Data will also be provided regarding referral tracking and network utilization reporting, monthly membership reports (including risk adjustment scores per Member), and provide modeling for provider incentives or alternative payment arrangements in order to support goals of providing low-cost, high value services to our Members.

Integrated Pharmacy Management

We are also interested in working with the Department on integrating pharmacy management into the RAE. If appropriate data is made available, we may be able to implement several pharmacy programs to encourage the best health outcomes for Members. These include programs such as the Controlled Substance Utilization Monitoring (CSUM) program to help decrease controlled substance over-utilization, and in-house BH, diabetes, and asthma medication management programs that monitor, evaluate, and encourage Member adherence to medications. We may also be able to offer another program that uses targeted, monthly communications to physicians with personalized, actionable information about their patients to promote coordination of care with information on appropriate use, compliance, and safety of medications for targeted conditions.

Client Over-utilization Program

CCHA *Plus* will partner with the Department to help administer the Client Over-Utilization program (COUP) for Members who meet criteria. As an existing RCCO, CCHA has developed a process for managing the COUP. CCHA *Plus* is committed to working with the Department and other partners to continue these efforts. Today, CCHA uses analytics to determine points of intervention and tracks progress on Care Coordination and the ultimate outcomes of each case. They also work closely with the FQHCs, who typically have 40% or more of the COUP attribution. The goal is to ensure that this population is being managed from a Care Coordination perspective. Going forward, tracking and evaluating the interventions being executed by our team and the FQHCs will be key to our strategy to effectively manage this population.

For Members who are enrolled in the COUP, our Care Coordinators will work to understand their needs and educate them about appropriate services. If we are unable to curb the utilization, we will work with the Department to lock into a PCMP or a pharmacy. CCHA *Plus* will comply with all of the deliverables required in the COUP reports and appear as an expert if necessary at the State Fair Hearing. In our efforts to recruit providers to serve as lock-in providers, we will educate them on what it means to be a lock-in provider. Once aligned, we will support these providers with technical assistance as needed.

Quality of Care Concerns

Our Utilization Management (UM) program will be an integral part of our quality improvement efforts. Through the collection and review of robust and integrated data, we will identify, investigate, and monitor potential quality of care concerns as well as other performance indicators. **We will identify potential quality of care concerns from a variety of sources including ongoing review of the following:**

- **Member Grievances,** which includes any complaints from Members about their care. This could include concerns about delayed referrals to specialists due to scheduling problems, inability to contact the physician resulting in an adverse outcome, or a safety issue
- **Critical Incident Reporting,** which includes homicide, attempted homicide, suicide, attempted suicide, unexpected death, abuse, neglect, exploitation
- **Quality of Care Reporting,** including misdiagnosis, inappropriate treatment, or complications after a procedure resulting in an adverse outcome
- **Unplanned Services Use,** such as inpatient readmissions or ER visits after a recent service or procedure
- **Service Utilization Patterns,** including indicators of over- or under-utilization

Incorporated into our quality monitoring processes is ongoing review of utilization data by service, provider, or facility; adverse events; or outlier indicators such as readmissions within 30 days, avoidable ER visits, and medications that exceed dosing limits or are outside of guidelines. We will also analyze data related to prior authorization requests, admissions, and continued stay reviews for inpatient services, as well as retrospective reviews for certain service types.

The CCHA *Plus* Quality Management Committee will monitor, investigate, and as applicable, initiate quality improvement activities. The UM team will work collaboratively with the QM team and participate in the investigation of all potential quality of care concerns. When we identify specific quality concerns, the committee will implement a formal process for rapid and thorough investigation and follow-up. Quality of care concerns will be prioritized according to 1 of 5 severity levels. When a quality issue is determined to have a severity greater than level 2, indicating an impact on the Member's health, the UM Reviewer will refer the issue to our Chief Clinical Officer (CCO) for review. The CCO will assign a priority rating, with those assigned a rating of level 3 or higher referred to the Quality Management Committee depending on the specific quality issue. The CCO will govern the oversight of the corrective actions related to clinical quality issues or provider behavior. The CCO may recommend immediate action if the Member's health or well-being is in jeopardy. Other corrective actions may include a formal written response from the provider, including a description of provider oversight and corrective action steps, medical records review, and referrals to credentialing and contract management for action, including possible termination from the network.

Our Quality of Care (QOC) Referral, Review, and Resolution Process workflow will include the following, in accordance with Statement of Work requirements:

- Acknowledgment letter sent to the party that originated the QOC concern
- QOC issue investigated
- Notification made to the appropriate RAE team members
- Member outreached to assess immediate needs
- Letter describing resolution and how the Member's needs are being met sent to party originating the QOC concern
- When appropriate, QOC issues referred to a peer review committee or the appropriate regulatory agency for further review and action
- Notification provided to the appropriate regulatory or licensing board when the affiliation of a Network Provider is suspended or terminated
- Documentation of incident, including name and contact information of party originating the QOC concern, description, steps taken during investigation and resolution, corrective actions and their results, evidence of the QOC resolution, acknowledgment and resolution letters, and referrals and notifications made by the RAE to its peer review committee and regulatory agencies or licensing boards, will be included in the QOC event tracking system database

Within 10 business days of the Department's request, unless otherwise permitted by the Department to conduct the investigation, we will follow up our investigation and documentation with a letter to the Department summarizing the QOC issue, how it was handled, and its resolution. The letter will alert the Department if the QOC issue was referred to the peer review committee. However, it will not identify anyone involved in the investigation or peer review process, nor will it disclose any information that is confidential by law. Additionally, we will submit a quarterly QOC report to the Department describing each QOC issue, as well as the outcome of each review identified during the previous quarter.

External Quality Review

CCHA *Plus* appreciates the opportunity to participate in the Department's external quality review efforts. We see these reviews as an opportunity to increase the transparency of our operations and to receive feedback and guidance from independent quality experts as well as the Department on informed, meaningful quality improvements that leverage best practices from our peers and other local, state, and national efforts.

For the past 6 years as a RCCO for Region 6, CCHA has participated in the ACC annual external independent Site Review with Health Services Advisory Group (HSAG), the Department's current EQRO. CCHA has benefitted tremendously from these reviews and each year looks forward to receiving the site review report from HSAG and implementing action plans to address recommendations. Over the years, CCHA has improved operations based on the advice and expertise from HSAG, ultimately resulting in a 97% score on the 2016 audit. While the EQRO did not score audits for 2017, CCHA received many positive affirmations from the auditor.

State Auditor Testimonial

CCHA demonstrated a thoughtful approach to each project, including the ability for leadership to engage with its partners to cooperatively and continuously improve processes, achieve mutual goals, and attain meaningful outcomes.
Health Services Advisory Group Auditor for the Department

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As a RAE, we have extensive experience and well-defined processes to support the State's required independent review processes. CCHA has worked with the Department's EQRO before and is committed to transparent participation in site reviews and performance measure validation. We are open to suggestions for improvement and respond to any requests for data or clarifying information. We look forward to working with the EQRO, and we view this as a time to demonstrate what we do well and identify areas for improvement. As a RAE, we will assist Department staff in developing external independent review and assessments and will follow all specifications for participation set by the Department.

We are accustomed to supporting state quality management requirements and providing all information needed for external quality reviews in the timeframes and formats requested by EQROs. We will collaborate with the EQRO to assess quality of care and services provided to Members, identify opportunities for improvement, and promptly respond to recommendations made by the EQRO within the established timeframes.

Advisory Committees and Learning Collaboratives

CCHA employees currently participate in several multidisciplinary statewide advisory and learning collaboratives such as the following:

- SIM Practice Transformation Workgroup
- Colorado Health Foundation - Health Insurance Literacy Workgroup
- Denver Chamber of Commerce Health Care Committee
- Mile High Health Alliance - Executive Committee
- Prime Safety Net Advisory Board

- Regional Health Connector Technical Advisory Board
- Colorado Prevention Alliance Workgroups
- Colorado Health Institute Safety Net Advisory Committee
- Pediatric Learning Collaborative
- Integrated Care Learning Collaborative
- Practice Transformation Trainers for SIM and ENSW with HealthTeamWorks
- Past member of the Executive Committee at the American Diabetes Association

ACC Program Improvement Advisory Committees

For the past 6 years, the CCHA Executive Director of State Programs has participated as an ex-officio member on the Department's Statewide Program Improvement Advisory Committee (PIAC). CCHA has found the Statewide PIAC to be an excellent opportunity to work with the Department, fellow RCCOs, providers of all types, stakeholders, and Members to coordinate, collaborate, learn, and provide feedback on our collective efforts to improve the health and well-being of Members. As a RCCO, CCHA has valued direct feedback from Members, Network Providers, the Health Neighborhood, and Community on operations. CCHA currently has an active Health Neighborhood Advisory Committee and Member Advisory Committee. Members of these committees are invited to nominate representatives to attend the statewide PIAC, understand the ACC Program, and represent the region's Members and Health Community. Currently, CCHA PIAC representatives include a Member (a mother/caregiver who has a son with special needs) and a provider (the CEO of Clinica, an FQHC serving approximately 9% of the attributed Region 6 ACC Members).

Regional Program Improvement (Health Neighborhood) Advisory Committee

As mentioned previously, CCHA *Plus* will establish the Program Improvement (Health Neighborhood) Advisory Committee, consisting of providers, Members, stakeholders, and others. The Committee will have many responsibilities to inform all kinds of RAE activities and responsibilities relating to quality improvement including:

- Review RAE deliverables
- Discuss program policy changes and provide feedback for improvement
- Review RAE performance data and provide recommendations on quality improvement activities
- Review provider and Member materials and provide feedback for improvement
- Appoint a liaison to bring committee recommendations to CCHA *Plus* Quality Improvement Committee
- Provide a representative for the statewide PIAC

We will ensure that this committee will have a dedicated operational budget and formal charter that clearly delineates committee members, governance structure, and meeting times. It is also important to us that the committee be known as a safe place for Members and their families to provide feedback. Key CCHA *Plus* personnel will be members of this committee. The meeting will be open to the public and minutes will be posted on our website within 30 days of the meeting.

Department Quality Improvement Committees

As a RCCO, CCHA has been an active participant in many Department quality improvement workgroups and committees. In the new phase of the ACC Program, CCHA *Plus* appreciates the opportunity to collaborate with the Department on quality improvement issues that impact our Program, our Members, and Network Providers. Currently, CCHA is participating on the PIAC subcommittee for Quality and Health Improvement, the Alternative Payment Methodology workgroups, the Medicare-

Medicaid Program subcommittee, and many other groups that address a myriad of program issues. The Quality Improvement Director will participate in the Department's Quality Improvement Committee to provide input on quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and timeframes, and other collaborative projects. CCHA has strongly advocated for the learning collaborative among RAEs that has been included in the RFP. The Operational Learning Collaborative provides an excellent opportunity to share lessons learned to help other ACC participants improve their performance. CCHA *Plus* will happily participate in these meetings to monitor and report on specific program activities of the RAE and the ACC Program, and share lessons learned.

Ad Hoc Quality Reports

We commit to providing the Department or its agents any information or data relative to the Contract in a complete, accurate, and timely manner. As a RCCO, CCHA has successfully submitted more than 20 types of reports to the Department monthly and annually. CCHA prides itself in providing accurate information within reporting timelines, and in creating comprehensive and robust deliverables that have become models for other RCCOs. With the combined experience of the CCHA *Plus* managing partners, we have wide-ranging experience with ad hoc reporting, and through our data and technology tools, we can provide ad hoc quality reports within 30 days or other mutually agreed upon timeframe.

Data collection, analysis, and reporting form the backbone of our comprehensive approach to quality management and improvement. We will use our sophisticated, well-designed quality infrastructure to systematically and objectively measure access to care, demand for service, and quality of care to improve Member outcomes through collecting, analyzing, and reporting data. Data analytics access the full spectrum of managed care data, including enrollment information, Member assessments and care plans, claims and encounters, disease and Care Coordination documentation, Member medical records, CAHPS® surveys, HEDIS® results, provider audits, and quality improvement/performance improvement studies.

CCHA *Plus* Will Meet All Section 5.14 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 23, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.14 that are not detailed in our response.

Section 5.15

COLORADO COMMUNITY HEALTH ALLIANCE

Compliance

5.15 COMPLIANCE

OFFEROR'S RESPONSE 24

Describe how the Offeror will ensure compliance with the Accountable Care Collaborative Program rules, Contract requirements, state and federal regulations, and confidentiality regulations. In addition, describe how the Offeror proposes to conduct compliance and monitoring activities in compliance with 42 C.F.R. part 2.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA *Plus* will use a proven operational model to effectively manage and control the ACC Program, activities, reports, and compliance with all Contract requirements, State and federal regulations, and confidentiality regulations. In this model, we will staff both a Compliance and Regulatory team designated to Colorado RAE operations. Our Compliance Officer will collaborate with the Program Officer and coordinate with the Regulatory Oversight Manager to manage reporting, communications, and policy development.

Our robust compliance program includes a set of initiatives, policies, procedures, systems, and best practices to confirm adherence to ACC Program rules, Contract requirements, State and federal regulations, and the detection and prevention of fraud, waste, and abuse. Our Compliance Plan, which we review and update at least annually, guides all ACC Program integrity activities.

How We, CCHA *Plus*, Will Comply with ACC Program and Contract Requirements

At Contract award, our Transition team, composed of tenured CCHA *Plus* leaders from both CCHA and Anthem, will manage and document ACC Program rules as they prepare for the implementation of our RAE operations. As the ACC Program transitions to an integrated model, we will engage the support of our organization's Implementation Management Office (IMO) and our Certified Project Management Professionals to bring a disciplined approach to the implementation. The IMO supports the implementation of all new Contracts according to the Project Management Institute's (PMI) global standards for project management methodology. Our approach helps confirm compliance with the ACC Program rules, as well as Contract requirements, state and federal regulations pursuant to CMS regulations in 42 C.F.R. § 438, and confidentiality regulations.

As the RAE Contract goes live, CCHA *Plus* will continue to bring discipline and rigor to operational program management across the organization to assure continued adherence to Program rules. We will incorporate comprehensive monitoring systems and leverage successes and lessons learned to refine our processes continuously.

Per Section 5.15.3 of the RFP, we will deliver the Compliance Plan to the Department no later than 30 days after the Contract effective date, whenever we make substantive changes, and annually on July 31.

Compliance with CMS Regulations

Our Compliance Officer will monitor and enforce Contract compliance, as well as confirm that our operations comply with State and federal laws. For the ACC Program, our Compliance Officer will work closely with the Regulatory Oversight Manager and our Legal team to confirm that Contract requirements are met. Our Regulatory team will coordinate all State deliverables and maintain subject matter expertise on contractual and regulatory requirements, monitor regulatory changes and communicate them to the organization, and respond directly to the Department on reporting issues. These positions are part of the Regulatory Compliance team, represented on the organizational chart in OR 4.

We will use a well-established and effective mechanism for communicating regulatory changes throughout CCHA *Plus*, assessing their impact, and implementing action plans to comply with the change. Upon receipt or identification of a regulatory change, the Regulatory Oversight Manager will alert employees and stakeholders to evaluate alerts and determine if they affect their units, plan tasks to meet Contract requirements, and document completion. Our teams will also have access to our Internal Audit team, which will offer an unbiased review of new changes and ongoing programs to identify problems and highlight operational issues. Our Compliance Officer will monitor timely assessments and task completion.

In addition, CCHA *Plus* leadership will meet monthly to review performance, identify any problems or risks, discuss opportunities for improvement, and work with Regulatory and Compliance teams to confirm contractual compliance and quality performance. The Compliance Officer will maintain a work plan with performance metrics, and the Compliance team will meet regularly to review compliance and quality issues. Our Colorado RAE Compliance team will build strong relationships with our department leaders and create an environment where they can discuss problems (quality or other) for a proactive response.

Compliance with State and Federal Regulations

Building on CCHA's established processes, CCHA *Plus* will confirm that we remain compliant with federal regulations and Colorado-specific requirements. Our internal experts will monitor State and federal regulations to assess the potential impact of changes on our systems and processes and create action plans, as necessary, to implement those changes according to regulations.

To make sure employees are aware of changes that impact CCHA *Plus* processes, our Regulatory Oversight Manager and Compliance Officer will distribute regulatory changes to functional managers throughout our organization to evaluate the impact and monitor compliance.

Compliance Program

Compliance will be an essential part of our culture, and CCHA *Plus* will work to meet the State's expectations, requirements, and standards as CCHA has done.

With the experience of our managing partners, CCHA *Plus* brings one of the most proactive compliance programs in the industry and will apply this level of detailed attention to the ACC Program. Our Compliance team will execute the compliance program, supported by extensive resources and best practices. This team will maintain a dedicated Colorado Regulatory Services SharePoint site that serves as a comprehensive repository of all our contractual requirements and commitments.

Our program will maintain a robust system of processes and controls to prevent, identify, and mitigate potential risks, founded on the principles of the U.S. Department of Justice (USDOJ) Seven Fundamental Elements of an Effective Compliance Program:

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Conducting internal monitoring and auditing
5. Reporting and investigating
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

Our commitment to compliance and establishing a culture that encourages our employees to embrace this commitment are reflected in our core values. We believe that fostering open communication among our employees and with the Department is key to meeting the expectations and goals of Members, Network Providers, and the Community.

To support our commitment to being trustworthy, we will invest in dedicated compliance resources that strongly focus on Contract compliance and education, monitoring and oversight, and risk identification and mitigation.

An outline of the components of our Compliance program and support resources, based on the USDOJ framework follows:

1. Implementing Written Policies, Procedures, and Standards of Conduct
Policies and Procedures. We will maintain a robust library of policies and procedures that address our regulatory, contractual, and other ACC Program obligations and requirements. Functional managers throughout the organization will develop our policies in consultation with our Compliance Officer and Regulatory lead. These policies will play a major role in guiding activities and operations. We will monitor and review policies and procedures regularly and publish them on an internal website accessible to all employees.

Standards of Ethical Business Conduct (Code). We will require that all employees acknowledge and agree to comply with the Code as a condition of employment. The Code helps employees understand and comply with our legal, regulatory, and contractual responsibilities and act in a way that supports our principles.

2. Designating a Compliance Officer and Compliance Committee
Regulatory Oversight Manager. Our Regulatory Oversight Manager will manage the submission of all required regulatory reports and serve as our internal subject matter expert and resource for contractual and regulatory obligations under our Medicaid programs.

Compliance Officer. We will maintain a full-time Compliance Officer who will partner with CCHA *Plus* leadership to provide extensive and focused engagement on issues, including compliance education and training, risk identification and mitigation, and the development and oversight of corrective actions. He or she will provide executive-level compliance oversight and management, and will collaborate across all functional areas to infuse compliance into everything we do.

CCHA Plus Internal Compliance Committee. Chaired by our Compliance Officer, our local Colorado Medicaid Compliance Committee will comprise our executive leadership, the Regulatory Oversight Manager, as well as leaders of Quality, Utilization Management, Care Coordination, Operations, Network Management, Marketing, Government Relations, and Human Resources departments. The committee will meet at least quarterly and provide a forum for leadership to review and discuss emerging issues and upcoming activities, assess potential compliance risks, and provide input into

mitigation activities and corrective action plans. The Compliance Committee will review reporting about compliance monitoring activities and provide necessary oversight of our Compliance program.

3. Conducting Effective Training and Education

Extensive Compliance Training. All employees will receive mandatory compliance training at initial hire and annually thereafter. Compliance training will include the requirements of any current agreements or corrective action; fraud, waste, and abuse; HIPAA; and other aspects of the Compliance program, such as the Code, Cultural Competency, Drug Free Work Place policies and procedures, and any contractually required training. We will track and monitor completion of all required training through our online learning systems. Our Compliance team will follow up directly with employees to verify completion.

Continuing Education and Awareness. We will conduct additional education and awareness activities throughout the year to reinforce the role that all employees play in compliance.

4. Conducting Internal Monitoring and Auditing

Colorado Medicaid Compliance Program and Work Plan. Our CCHA *Plus* Compliance Officer will develop and maintain a Colorado Medicaid Compliance Program and Work Plan, building on the one CCHA already has in place as a RCCO. The Compliance Committee will review and approve the Work Plan each year and receive regular progress updates. The Work Plan's core functions will track the 7 elements of an effective Compliance program, including written standards, structure, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention.

Partnership with Internal Audit. Our compliance resources and Internal Audit department will collaborate to confirm that master audit plans include key compliance issues and risks for detailed review, evaluation, monitoring, and corrective action as needed.

5. Reporting and Investigating

Speaking Up. We will work to establish a culture that encourages employees to "speak up" and identify any potential compliance concerns through multiple reporting avenues. We will maintain a strict and highly publicized policy of non-retaliation for any employee who comes forward to identify potential compliance risks or concerns.

Confidential Compliance Hotline. Our Compliance Hotline will support confidential (anonymous, if requested) and secure reporting of potential violations. We will investigate all hotline reports and communicate the results to the Medicaid Compliance Officer.

6. Enforcing Standards through Well-Publicized Disciplinary Guidelines

Ethics and Compliance Office. The Ethics and Compliance Office will administer and advise employees on the Standards of Ethical Business Conduct, serve as an independent resource to receive and investigate allegations of employee misconduct, provide employees with training on ethics and compliance issues, and provide high-level oversight of Compliance programs across the organization.

7. Responding Promptly to Detected Offenses and Undertaking Corrective Action

Corrective Action. When we learn of any deficiency, whether identified by the State, Network Provider, or internally, our Compliance Officer will collaborate with other internal stakeholders and functional managers to investigate the root cause and develop an action plan to address the deficiency and prevent a recurrence.

Taken together, these Compliance program components and support resources will represent a comprehensive, proactive approach to ACC Program monitoring and enforcement that will promote full compliance with all State and federal requirements, provide the fullest protection of Members' rights,

and fully support the goals and objectives of the State's mission to provide high-quality health care services at reasonable and predictable costs.

Inspection and Audits

CCHA *Plus* will grant access to the Department, CMS, the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General, and their designees to inspect and audit any records or documents, premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

Fraud, Waste, and Abuse

We will ingrain protection against fraud, waste, and abuse in all we do. We will reinforce our commitment to prevention through new hire and annual employee training, focused Fraud Prevention Week initiatives, in Network Provider orientations, the Member handbook, and through well-publicized reporting channels such as our hotline and website.

Our comprehensive Fraud, Waste, and Abuse program will comply with all applicable laws, and we will enhance it to comply with Colorado-specific requirements contained in RFP Section 5.15.5. Our program will include a set of initiatives, policies, systems, and best practices directed at the prevention and detection of fraud, waste, and abuse. Our Colorado Compliance Plan and comprehensive policies and procedures will guide our activities.

Our program will employ a variety of tools and processes to make sure Member services are effective, efficient, and safe, and that we make payments only to legitimate Network Providers for reasonable services to eligible Members. Processes will focus on preventing and detecting fraud, waste, and abuse; encouraging reporting; investigating allegations; and implementing corrective actions and other strategies. Our tools and processes will enable us to monitor different Network Provider types, as well as Member fraud.

Proactive and Reactive Fraud, Waste, and Abuse Methods

CCHA *Plus* will employ both proactive (pre-payment and prevention) and reactive (post-payment) detection methods and internal controls in Colorado, including:

- Systems and oversight activities to identify, reduce, review, recover, and report fraud
- Advanced data analytics and detection capabilities across all clinical services types
- Announced and unannounced onsite visits to Network Provider locations
- Member interviews by telephone or in person
- Operational performance and metrics deployment to optimize savings

Internal controls will drive our program integrity's philosophy of prevention. Pre-payment review is highly effective in stopping suspect claim payments. Based on Anthem's experience, these upstream activities account for roughly 3 times the savings of downstream post-payment recoveries. The primary tools CCHA *Plus* will use for detecting abnormal behaviors will include coding software; fraud and abuse analytics; and our internal, proprietary health care analytics. Mining claims data will be the primary way our investigators detect and deter fraud, waste, and abuse. Coding software and various data analyses such as exploratory, confirmatory, and predictive analytics will help us review atypical claims. In addition to pre-payment review, we will use several prevention tools, including:

- McKesson ClaimsXten, which automatically and comprehensively audits codes to identify the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesiology procedures identified by CPT®-4 and HCPCS codes

- The Policy Administration Model, which addresses claims editing based on national reimbursement policies and national coding standards not currently available in ClaimsXten
- Cotiviti, which validates services across Network Providers while considering claim modifiers and specialties, as well as how often the service can be performed
- FICO Insurance Fraud Manager, which is a pre- and post-payment predictive model that scores claims and Network Providers on the likelihood of fraud, abuse, and the level of financial risk

While we will focus heavily on pre-payment activities, CCHA *Plus* will also use analysis-driven post-payment review to identify erroneously billed claims and behaviors undetectable by pre-payment edits. Our detection systems and resources will include our medical management team who will be available for training and analysis, facility site information, membership information, medical record reviews, field staff information, and information databases.

We will apply sophisticated detection tools and systems during post-payment claim review, as part of systematic data mining, and during referral follow-up that have proven very effective in detecting fraud, waste, and abuse, and recovering inappropriate payments. Additionally, CCHA *Plus* will use post-payment reviews to see that we have processed claims in accordance with Contract terms and all applicable laws.

Process for Suspected Cases of Fraud, Waste, and Abuse

Our CCHA *Plus* Compliance Officer will work closely with our Special Investigations teams, who have primary responsibility for the investigative process.

In partnership with the Department, we will take appropriate action to address each confirmed case of fraud or abuse. Those actions will vary based on scope, severity, and circumstances of each case. In planning appropriate actions, we will leverage our managing partners' knowledge of and experience with the local community. This will set us apart from other companies that apply a rigid, inflexible approach.

Actions may include:

- Network Provider notifications
- Targeted education
- Medical record audits
- Member lock-in
- Pre-payment reviews
- Recoupment of overpayments
- Reporting Network Provider to legal/regulatory agency
- Corrective Action Plans (CAPs)

Our ultimate goal is to educate, not penalize, Network Providers for aberrant practice patterns. We will then monitor them for a year to confirm compliance and report any resulting savings. If necessary, we will terminate the Network Provider when it is in the best interest of our Members and the Department.

Quality Improvement Inspection, Monitoring, and Site Reviews

Within our information system and operations, integration will be the heart of our philosophy and comprehensive approach. Our Technology Services team will use established data exchange systems and protocols, according to Colorado and federal requirements, including HIPAA regulations and 42 C.F.R. Part 2.

CCHA *Plus* will conduct compliance and monitoring activities pursuant to RFP Section 5.15, including:

- Supporting annual site reviews by the Department to confirm our compliance with Department regulations, State and federal regulations, and Contract requirements

- Supporting emergency or unannounced review by the Department for Member safety, quality of care, potential fraud, financial viability, or other purposes
- Cooperating with independent reviews by a Department-selected External Quality Review Organization
- Responding to corrective actions resulting from any site visit
- Prohibiting payments for Network Provider-preventable conditions, as identified in the State Plan
- Severing all relationships with an individual or entity excluded from participation in any federal health care program, as described in Sections 1128 and 1128A of the Social Security Act
- Screening employees and Contractors to confirm eligibility to participate in Medicaid
- Submitting requisite reports within required time frames

We will require employees and Network Providers to comply with all relevant State and federal laws regarding PHI privacy and confidentiality, including protecting and maintaining the confidentiality of substance use disorder information. We will use stringent policies, processes, and systems to make sure we do not share sensitive information inappropriately. We will include privacy and confidentiality requirements in our Network Provider contracts and conduct annual privacy training for our employees.

Our Network Provider agreements will require compliance with HIPAA protocols, as well as 42 C.F.R. Part 2 and other applicable State and federal requirements when coordinating Member care with other Providers (in- or out-of-network). In accordance with 42 C.F.R. Part 2, we will obtain a Member's consent to release information related to any substance use treatment that we use to address his or her care and service needs; Network Providers must obtain this Release of Information from the Member to discuss treatment.

We will store scanned, written, and signed Consent to Substance Use Disorder Treatment disclosures in our system, and maintain security policies and procedures that protect the confidentiality, integrity, and availability of this data, as well as all electronic PHI collected, maintained, used, or transmitted. This includes role-based security limiting access to authorized staff. We will use secure email systems and encrypted file transfer protocols to protect PHI that is exchanged both inside and outside of our organization.

Together, our Compliance Officer and Regulatory Oversight Manager will conduct compliance and monitoring activities to verify our adherence to 42 C.F.R. Part 2.

Policies and Procedures

Documented policies and procedures that are readily available to employees will be an important part of ACC Program control. Policies and procedures will help us make sure that we are managing the ACC Program consistently and serve as an important resource during employee transition.

Confidentiality Regulation

Our information-sharing processes and systems comply with all HIPAA privacy and confidentiality requirements.

To protect confidentiality, integrity, and availability of data, our Technology Services team will employ a defense-in-depth security strategy that incorporates administrative, technical, and physical controls at the facility, network, operating system, application, and data store levels. Information security standards will be consistent with industry best practices, standard frameworks, and the regulatory requirements of HIPAA. Some of the many controls include:

- **Facility Access** will be controlled with proximity-based electronic security badges. We will require all employees and visitors to complete a security access request form and obtain approval signatures

for unsupervised access. After-hours access will require specially coded security badges. We will limit data center access to employees responsible for network engineering, system administration, and network security. All servers and data storage devices will be located within secure areas.

- **Access to Workstations or Systems** will require the use of a unique user identifier and a complex password that is changed at regular intervals.
- **Role-Based Security** will limit update capabilities and access to application functionality. We will limit access to Member medical records to individuals whose roles require such access (for example, Chief Clinical Officer). Users with inquiry-only privileges will be unable to modify or update information. These different security functions will enable us to provide users with multiple levels of privileges. Our system will log all views of Member clinical data.
- **Network Security** will be managed and monitored using several technologies and management systems that provide 24/7 real-time security event monitoring and reporting capabilities. Our Vulnerability Management program will identify vulnerabilities, report them for remediation, and track remediation efforts. In addition, an independent third party will perform an annual external penetration test.

Prohibitions

Recognizing the dramatic human and financial costs of preventable medical errors, we will do our part to reduce their incidence. CCHA *Plus* will deploy established protocols and policies to promote safe, effective care for Colorado Medicaid Members and, as CMS rules require, prohibit payment for Provider-preventable conditions, including Never Events and Sentinel Events.

As part of our Network Provider contracting and BH provider credentialing processes, we will confirm all applicant Providers are enrolled with the State as Group or Individual Medicaid Providers.

We acknowledge the provisions described in RFP Section 5.15.7.3 and the Department's right to withhold payments for the stated situations.

As a new entity, CCHA *Plus* confirms we have not been sanctioned by a state or federal government in the last 10 years. In addition, we will abide by the requirement that prohibits affiliation with individuals debarred, suspended, or otherwise excluded from participation as a director, officer, partner, or person with ownership of more than 5%.

Screening of Employees and Contractors

Following the practice of CCHA and Anthem, CCHA *Plus* will conduct in-depth background screenings at the federal, State, and local county levels for all new employees, temporary employees, and independent contractors upon hire. Our robust criminal background checks will comply with all Office of Federal Contract Compliance Programs' requirements to verify that individuals we hire meet stringent criteria related to providing services for our government-contracted business.

As part of our screening process, we will perform the following verification checks:

- Social Security Number Verification – including trace, a search for any aliases tied to the individual applicant to verify identity, and a search on any other known names for the past 10 years.
- Criminal Search – including county criminal, residence, school, and employment background searches and all years reportable by the courts.
- National Criminal Database Search – including a county criminal search if any results are obtained from a nationwide search.
- US Department of Treasury's Office of Foreign Assets Control Specially Designated National or a Blocked Persons List.
- National Sex Offender Check.

- Military Records Check.
- Employment Verification – including check of last 3 employers or employment history for the past 10 years, whichever is applicable.
- Education Verification – including check of highest level of education obtained post-high school, and international verification, if applicable.
- Professional License or Certificate Verification and Health Care Sanctions Check, if applicable.
- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) – OIG's LEIE provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. Reinstated individuals and entities are removed from the LEIE.
- General Services Administration (GSA) List of Parties Excluded from Federal Programs, now known as the System for Award Management (SAM), formerly Central Contractor Registration – SAM is the Federal repository of required information provided by an entity for the conduct of business.
- E-verify Program/I-9 Verification – We comply with the requirements of 48 C.F.R. 52.222-54 and the U.S. Citizenship and Immigration Services' E-Verify Program. E-Verify enables participating employers to verify electronically the identity and employment eligibility of their newly hired employees, regardless of citizenship.

Reporting

In Colorado and nationally through our managing partner Anthem, CCHA *Plus* offers extensive experience working with state entities to capture, process, and submit reports according to Contract requirements. We will maintain comprehensive processes to produce scheduled and ad hoc reports at the frequency and in the format and level of detail required by the State. We will continuously test the data through careful review and analysis of management, operational, and regulatory reports.

Anthem and CCHA reporting teams have built an inventory of more than 1,000 reports that span all aspects of the Medicaid experience and, through a mature reporting process, deliver more than 10,000 reports a year. CCHA *Plus* will leverage this repository of proven, tested, and accurate reports to develop customized reporting that tracks utilization and outcomes for the ACC Program.

Our Regulatory team will maintain an Intranet site for tracking requests submitted by State agencies. This site will feature automatic notification functionality from initial dissemination of the request through completion. Functional managers will receive communications from a centralized address, making emails related to State requests easily identifiable and trackable. The site will also be accessible by executive leadership and functional managers, offering an overview of both active and historical State requests and responses. ***In 2016, Anthem's Regulatory team alone coordinated completion of 12,645 requests across the states they serve.***

We will complete all requests to the Department's satisfaction and within the specified time frames listed in RFP Section 5.15.9. We understand that urgent requests may include issues involving legislators, legislative committees, other governmental bodies, and care management evaluation that require prompt responses based on Members' health conditions. We will also consider executive requests, ACC Program requests, and Medicaid Investigated Grievances urgent.

On or before the required date of completion, we will submit a detailed summary advising the Department of our action and resolution. The completion summary will contain all information necessary to determine if a request has been completed and will conform to specifications requested by the Department concerning form, format, or content.

CCHA *Plus* Will Meet All Section 5.15 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 24, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.15 that are not detailed in our response.

Section 5.16

COLORADO COMMUNITY HEALTH ALLIANCE

Start-up and Closeout Periods

5.16 START-UP AND CLOSEOUT PERIODS

CCHA *Plus* Will Meet All Section 5.16 Requirements

CCHA *Plus* acknowledges that there are no Offeror Response questions associated with the requirements set forth in Section 5.16. We affirm that CCHA *Plus* will comply with all the requirements listed in Section 5.16, specifically noting our obligations to the Department in:

- 5.16.1 The Contract shall have a Start-Up Period and a Closeout Period.
- 5.16.2 Start-Up Period.
- 5.16.3 Closeout Period
- 5.16.4 Start-Up and Closeout Planning

Section 6.1

Addition of additional Work

6.1 ADDITION OF ADDITIONAL WORK

CCHA *Plus* Will Meet All Section 6.1 Requirements

CCHA *Plus* acknowledges that there are no Offeror Response questions associated with the requirements set forth in Section 6.1. We affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.1, specifically noting our obligations to the Department in:

- Performance of activities as part of the Work when requested by the Department
- Acknowledgment that CCHA *Plus* shall not perform any activities included in Section 6.0 without the Department's notification and without funding being added to the Contract for these activities

Section 6.2

COLORADO COMMUNITY HEALTH ALLIANCE

Accountable Care Collaborative: Medicare-Medicaid Program

6.2 ACCOUNTABLE CARE COLLABORATIVE: MEDICARE-MEDICAID PROGRAM

OFFEROR'S RESPONSE 25

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Accountable Care Collaborative: Medicare-Medicaid Program scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

As a RAE, CCHA *Plus* is willing and able to perform the work described in the proposed Accountable Care Collaborative: Medicare and Medicaid Program (ACC MMP) scope of work and will negotiate with the Department in good faith, provided existence of appropriate funding.

We appreciate the opportunity to continue the work that CCHA has done as a RCCO with the more than 3,000 attributed full benefit Medicare-Medicaid enrollees in Region 6. Since inception of the ACC MMP, CCHA has gained valuable experience and developed a program to meet the unique needs of this population and empower Members to self-direct their care and live independently in the community.

Anthem brings a balanced perspective on managing primary, acute, and behavioral health (BH) for more than 336,000 dual eligible individuals through a variety of programs. CCHA brings an extraordinary degree of local experience in Colorado and strong relationships with the community-based organizations, providers, and state and local agencies that participate in the system. With this expertise, CCHA *Plus* will be able to provide the Department with a tailored solution that can be implemented quickly and with minimal execution risk.

Together, we are committed to building an integrated care team that is inclusive not only of our Members, but also of the existing Long-Term Services and Supports (LTSS) providers, community-based organizations, and providers that make up the State's infrastructure. Our care team of collaborative partners will include CCHA *Plus* Care Coordinators, LTSS case workers, the Member's PH and BH providers, and other important supports. We will work closely together to create and follow a truly integrated, Member-directed care plan. We believe our distinctive qualifications and local relationships uniquely position us to perform the work described in the ACC MMP scope of work.

Experience with the ACC MMP

We understand that there are barriers that the ACC MMP population faces that make the delivery system complex and difficult for Members to navigate. CCHA and Anthem have made great strides with improving the coordination of care across existing providers. Continued progress toward eliminating duplication of services, especially in care coordination, has helped expand Member access to care. This population is high-cost and high-need, and we will continue to evolve our offering to bring value to the Program and the Members we serve.

Since ACC MMP inception in 2014, CCHA has worked with Members and the Community to meet the objectives of the demonstration, which include:

- Improve the Member experience in accessing care
- Promote person-centered planning
- Promote independence in the community
- Improve quality of care
- Help Members get the right care, at the right time, and the right place
- Reduce health disparities
- Improve transitions among care settings
- Achieve cost savings for the federal and state governments through improvements in health and functional outcomes

Following are some CCHA performance highlights from the 2015-2016 ACC Program audit, conducted by Health Services Advisory Group, Inc. (HSAG) on behalf of the Department. The purpose of the audit was to assess success and challenges in implementing key components of the ACC.

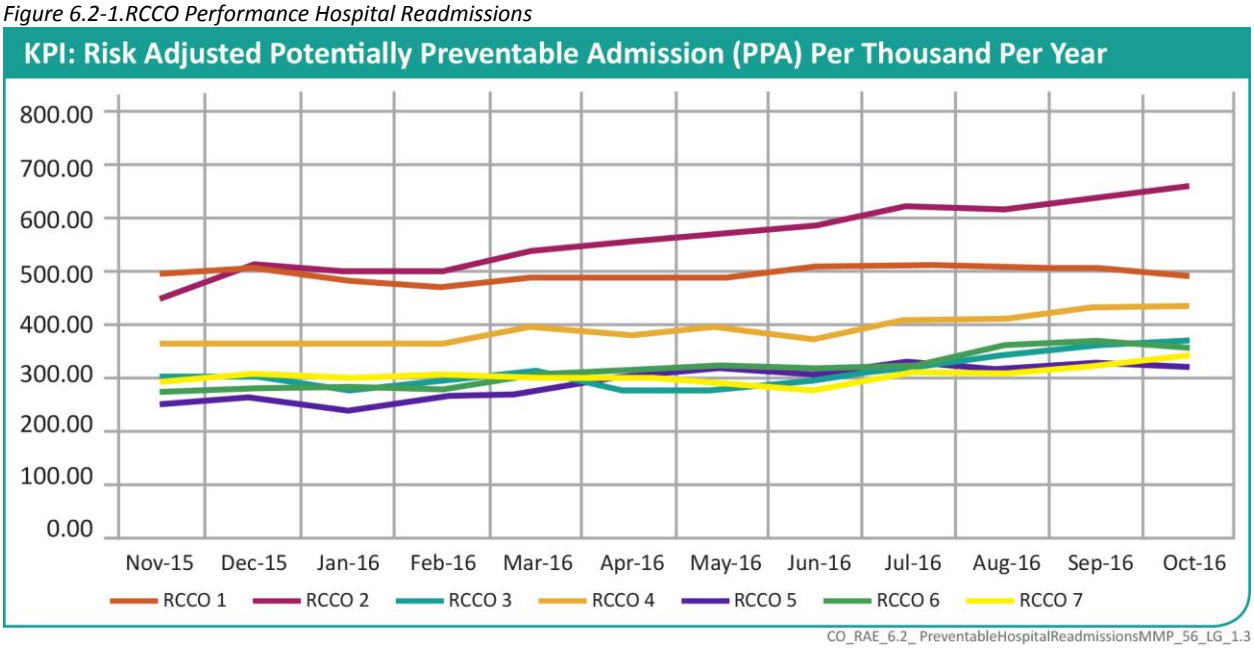
ACC MMP Member Care Coordination
CCHA Performance Highlights from 2015-2016 ACC Program Audit

HSAG found 9 of the 10 records reviewed to be 100% compliant with care coordination requirements.
CCHA and its delegates were routinely documenting all elements of the service coordination plan (SCP), which included a comprehensive assessment, Member goals, action items, and documentation of other agencies working with the Member.
SCP documentation indicated that Care Coordinators focused actions on Member-defined goals.
Several cases involved coordination with agencies, such as Single Entry Points and Community Centered Boards, that were already working with the Members and meeting the majority of their needs and goals.
CCHA demonstrated excellent leadership, expertise, and enthusiasm among care coordination employees.

CO_RAE_6.2_MMPCareCoordinationPerformance2015-2016_11_COB_1.4

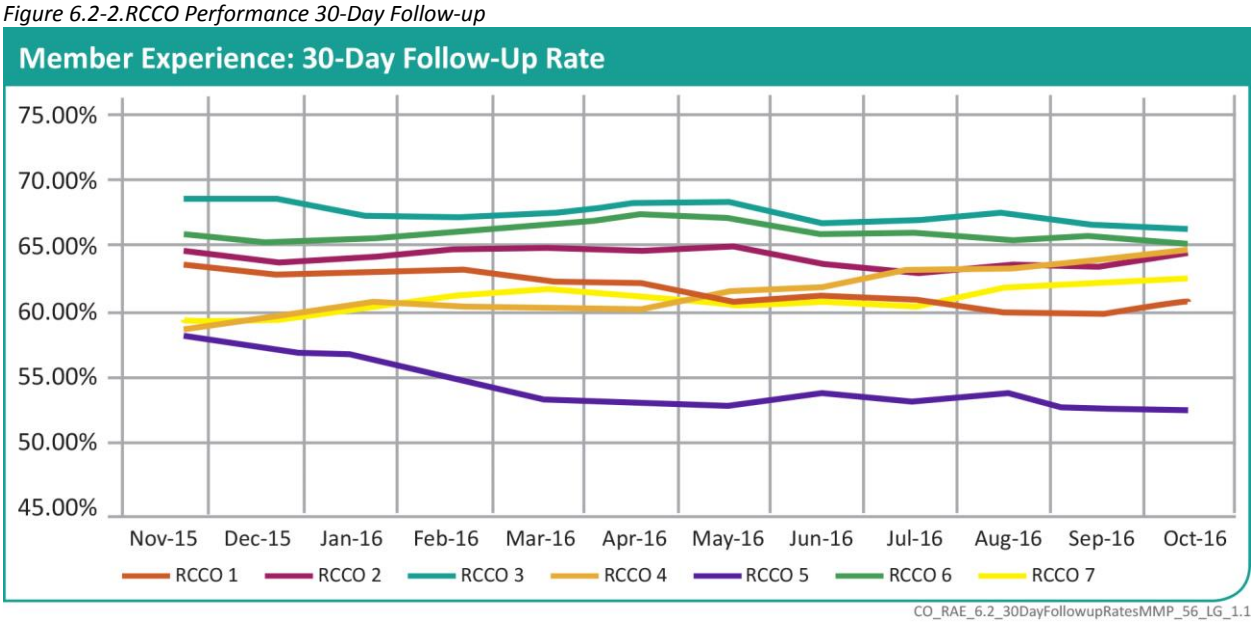
The CCHA ACC MMP model improved Member outcomes in just a short period of time. The Department provides reports to RCCOs to show progress meeting the Key Performance Indicators (KPIs). These reports help RCCOs monitor their performance and focus their efforts to work toward continued improvement. For the period November 2015 through October 2016, Figure 6.2-1 illustrates that CCHA was one of the highest performing RCCOs for reducing preventable hospital readmissions in the ACC MMP population.

Figure 6.2-1.RCCO Performance Hospital Readmissions



Additionally, the same report shows that CCHA performance for 30-day follow-up rates for the ACC MMP population was second among RCCOs across the State (Figure 6.2-2).

Figure 6.2-2.RCCO Performance 30-Day Follow-up



The CCHA ACC MMP Model

The CCHA model consists of several approaches that together create a Member-centered Community-based program, including:

- Multidisciplinary, team-based approach
- Service coordination plans
- Member outreach
- Determination of Member needs
- Partnership in the community
- Collaboration with the Department
- Data and reporting
- Integrated BH service

Multidisciplinary, Team-Based Approach

The CCHA ACC MMP model applies a multidisciplinary, integrated team-based approach to care coordination. The CCHA Care Coordination team includes community-based social workers and registered nurses, as well as telephonically-based community resource experts. This integrated team of PH and BH Care Coordination experts offers a unique, person-centered system of support to Members. They work directly with the Single Entry Points (SEP), Community Centered Boards (CCB), and other LTSS providers to identify roles and avoid duplication of services and confusion for Members. Additionally, CCHA Community Liaisons continue to expand and formalize collaborative relationships with additional Community partners, including the Area Agency on Aging (AAA), the Aging and Disability Resource Center (ADRC), and Complete Home Health Care. Members may also receive care coordination through other CCHA programs to best meet their identified needs, including criminal justice, transitions of care, or complex care coordination.

Provider Testimonial

I am happy to endorse CCHA as they are the most proactive ACC in the state. Keep up the good work.
Cathy Kaufman, RN, CEO, Complete Home Health Care

CO_RAE_OR27_Kaufman_06_COB_TST_4.2

Service Coordination Plan

In the existing ACC MMP, each enrollee must receive a Service Coordination Plan (SCP). CCHA has integrated the SCP into an electronic care coordination tool and has been successful in reaching and working with Members to complete the SCP. Members are reassessed every 6 months, or as needed with a precipitating event (such as change in status, level of care, or transition). At that time, the SCP is reviewed with the Member and updated. New ACC MMP enrollees are offered a SCP within 90 days of their enrollment.

CCHA Care Coordinators are an essential link connecting Members, their medical homes, and other providers delivering services. Using this model, CCHA *Plus* will do more for Colorado Members and use resources more efficiently. Care Coordinators collaborate with all providers, caregivers, community agencies, and other supports the Member is using. They review and attach Member records from sources such as the Statewide Data Analytics Contractor (SDAC), Benefits Utilization Systems (BUS), and electronic health records to the SCP. They also collect records, with appropriate permissions from the PCMP, any other BH or PH health care providers, and community agencies that are part of the Member's care team. Also included are a medication list, disease education needs, and Member health goals.

Establishing a Medical Home helps MMP Member connect to needed services

Steven called CCHA because his landlord told him he could no longer have his dog, which provides emotional support in dealing with his depression and multiple medical issues, in the apartment. His call triggered Mia, our Care Coordinator, to visit Steven at home and complete a person-centered Service Coordination Plan. First, she contacted his PCMP who wrote a letter to the landlord supporting having the dog for health reasons, and Steven was able to keep his companion.

While listening to Steven's concerns, Mia discovered that after paying rent, Steven was living on $11 per month for food. So she helped him apply for food stamps, Old Age Pension, and rental assistance and helped him create a list to keep track of his doctors' appointments. Mia also talked with Steven about his depression, which he felt was managed well by his PCP. ***Steven thanked Mia for her help in making connections for much needed services and improving his quality of life.***

CCHA — Member Centered

CO_RAE_OR25_Steven_11_COB_RS_1.1

Member Outreach

Members are engaged in a number of ways, including direct contact and referrals from their Health Neighborhood. CCHA Care Coordinators connect with ACC MMP Members telephonically and via mail to offer in-person visits wherever the Member is most comfortable, such as home, in the community, or at a provider office. CCHA collaboration in the Community has led to cross-directional referrals from many organizations working with the ACC MMP population, including:

- PCMPs and other health care providers
- Community and county agencies
- Hospitals
- SEPs and CCBs
- Member and caregiver referralsIn our role as a RAE, CCHA *Plus* will continue to expand and enhance Member engagement strategies, as detailed further in OR 9.

Determining Member Needs

The CCHA Care Coordination team assesses Members' needs and works together with them to create a care plan that reflects their personal short and long-term goals. In addition to addressing the Member's PH and BH status and needs, the plan also captures important information such as living arrangement preference, cultural and spiritual considerations, language and communication preference, and needs or access barriers for transportation, employment, school, child or dependent care, or family and friend support system.

The Care Coordination team also:

- Provides education to help Members understand their benefits and services, including PH, BH, and dental health
- Works to create a personalized SCP to help ensure Members get access to all the services they need (such as eyeglasses, hearing aids, household and automobile repairs) and are reaching their goals
- Coordinates access to benefits, services, and providers
- Communicates back to providers with health updates
- Provides support and resources for caregivers
- Assesses for things such as fall risk, depression, and avoidable ER utilization, as well as needs for community-based resources

A CCHA MMP screening tool is used to assess whether a Member is connected to a Medical Home, whether they are receiving or need BH services, their hospital and ER utilization, and any other medical or non-medical needs. The screening outcome determines what level of care the Member needs, which can range from receiving mailed information or telephonic care coordination to more intensive community or home-based visits. These assessments, along with referrals, help support the Key Performance Indicators (KPI) for the Program including Total Cost of Care.

Partnership in the Community

ACC MMP Members rely heavily on both the health and supports delivery systems, often requiring services to perform activities of daily living. Many Members are vulnerable and have disabilities that impact their ability to advocate for themselves to receive quality care and services. One barrier Members face is navigating the complex LTSS system. We understand the importance of working as a team with providers and community organizations to help Members achieve their health and wellness goals.

CCHA has worked alongside the LTSS providers and community organizations to develop a more integrated system of care for Members enrolled in the ACC MMP. CCHA has partnered with SEPs and CCBs to establish formal agreements that enable data sharing, identification of shared Members, and bi-directional referrals without duplicating care coordination efforts. The formal partnerships have significantly improved the coordination between the LTSS providers and the Members' PH and BH providers.

CCHA has designated a single point of contact Care Coordinator for each of the SEPs and CCBs in Region 6 to ease navigation of referral and support for these partners. These Care Coordinators have consistent communication with SEPs and CCBs and provide ongoing education to them along with a CCHA Community Liaison. Care Coordinators also attend collaborative home or community visits with SEP and

CCB caseworkers to complete SCPs. This helps reduce confusion for Members and avoid duplication of services and support. Feedback received from these collaborative visits has been positive from Members and the SEPs and CCBs. ***CCHA has been able to complete more SCPs through this collaborative effort, because many of these shared visits are with Members who previously were not reachable due to lack of accurate demographic information or lack of Member engagement.***

As a RAE, CCHA *Plus* will continue to evolve the program to be more efficient and provide better care.

Collaboration with the Department

As a current RCCO, CCHA has partnered with the Department in the implementation, administration, and evaluation of the ACC MMP. CCHA has appreciated the opportunity to collaborate with the Department to develop the SCP and protocols for working with providers, as well as participating in the ACC MMP Advisory Committee and SCP workgroups. CCHA *Plus* looks forward to continuing this partnership into the next phase of the ACC Program and working with the Department to engage in continuous evaluation and quality improvement efforts to strengthen the Program. We will continue to engage with the Department, leveraging the infrastructure set forth in the ACC Program, and will report all required information as stated in the Memorandum of Understanding and Final Demonstration Agreement.

Data and Reporting

The Department has significant reporting requirements from the Centers for Medicare and Medicaid Services for the ACC MMP. As a RAE, we will continue to provide timely and comprehensive reporting to the Department through reports from our electronic care coordination tool and supplementary CCHA *Plus* assessments. We have adopted extensive data systems to enable us to share information with the Department, providers, and Members.

CCHA *Plus* Will Meet All Section 6.2 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 25, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.2 that are not detailed in our response.

Section 6.3

COLORADO COMMUNITY HEALTH ALLIANCE

Wraparound Program for Children and Youth with Significant Mental Health Conditions

6.3 WRAPAROUND PROGRAM FOR CHILDREN AND YOUTH WITH SIGNIFICANT MENTAL HEALTH CONDITIONS

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

As a current Regional Care Collaborative Organization (RCCO), CCHA brings extensive experience working with children and youth in the local community who are at risk for significant mental health conditions. Through this experience, we understand the challenges faced by these Members and their providers with multiple child-serving systems, as well as the value of effectively integrating and coordinating care planning and interventions that are family-driven, youth-guided, and strength-based. As a RAE, CCHA *Plus* is also excited to add the extensive experience Anthem brings to implementing wraparound services and all the components of the System of Care, including care coordination, parent/caregiver peer support, intensive in-home therapy services, and flexible funds. We will bring our experience in managing these services, along with successful fully-developed strategies, to create a person-centered wraparound approach to address the evolving needs of these complex, high-risk Members.

Studies have found that half of the individuals who develop serious mental illness had symptoms by age 14, and children are more at risk of relapse and readmission than adults are. Our guiding principle for a System of Care for children and youth with significant mental health conditions is that they are best served at home, going to school, and participating in other age-appropriate activities whenever possible. Helping a child or youth with significant mental health illness is difficult for the entire family, so supporting the family is critically important. In our work with Members, we understand the importance of supporting the family and the child's natural supports with education, community support, and respite options. We will work with pediatricians to make sure they have the tools and training needed to provide screening and brief intervention to identify these Members and make referrals so they have timely access to wraparound and other community and faith-based services and supports. Likewise, we will team with local organizations working with the schools to promote screening and prevention activities and ensure community collaboration. In addition, families may lack access to important diagnostic services that are the foundation for development of effective service plans and Individual Educational Plans (IEPs). We will train providers on evidence-based practices in working with children and youth who have significant mental health conditions, and help providers connect parents to relevant educational materials.

We will use best practices developed and tested across similar programs and populations, including foster care and juvenile justice programs. These tools will be leveraged to pinpoint opportunities and develop strategies to achieve delivery system efficiencies, optimal utilization patterns, and quality gains

across all programs. We will combine our critical knowledge and understanding of what Members need with our resources to create a collaborative, coordinated, community-based approach to a service delivery program that emphasizes quality, training, and timely access to care.

Extensive data was collected from the nationwide outcomes evaluation of a Center for Mental Health Services (CMHS) initiative involving funding of demonstration projects across all 50 states. The data indicates that System of Care programs have reduced the number of hospital and out-of-home residential placements, improved school performance, improved behavioral and emotional functioning, reduced violations of the law, and provided more services to children, youth, and their families who need them.

Serving this population with complex needs is challenging and requires comprehensive community collaboration, high-fidelity Wraparound care coordination, and parent/caregiver peer support. The proposed Wraparound Program will help children and youth, along with their family members and caregivers, by establishing a System of Care model that:

- Emphasizes individualized, strength-based care focused on the child, family, and community
- Is specifically tailored to the needs and preferences of the child and family
- Includes family at every level of care planning and implementation
- Assures collaboration and coordination between all system partners
- Is culturally competent
- Serves children and youth in their communities in the least restrictive setting
- Serves to integrate and coordinate key Health Neighborhood and Community organizations

A successful System of Care Model relies on collaboration among primary care, mental health treatment, and community resource support. As a RCCO, CCHA established strong relationships with local providers in both the medical and behavioral health (BH) community. Through this experience, they have become well versed on navigating community resources and recognize that the one-size-fits-all model does not serve families well. By adding Anthem to the CCHA *Plus* partnership, we will bring more BH providers to our network, which will mean easier and more efficient access for our Members. To promote fidelity and adherence, we will provide education to Primary Care Medical Providers (PCMPs), BH providers, and community resources on the Systems of Care model.

CCHA *Plus* supports a statewide High-Fidelity Wraparound program and looks forward to building upon the current model and partnerships in the community to integrate the System of Care in the Region 6 delivery system.

Serving Children and Youth with Significant Mental Health Conditions (6.3.3, 6.3.4, 6.3.5)

CCHA *Plus* will collaborate with the Department to administer the Wraparound Program for children and youth from birth to age 21 who, based on initial assessment, are likely to benefit from it and meet Medical Necessity criteria outlined in the RFP. We will develop a consent protocol where the Member's representative consents to medical treatment for the child or youth and will voluntarily agree to participate in the Wraparound Program. The assent of the child or youth who is not authorized under applicable law to consent to medical treatment is desirable but not required. We will develop a consent form specifically for the Wraparound Program to enable participation and communication among service providers who are engaged with the family. We will work with the family and caregivers, as well as with community partners such as psychiatric hospitals, Colorado Division of Youth Services (DYS), and Residential Child Care Facilities, to make sure data sharing and discharge processes are met during transitions (such as children transitioning from an institutional setting to a community setting or a youth transitioning from foster care).

We will submit a monthly Wraparound Program Enrollment Report that provides the required information for Members who have been newly enrolled, remain enrolled, or whose enrollment has terminated. We will also use claims, referral, and any other necessary data to identify Members who may benefit from the Wraparound Program and report this information to the Department monthly. We will continue or discontinue administering the program for children or youth according to the criteria identified in 6.3.3.4 and 6.3.3.5.

Wraparound Program Network (6.3.5, 6.3.6, 6.3.7)

CCHA *Plus* will establish a Wraparound Program network that includes licensed Community Mental Health Centers (CMHC), residential treatment centers, and private practitioners. We will see that Network Providers are trained in high-fidelity Wraparound and have experience with various models, including strength-based and family-driven practice and service models. We will provide annual training for Network Providers to assure engagement and participation. Additionally, we will confirm that they have experience with various models of care. We will continue our development and enhance our partnerships with organizations such as schools, child welfare, youth and family service providers, the Colorado Crisis Support Line vendor, probation offices, faith institutions, and Network Providers. We look forward to continued collaboration with these partners to promote bi-directional referrals and enhanced care coordination for Members in this program.

To build the network necessary for serving this population, we will begin by leveraging existing partnerships CCHA has established in the Region 6 Health Neighborhood to recruit providers and community partners, such as those shown in Table 6.3-1.

Table 6.3-1. Partnerships to Build Health Neighborhood

Type of Provider	Region 6 Current Partnerships
Assessment Providers	•Children's Hospital Colorado •Developmental FX
Residential Childcare Facilities and Day Treatment Centers	•Savio House •Tennyson Center for Children •Mount Saint Vincent •Children's Hospital NCS Program
Community Mental Health Centers	•Jefferson Center for Mental Health •Mental Health Partners
CCHA Network Providers	•Primary Care Medical Providers •Specialists •Private BH Providers
Managed Services Organizations	•Signal Behavioral Health Network
Respite Providers — CCHA engages in Denver Respite Coalition meetings	•Dungarvin •CareProx •Easter Seals •Megan's Place
Community Centered Boards (CCBs)	•Developmental Disabilities Resource Center (DDRC) •Imagine!
Child Welfare Agencies	•Department of Human Services in Boulder, Broomfield, and Jefferson Counties
Youth and Family Service Providers	•Griffith Centers for Children •Children's Hospital Colorado •Kempe Center
School Districts	•Jefferson County •Boulder County

Additionally, CCHA has a track record of building strong provider networks to improve access issues. As CCHA *Plus*, we will leverage this experience and success as we expand our networks of PH and BH providers, as well as community partners, to address the unique needs of children and youth served in the Wraparound Program. This network will be invaluable to our efforts to reduce potentially preventable ER, inpatient, and residential childcare facility utilization. In connection with CCHA *Plus* care coordination efforts, our network will provide the full range of services needed by this population. Services will include PCMPs, BH providers (both in-home and community-based therapists), psychiatrists, child welfare agencies, assessment providers, educational services and vocational services, substance use services, operational services, youth mentorship programs, recreation services, and respite care providers.

Care Coordinators Facilitate Our Wraparound Program

In Region 6, CCHA Care Coordinators currently work with children whose diagnosable disorders interfere with their education, family, employment, and engagement in other community activities. CCHA collaborates with Wraparound facilitators in the Denver metro area to improve the quality of care for these Members. CCHA has received a preliminary program conceptual overview from one of the few certified trainers of High-Fidelity Wraparound, Laurie Fowler Beckel, PC, to discuss best practices and implementation of the model. CCHA *Plus* is confident we can adhere to the Department's request to provide Wraparound care. To assure an adequate network of trained Wraparound Care Coordinators to meet the needs of eligible children and youth in the region, we will hire both external facilitators and will train our Care Coordinators to provide high-fidelity Wraparound Services. We will also work with parents and caregivers with real-life experience with the Wraparound Program to provide peer support, system navigation, and other types of assistance to families participating in the program through the four phases of the Wraparound care coordination process:

- A comprehensive home-based assessment of Medical Necessity for Wraparound Program
- Development and facilitation of a Child and Family Team to identify and address their unique needs
- Creation of an individualized care plan
- Monitoring and follow-up activities to enable successful implementation of individualized care plans

We recognize that children and youth often receive multiple services through various agencies. It is common for families to feel overwhelmed by many different providers, not

Community Partner Testimonial

I have met with staff from CCHA on several occasions to discuss the High Fidelity Wraparound Model of intensive case management. We have agreed that the benefit to youth and families with complex needs within their service system would be of great benefit. I would be honored to train and coach the staff responsible for implementing the model with fidelity.
Laurie Fowler Beckel, PC, National Trainer and Coach of High Fidelity Wraparound

CO_RAE_Beckel_12_COB_TST_1.1

System of Care Framework

Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Reprinted by permission.

CO_RAE_6.3_SystemOfCare_12_COB_DP_1.2

knowing who to call when, or who is taking on each role. ***CCHA Plus will serve as a coordinator of the coordinators*** — working alongside families to help advocate for their needs and to build upon their strengths. Our Care Coordinators will see that services are not duplicated and that families feel services are streamlined and effective. Most importantly, they will see that their care coordination responsibilities include the following:

- Bi-weekly face-to-face meetings
- Regular telephonic, electronic, and other contact with youth and a parent or caregiver at least once a week
- Linkage and referrals for supports and services
- Assistance with system navigation
- Attendance at relevant treatment provider meetings, such as Individualized Education Plans and hospital discharges

Our Care Coordination program will deliver support for children, youth, and young adults in the child welfare system, and demonstrate our involvement in the Member's System of Care. Using this model, we will link Members with providers, community resources and stakeholders, technology, and the Department and sister agencies to support their health, safety, permanency, and well-being. The critical linkage we create will not stop with the Member.

With our model, these resources will be connected with each other, encouraging collaboration, efficiency, exchange of meaningful information, and shared responsibility for improved outcomes. We support a comprehensive System of Care that wraps around each Member with a unique plan or program of care and services that address his or her needs.

***Alyssa's Story:* Collaborating Services to Meet Complex Health Care Needs**

Alyssa was adopted as a toddler after experiencing severe abuse from her birth parents, and she has a seizure disorder, fetal alcohol syndrome, and a low IQ. She demonstrates aggressive behaviors, rages, and has a history of running away. Her complex medical and psychosocial needs often interfere with her functioning at home, at elementary school, and in the community.

Our Care Coordinator, Ava, first met Alyssa and her family at a care conference with multiple agencies and providers in attendance. Her family had requested out-of-home respite care every other weekend. The Developmental Disability Resource Center (DDRC) sent a request for services to nearly 100 contracted providers, but they were unsuccessful. During the care conference, Ava agreed to assist with finding respite care services and to provide care coordination for the family. Kathy, Alyssa's mom, also expressed a desire for advocacy – someone to work alongside her to advocate for her daughter when Kathy felt she wasn't being heard by all the professionals or they weren't communicating with one another. So Ava became the coordinator of the coordinators, helping the family navigate the complexities of multiple systems, eliminating confusion, and reducing their stress.

Ava collaborated with DDRC to contact 75 providers and found one that could meet Alyssa's complex needs – much to the relief of her family. While Kathy explored out-of-state residential placement, Ava explored alternative treatments and collaborated with Alyssa's psychiatrist, who recommended a special program at Children's Hospital. Over her 14-day stay, Alyssa experienced medication changes, and new behavioral techniques were recommended and implemented in all areas of her life – home, school, and therapy. Through this collaboration, Alyssa had her needs met. As a result of Ava's close coordination and collaboration with the family, multiple agencies, providers, and her school, all are working in concert to meet Alyssa's needs, and her family is experiencing the positive effects of these Wraparound Services.

CCHA Member Centered

CO_RAE_OR26_Alyssa_15_COB_RS_1.4

Our Wraparound Program Activities (6.3.7)

CCHA *Plus* will provide, arrange for, or otherwise take responsibility for the provision of high-fidelity Wraparound care coordination and parent/caregiver peer support. We will ensure program effectiveness through ongoing program monitoring and evaluation, monthly program meetings, intentional staff development and training, and mentorships including field-based observation and feedback. Our program will also include clinical oversight and availability to all employees, including parent/caregiver and peer support staff.

We will facilitate delivery of a high-fidelity Wraparound model as defined by the National Wraparound Implementation Center and will measure quality assurance and fidelity monitoring through the most current version of the Wraparound Fidelity Index. We will collaborate with the National Wraparound Implementation Center to design a comprehensive support plan that addresses identified needs upon implementing this model. CCHA *Plus* will adhere to the three main areas that the National Wraparound Implementation Center focuses on, which include organization and system development, workforce development, and accountability. We will also provide training, coaching, and supervision to facilitators. We will assure program adequacy as outlined by the Department in RFP Sections 6.3.7-6.3.7.5.1, and will implement the four phases of the Wraparound Care Coordination Process.

The existing CCHA Care Coordination program is built on a Member-centered, team-based, and community-driven approach that aligns with the System of Care model. This model focuses on home and community-based, face-to-face interaction with Members to conduct comprehensive assessments, facilitate a care team, develop goals and care plans with them and their caregivers, and conduct follow-up. This information is captured in an electronic care coordination tool, which allows for timely follow-up and reporting of information to Network Providers and the Department.

Care Coordinators consider the family as a whole when assessing Member needs. Supporting the entire family has resulted in better outcomes, including feedback from Members that they feel more confident in managing their health care needs. Members are connected to community-based services that are child-centered and family-focused. This includes therapeutic providers, day treatment centers, recreational services, and hard-to-find services, such as respite. Care Coordinators engage in individualized planning with the family and service providers, and seek services that are least restrictive, most cost-effective, and coordinated both at a system and service delivery level. We look forward to incorporating the Child and Adolescent Needs and Strengths (CANS) assessment and the experience Anthem brings with using this tool for care planning. We appreciate the multiple pathways this tool offers that can be easily understood by the Member and family, and that it incorporates the Member's functioning, strengths, risks, and needs in a culturally competent design. ***Children and youth and their families are full partners in both the assessment and care planning process and are seen as the experts within their own family systems.***

We understand the benefits of peer support between a trained parent/caregiver who has walked a similar journey and a parent/caregiver whose child or youth is currently engaged in the Wraparound Program. CCHA *Plus* will ensure the provision of parent/caregiver peer support for those who require additional assistance to more effectively support the recovery of their child or youth. We will employ or have contracts with parents/caregivers who have lived the experience with the Wraparound Program and are interested in supporting those who are currently living the Wraparound experience. We will explore implementing a support program that creates a structured, one-to-one, strength-based relationship between a trained parent/caregiver with program experience and a parent/caregiver currently engaged in the Wraparound Program. Bringing value and real life experience, peer support staff would offer a true understanding and real-life strategies to help families who choose to engage in this aspect of the program. This support program would help families resolve or ameliorate the emotional and behavioral needs of the Member by improving the capacity of the parent/caregiver.

Our Wraparound Program Administration (6.3.8)

We will see to it that the Wraparound Program is appropriate and cost-effective by performing or reviewing eligibility assessments, using trained facilitators, monitoring the delivery of services, and coordinating care for all active Members. This will include a review of the statewide Systems of Care software program. So that Members get the resources they need, our Care Coordinators will not exceed a 10:1 ratio with the families they serve, while peer support providers' caseloads will not exceed 20 families.

We will use our electronic care coordination tool to document Member needs, strengths, and goals, as well as monitor services to assure successful implementation of the individualized care plan. We will explore using the tool for the Wraparound Program to facilitate data sharing across all treating providers with the appropriate consent and releases of information. This tool also includes the required functionality to report directly to the Department, Child Welfare, and local Collaborative Management Program on Wraparound Program utilization and referrals. We will continuously perform quality improvement activities, including monitoring outcomes, to help ensure the program is nimble, cost-effective, innovative, and person- and family-centered.

Department Collaboration (6.3.8)

CCHA *Plus* will collaborate with the Department to implement the Systems of Care model for children and youth and their families. We will designate a staff liaison to serve as the primary contact for the Wraparound Program within the region and will comply with all reporting and deliverable expectations of the Department, including the Monthly Enrollment Report and Quarterly Report.

We are confident that our model will enhance the Wraparound Program. CCHA and Anthem already promote services that are individualized to meet the unique needs of children and youth and their families at all levels of care planning and address physical, emotional, educational, and social issues. Our Wraparound Program will be flexible and meet the 'person in environment' objective. ***Our primary goal is to enhance families' capacities by empowering them through a collaborative and holistic approach.***

CCHA *Plus* Will Meet All Section 6.3 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 26, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.3 that are not detailed in our response.

Section 6.4

COLORADO COMMUNITY HEALTH ALLIANCE

Pre-Admission Screening and Resident Review (PASRR) General Requirements

6.4 PRE-ADMISSION SCREENING AND RESIDENT REVIEW GENERAL REQUIREMENTS

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

As a RAE, CCHA *Plus* is willing and able to perform the work described in the proposed Colorado Pre-Admission Screening and Resident Review (PASRR) scope of work and negotiate with the Department in good faith, provided the existence of appropriate funding.

We will leverage the experience CCHA has as a current RCCO working with Members who have a mental illness or intellectual or developmental disability (I/DD). CCHA Care Coordinators have worked with these Members since inception of the Colorado Medicaid Accountable Care Collaborative Program (ACC Program). With this hands-on experience, we understand the importance of a comprehensive approach to align funding decisions with Member strengths, goals, needs, and preferences. Today, nearly 3,000 Members eligible for both Medicare and Medicaid services are engaged with CCHA in Region 6. CCHA completes assessments on all Members, develops Member-directed care plans, and works as a Community Care team with their Long Term Services and Supports (LTSS) providers. CCHA engages in oversight and compliance with Safety Net Providers and collaborates regularly with neighboring RCCOs to assure the continuity of care when Members transition out of Region 6. As a RAE, CCHA *Plus* also brings the extensive experience of Anthem to this scope of work. Anthem currently serves more than 61,000 I/DD Members in 13 states and more than 303,000 Members with serious and persistent mental illness (SPMI) in 13 states. They also serve approximately 57,000 children with serious emotional disturbance (SED) in 14 states.

Recognizing that Members with a mental illness or I/DD can have significant challenges, we will continue to support and assist them, their families, and caregivers to access the care they need in the least restrictive setting of their choice. We will encourage Members and their families or caregivers to self-direct their care, and we will work closely with their LTSS and behavioral health (BH) providers as a care team.

As a RAE, CCHA Plus also brings the significant experience of CCHA in working with State partners who retain responsibility for Medicaid eligibility and level of care determinations for enrollment in nursing facilities, intermediate care facilities for individuals with I/DD, or 1915(c) Home and Community-Based Services (HCBS) waiver programs. We will coordinate with the Department to obtain and include level of care determinations and initial assessment and reassessment results. We support the Department's commitment to use its adopted core standardized assessments to promote fair and equitable allocation of funding resources based on each Member's support needs. This process will inform the development of person-centered service plans based on the individual Member's selected services and personal goals.

We recognize the value of streamlined assessment and documentation across populations and programs and will collaborate with the Department to achieve the State's goals. We will not revise the adopted assessment tools or use other tools without State approval.

CCHA has ***extensive experience collaborating with LTSS providers in Colorado on behalf of Members*.** For those receiving LTSS or BH services in Region 6, CCHA has established formal partnerships with the Single Entry Point (SEP) agencies, Community Center Boards (CCBs), Community Mental Health Centers (CMHCs), and skilled nursing facilities (SNFs), with the highest volume of Colorado Medicaid ACC Members in the region. Business associate agreements are in place with these providers, which enable sharing of patient health information in compliance with HIPAA and establishing formal bi-directional referral processes. CCHA Care Coordinators get together regularly with various providers' case management staff to foster relationships and encourage Team-based Care.

When the PASRR scope of work was included in the Department's draft RFP, we consulted LTSS partners to learn more about current issues and barriers with PAS Levels I and II and resident review. We gained insight into the challenges that exist today, as well as opportunities to improve the system by reducing duplication and helping Members and their supports navigate the system. To improve the experience with PASSR processes, we will place Members and their families and caregivers at the center of care, and wrap services around them as part of the care coordination process. We will build on the current partnerships with LTSS providers to improve the system by connecting Members to the right level of care and reducing unnecessary health system costs.

CCHA *Plus* will manage the Colorado PASRR according to State and federal statutes, rules and regulations.

Improving the PASRR Process

During consultations with Health Neighborhood partners, including SNFs and rehabilitation facilities, we learned of challenges and concerns with the PASRR process and the accuracy of its reviews. Current issues include:

- Level I assessment and recommendations are not received in a timely manner
- No PASRR received upon SNF admission
- Problems with PASRR accuracy upon SNF admission, including incorrect information such as diagnosis or medication dosages
- No structured process for updating medications on PASRR
- Level II PASRR not submitted appropriately or within time frames
- Lack of communication between nursing and social service staffs inside the facility when a medication has been changed
- No time to provide audits on current PASRR
- Challenges implementing PASRR policy changes to promote accuracy of the PASRR; providers are often out of compliance when PASRR policies change
- Providers need in-depth trainings on staying updated on policy changes, gaining buy-in from other multidisciplinary team members, and importance of PASRR

The facilities report that these issues are a combination of external processes from the hospital and internal processes. We will strive to close the gap on these issues, and we propose several ways we may be able to help:

- Establish PASRR management policies and procedures — working with Network Providers, Members, and the community to identify best practices for both receiving and maintaining PASRR, and requiring compliance from all facilities engaged in the process

- CCHA *Plus* Care Coordinators who are licensed clinical social workers (LCSW) will complete Level II assessments or supervise trained employees or subcontractors in completion of the assessment
- CCHA *Plus* Care Coordinators who are registered nurses will review the PASRR between the hospital and the SNF or long-term care facility to verify accuracy and completion of the required assessments
- Educate all facility staff on PASRR processes and offer additional in-depth training for all policy changes and updates, including guidance on how to remain in compliance
- Have additional Omnibus Budget Reconciliation Act (OBRA) coordinators for counties to complete assessments and audits, offer support in plan of correction process, and provide ongoing support
- Implement structured audit and plan of correction processes to support providers and assure compliance

Provider Testimonial

Stephanie has been working as a Care Coordinator with us for over a year now. She has identified areas for improvement in our PASRR accuracy, tracking and implementation systems. I believe that the RFP is a strong way to improve these PASRR continued challenges and would support CCHA moving forward with it.
Ray Lauritzen, NHA, Arvada Care and Rehab

CO_RAE_OR27_Lauritzen_21_COB_TST_1.2

Should the PASRR process be assigned to CCHA *Plus*, we will meet with our Member Advisory Committee and interview Members and family members or caregivers directly to understand their experience with the process and how it may be improved. LTSS provider partners indicated that these suggestions, along with any other innovative ideas, would be welcomed and appreciated. One of the LTSS partners indicated the RFP contains great provisions to improve the PASRR process and supports CCHA managing the process. To address current challenges identified by our provider partners and comply with Department expectations, we will implement the PASRR policy improvements, as detailed below.

PASRR Policies and Procedures

We will leverage Anthem's organizational experience coordinating with states throughout the PASRR process. Just as they do in other states, we will work closely with the Department in the step-by-step completion of PASRR Level I screenings and Level II evaluations. Our policies and procedures will adhere to federal regulations and be modified to comply with Colorado-specific rules and regulations.

CCHA *Plus* will continue to support current PAS Level I assessment requirements and Level II requirements by obtaining the necessary documentation to complete assessments and submit to the referring agency and the accepting SNF. We will find ways to collaborate with the existing information management system to manage and coordinate PASRR activities.

PASRR Training and Preparation

We will educate our staff on current PASRR goals, assessments, coordination of care planning, continuity of care, quality, and compliance, as well as resident review status changes. This training will be supplemental to that required by the State. We will educate referring agencies on submitting a Level I assessment in the management information system, and will recommend the referring agency complete the Department's PASRR training. Our Care Coordinators will support the SNFs by providing education on processes and completion of Level I updates.

Prior to Members' involvement in the PASRR process, our community-based Care Coordinators will work closely with them and their multidisciplinary team through the Member-centered planning process. Together, they will develop a service plan that maximizes available resources through Medicaid, other State and local programs, our value-added benefits, family and natural supports,

Provider Testimonial

The care and compassion that CCHA has towards Members is apparent on a daily basis, and the Member's best interest is always their primary focus. As a homecare company, we work with many patients who do not have access to this program and see firsthand the benefits this brings to the community.
Erica Wagner, Client Relations Director, Epic Health Services

CO_RAE_OR27_Wagner_11_COB_TST_9.2

and community resources, with the goal of remaining in the community. These efforts will take place when Members have experienced significant life changes that require additional home and community-based services and supports to avert potential institutional placement or when they express the desire to reintegrate into the community. For example, if a Member is hospitalized, we will work closely with the discharge planner to make sure services and supports needed in the home are in place prior to discharge.

Review PAS Level I Assessments

CCHA *Plus* will maintain deadlines for PAS Level I by bridging the communication gap between the referring agency and admitting facility. We will do this by completing the Level I review, updating the system, and notifying the referring agency within the required timeframe specified in Section 6.4.6.2. We will work in partnership with referring agencies to review documentation (such as ULTC 100.2 form) and see that family members or caregivers and Providers are kept current on the Member's status. We will evaluate Serious and Persistent Mental Illness (SPMI) or I/DD for Members outside of Colorado, including reasons for relocating, current supports in place, and all health-related concerns, including past and present treatment, to gain knowledge of their psychiatric stability in accordance with PASRR requirements.

Our Care Coordinators will communicate directly with nursing facilities and other entities required to complete and report PAS Level 1 screenings and Level II evaluations within State and federal timelines. Upon notification that a Member has been admitted to a nursing facility, our Care Coordinators will promptly confirm completion of the Level 1 assessment. The Care Coordinator will request confirmation from the State or its designee to verify that a quality review of the Level I screening has been completed accurately and prior to admission. If the Member is deemed to meet nursing home admission criteria, the Care Coordinator will request Level I results to make sure that all PASRR requirements have been met. For example, in the event that a Member with I/DD or SPMI is approved for admission, a Level II evaluation will be triggered to identify needed specialized services. If we are unable to obtain a record of the Member's Level I screening, the Care Coordinator will work collaboratively toward accurate and timely completion as directed.

If a Member is unwilling to be admitted to a nursing facility, or if a facility plans to place a Member in a secure unit, we will reach out to the appropriate medical power of attorney, power of attorney, or current guardian. If there are none, we will collaborate with the facility to obtain a proxy for the Member and complete the paperwork. We will make sure that the SNF provides updates on Level I if any changes have occurred regarding status affecting SPMI or I/DD, a new diagnosis of SPMI or I/DD, signs of changes in Minimum Data Sets, and expiration of a time limited approval.

Complete PAS Level II Assessments

As a RAE, we offer experience establishing contractual agreements with nursing facilities. These agreements include compliance with federal and state regulations that require a Level II evaluation for all Members with I/DD or SPMI to make sure needed specialized services are completed as part of the preadmission screening. For all other Members suspected of having a diagnosis of I/DD or SPMI post-admission, or who have experienced a change in conditions, a PAS Level II assessment will be completed to identify and address specialized needs.

CCHA *Plus* will implement an established protocol to accept and respond to all Level I updates, and assess for any Level II assessments that need to be completed, within 3 business days of receiving the Level I update. If a Level II assessment is needed, we will:

- Aid in determining the necessity of a Level II assessment, including analysis of exemption factors outlined by the Department
- Assure an accurate, comprehensive desk review and perform face-to-face interviews to complete the assessment, using our staff members established in hospitals to aid communication between referring and accepting agencies
- Arrange for a developmental disability determination for Members identified as possibly having an I/DD but with no prior history of a determination
- Include assessments for all community-based alternatives prior to considering SNF placement and request any additional information needed from State agencies
- Coordinate care with the CCBs and CMHCs for those individuals who have developmental disabilities or mental illness to verify that proper recommendations are provided and implemented in the SNF
- Maintain deadlines for PAS Level II by bridging communication gaps between the referring agencies and admitting facilities through completion of the Level II review and timely update of the system
- Complete and submit all reviews, including face-to-face interviews, within 9 days from the date of referral
- Collaborate with authority agencies to complete an assessment review and provide a determination letter stating services to be implemented upon admission
  - If the Member requires specialized services, we will assist the individual and family in finding an appropriate care management agency to address needed services
- Support the facility to see that needed services are in place and communicate what agencies are involved in the Member's care, keeping track of the location and outcome of Members who had a PAS Level II assessment

Coordinate Care Planning and Ensure Continuity of Care

CCHA *Plus* Care Coordinators will engage in continuity of care planning to facilitate Members' access to the services they need, when they need them, and in the setting they choose. When a Member either chooses or requires the care of a nursing facility, intermediate care for the I/DD, or a psychiatric residential treatment facility, the Care Coordinator will work to facilitate a seamless transition to the facility. Our Care Coordinators will see that a pre-admission care plan is established through collaboration between the nursing facility, and as applicable, the Case Management Agency and mental health center. The care plans will include any specialized services and how they will be provided, as well as plans for continuity of care if required. We will obtain approval from the State Mental Health Authority or State Intellectual Disability Authority and coordinate with the SNF if any revisions are needed. To assist Members needing long-term institutional care, we will leverage our existing partnerships with local Area Agencies on Aging, using them as a gateway to coordinate completion of the PASRR.

When a Member transfers from another RAE, we will collaborate to include mental health centers, case management agencies, I/DD service providers, and State authorities. Our Care Coordinators will work to make sure that any revisions are implemented and provide a final Level II assessment for all Members transferring to another RAE.

Assure Resident Review for Status Change

As stated above, as part of the process for Level I and Level II assessments, we will make sure that the SNF provides updates on Level I if any changes have occurred regarding status affecting SPMI or I/DD, new diagnosis of SPMI or I/DD, signs of changes in Minimum Data Set, and expiration of a time limited approval. We will implement an established protocol to accept and respond to all Level I updates, and assess for any Level II assessments that need to be completed, within 3 business days of receiving the

Level I update. We will work closely with the SNFs to ensure they are educated about the process for completing and submitting a Level I update resident review.

Oversee Quality and Compliance

CCHA *Plus* has administrative and quality assurance oversight processes in place to promote conflict-free Care Coordination in accordance with State and federal regulations. We will maintain appropriate oversight, including review of all PAS reviews to confirm that referring agencies are complying with the PASRR program. In performing oversight of the PASRR process, we will leverage CCHA's experience with oversight of Region 6 Network Providers, including conducting audits and desk reviews. To monitor the quality of all PAS reviews and see that referring agencies are complying with the PASRR program, we will:

- Complete desk reviews on all PAS assessments, regardless of level, to verify compliance
- Work with the Department, SNF, and referring agencies on any noncompliance concerns
- Review findings with the State Mental Health Authority and the State Intellectual Authority
- Implement a corrective action plan (CAP), when appropriate, with the entity and the Department to address concerns, and provide education and technical assistance to address compliance issues, as well as follow up with the referring agency once the terms of the CAP have been met
- Serve as a liaison between the Department and identified entities on the status of the CAP and when its terms and conditions have been met
- Maintain records of non-compliance and enter all CAPs and corrections into management information system

With the experience Anthem and CCHA bring working with Members receiving LTSS and BH services, as well as our strong partnerships within the Health Neighborhood, including SNF, long-term care, and hospital facilities, we believe CCHA *Plus* is well-positioned to manage the PASRR process. Members deserve a straightforward and efficient PASRR process, where Providers and CCHA *Plus* collaborate closely to conduct assessments, empower Members and their families or caregivers to participate in care planning, ensure Members receive the services they require, and see that Members are placed in the least restrictive setting possible. Our provider partners have given us specific feedback on how to improve their experience and agree with the suggestions we have provided above. We look forward to working with Members, the Health Neighborhood, and the Community to meet the three goals of PASRR:

- Identify individuals with SPMI, I/DD, or both
- See that individuals are placed appropriately, whether in the community or a nursing facility
- Make sure that individuals receive the appropriate services for their diagnoses in the setting where they reside

In addition to working with provider partners to improve the process, we are committed to collaborating with the Department to meet expectations.

CCHA *Plus* Will Meet All Section 6.4 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 27, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.4 that are not detailed in our response.

Section 6.5

COLORADO COMMUNITY HEALTH ALLIANCE

Brokering Of Case Management Agencies

6.5 BROKERING OF CASE MANAGEMENT AGENCIES

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.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

CCHA *Plus* is able and willing to perform the work described in the proposed Brokering of Case Management Agencies scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

We know very well the important role Case Management Agencies (CMA) play in helping Members choose the providers they want and receive the supports and services they need. Both CCHA and Anthem have partnered closely with CMAs locally and in other states to assist them with the important responsibility of connecting Members with high-quality services and supports and constantly monitoring their health, safety, and welfare. Serving as the Region 6 RCCO for the past 6 years, CCHA and its Care Coordinators have gained valuable experience helping Members navigate the LTSS system and receive the services they need. As a RAE, CCHA *Plus* welcomes the opportunity to take this work a step further by providing person-centered counseling to help Members make an informed choice in selecting the CMA that best fits their needs.

We understand the regulations issued by the Centers for Medicare and Medicaid Services (CMS) and House Bill 15-1318, which required the Department to develop an implementation plan to deliver conflict-free case management to Members. We look forward to partnering with the Department, Single Entry Points (SEPs), Community Centered Boards (CCBs), and other stakeholders to execute the plan and provide person-centered counseling to help Members select the CMA that best fits their needs.

We recognize that implementing the new conflict-free case management system will impact Members who might need to change their CMAs. Our Care Coordinators will apply a person-centered approach to help Members select a new CMA. We will work diligently with our CMA partners to make the transition as seamless as possible without disruption in services as Members' needs continue to be met.

Providing Person-Centered Counseling for Choosing a CMA and Referring Members to a CMA

CCHA *Plus* offers vast experience working with Members receiving Long Term Services and Supports (LTSS) and the Network Providers that serve them. As a RAE, we will bring Anthem's direct experience administering LTSS services to Medicaid Members in 9 states. More than 295,000 Members enrolled in these programs have access to a range of LTSS that include both 1915(c) waiver and state plan LTSS, such as personal care. In addition, as a current RCCO, CCHA has worked closely with Members receiving LTSS and their family members/caregivers to help Members self-direct their care and get access to the services they need in the least restrictive setting possible.

Many activities CCHA currently undertakes on behalf of ACC Members align with the Department's expectations for brokering of CMAs. Today, CCHA Care Coordinators help Members receiving CMA services in the following ways:

- Providing person-centered care coordination, meeting Members where they are — whether in the home, at a facility, or in the community
- Filling out LTSS paperwork (waiver applications)
- Helping Members understand their benefits, determine their health needs, and establish their own health and wellness goals
- Connecting Members to CMAs and transitioning Members who choose a new provider
- Outreaching CMAs to set up meetings and connect Members to services
- Using the Department's case management software
- Providing disability-competent care training for CCHA Care Coordinators and other staff members
- Transferring Members and responsibilities between RCCOs
- Taking a neutral approach to helping Members understand their options and right to choose
- Establishing and transmitting referral protocols
- Communicating with Members, both verbally and in writing
- Administering Member satisfaction surveys
- Assuring network adequacy to meet a continuum of services and supports
- Assessing providers to identify conflicts of interests

The experience of CCHA and Anthem in helping Members self-direct their care and select the right providers for their needs equips us well to broker CMA services for Members. In addition to the above activities that CCHA Care Coordinators currently do to assist these Members, CCHA *Plus* Care Coordinators will clearly explain the choice process to Members, including their right to choose at any time, and explain our role as an unbiased broker. If Members do not have a preferred CMA, Care Coordinators will review the options with them and honor their choice as long as it complies with conflict-free case management requirements. This will include assisting a Member or their designated representative with scheduling interviews with CMAs to help make an informed decision.

Referring Members to a CMA

We will work with our CMA partners to implement the Department's referral protocols according to requirements in Section 6.5.3 to connect Members to a CMA of their choice. To avoid a conflict of interest, our protocols will include confirming that the CMA does not also provide HCBS direct services for the referred Member. Within 2 business days of making a referral, we will follow up with the CMA to ensure they have received the information and are connecting with the Member. We will also send a letter to the Member 6 months after referral to get feedback on satisfaction of the CMA services, remind them of their right to switch to a different provider, and include an updated CMA list.

Provider Testimonial

Collaborative home visits are beneficial to Members because they are able to tell their story and share their challenges and needs to both Jefferson County OLTC and CCHA Care Coordinators at the same time. By having both Care Coordinators at the visit, the professionals are able to brainstorm the best resources, each pulling from their respective areas of knowledge and experience. The result is a more robust conversation with the Member about the best Member supports, a more comprehensive assessment of needs, and ultimately, better Member outcomes.
Karin Stewart, Jefferson County Options for Long Term Care

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Maintaining an Adequate Network of CMAs

CCHA *Plus* is familiar with the LTSS system locally and nationally, and we have proven through the existing work of CCHA and Anthem that we can build partnerships with CMAs and offer Members Team-based Care. We are confident in our ability to provide Members with open and informed choice from at least 3 CMAs in urban areas and 2

CMAs in the areas that are rural. We will maintain a list of available CMAs in the region that includes a summary of qualifications and expertise of each, as well as notes regarding other services they provide that may conflict with unbiased case management.

CCHA currently has strong partnerships with the 4 CMAs in Region 6, including Adult Care Management, Inc. (ACMI), Developmental Disabilities Resource Center (DDRC), Imagine!, and Jefferson County Options for Long Term Care (OLTC). Formal agreements with each CMA enable bi-directional sharing of data so CCHA Care Coordinators and agency case managers may communicate about common Members. They have also established bi-directional referral processes to streamline access to one another's programs and defined their roles to avoid duplication of services, ultimately improving the experience for the Member. CCHA has identified a single point of contact at each Region 6 CMA to reduce barriers to making referrals, resolve difficult situations, and case conference when helpful.

Additionally, CCHA has engaged in creative ways to improve collaboration among CCHA Care Coordinators and SEP/CCB case managers. In the last year, CCHA initiated luncheon 'meet and greets' between the Care Coordinators and SEP/CCB case managers to help educate and build relationships so they can work together seamlessly to improve Member experience. In fact, CCHA Care Coordinators are currently conducting Member home visits alongside SEP case managers.

This successful model has resulted in collaboration and improved education on the roles of various organizations serving the LTSS population. Brokering of case management will enable us to apply our experience working with CMAs to establish an adequate network of providers, help Members make an informed provider choice, and continue our efforts to achieve an integrated, team-based, person-centered LTSS system.

Aligning Activities with State Systems

CCHA *Plus* supports the No Wrong Door project as an excellent opportunity to improve communication among LTSS entry point agencies. We wholeheartedly believe in this concept's driving principals, and CCHA is already working successfully with SEPs, CCBs, and other LTSS providers and stakeholders in Region 6 to create a common entry point for Members and see that they receive timely, consistent information.

CCHA is currently an active participant in the Boulder No Wrong Door Task Force. The mission of this task force is to facilitate access to LTSS in Boulder County by creating streamlined referral processes, educating those making the referrals, staying mindful of changing landscapes, planning in a way that is sustainable, and using resources efficiently. CCHA was also heavily involved in pursuing the No Wrong Door grant opportunity with a strong group of Jefferson County organizations. While that group did not ultimately submit a bid for the No Wrong Door contract, CCHA continues to work with the LTSS partners there to improve coordination and collaboration on behalf of Members.

These formal partnerships with CMAs and participation in No Wrong Door projects has significantly improved the coordination of LTSS with Members' physical and behavioral health needs, and has also helped close the feedback loop on referrals and foster continuity of care.

CCHA *Plus* supports the Department's transition to conflict-free case management, and we will adjust our activities to support the transition during each phase of implementation. Throughout the Department's implementation plan, we will support CCBs to transition Members to other service providers or to other case management services. We will facilitate conversations with Members to assist with transition services as outlined in the Department's implementation plan to fully convert to conflict-free case management for all Members. During the planning, design, and implementation processes, we

will support our Members during each step — from initial identification of those with case management and service conflicts through the final transition phases and the post-survey process.

Through our quality assurance processes, we will monitor the delivery and quality of services and supports, the health safety and welfare of Members, and their satisfaction with services and choice of service provider. We will help the Department monitor CMAs through their quality assurance functions, and will participate in CMA human rights committees, provide oversight and hold ultimate responsibility for review and resolution of any Member's complaints to the CMA, develop a Quality Improvement Strategy for activities and reporting, and investigate allegations of mistreatment, abuse, neglect, or exploitation.

CCHA *Plus* Will Meet All Section 6.5 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 28, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.5 that are not detailed in our response.

Section 6.6

COLORADO COMMUNITY HEALTH ALLIANCE

Health Information Exchange Connectivity Assessment

6.6 HEALTH INFORMATION EXCHANGE CONNECTIVITY ASSESSMENT

OFFEROR'S RESPONSE 29

Provide a positive statement attesting to the Contractor's willingness and ability to perform the work described in the proposed Health Information Exchange Connectivity Assessment scope of work and negotiate with the Department in good faith, provided existence of appropriate funding.

***CCHA Plus** is one unified entity established solely to promote the physical and behavioral health of ACC Members. Our foundation is **CCHA**, a peak performing RCCO with deep local roots including local primary care doctors, specialists, and the largest hospital system in Colorado. To CCHA, we add **Anthem**, an organization known for its evidence-based practices in delivering integrated physical health and behavioral health to Medicaid members across the country. Together we make **CCHA Plus**: one accountable entity that is Colorado based, because health care is local, and driven by evidence-based approaches to keep up with the evolving health care system.*

Over the last 6 years as a Regional Care Collaborative Organization (RCCO), CCHA has leveraged the experience and subject matter expertise of managing partner Physician Health Partners (PHP) in helping primary care providers understand the importance and benefit of electronic health records (EHRs) and the health information exchange (HIE). For example, CCHA worked closely with the Colorado Regional Health Information Organization (CORHIO) and other HIE partners across the State on the Regional Extension Center (REC) national grant program. As a result, Colorado became a leader in this program, which was led by the Office of the National Coordinator for Health Information Technology. Through the REC program, CCHA was able to train other key staff in areas of health information technology system selection, implementation, and best practices. Today, this REC work continues beyond the grant funding to make certain that adoption of technology systems does not stop with the EHR and Meaningful Use.

CCHA took an early, active role with CORHIO to provide funding to cover EHR implementation costs to the HIE, as well as ongoing monthly fees for all Network Providers. There were many discussions with community hospital partners to confirm that PCMPs would not be alone in the decision to move forward with HIE. Many large hospitals in Colorado connected to CORHIO as a result of these discussions and the success of PHP and CCHA in implementing PCMP with CORHIO.

Today, CCHA and PHP are participating in several national and State initiatives, such as the Medicare Shared Savings Program, Colorado State Innovation Model (SIM), EvidenceNOW Southwest, and Comprehensive Primary Care Plus. Data has been successfully exported from individual practice EHRs to meet reporting requirements for each of these programs. In addition, CCHA has helped support the Accountable Care Collaborative (ACC) Network Providers in adopting HIE. As explained further in OR 17, the CCHA Provider Support Program has provided extensive support around EHR adoption and HIE. As we move into the next phase of the program, CCHA *Plus* will continue this support.

In early 2017, CCHA partnered with the Department to conduct the first HIE Connectivity Assessment of ACC Program contracted practices in Region 6; they also took an active role in providing guidance to the Department during development of the initial assessment questionnaire. CCHA created practice scope deliverables and delivered them to the Department on time. Some highlights of this partnership thus far with the State include:

- Assisting the Department in developing the assessment tool and practice questionnaire for barriers with EHRs and HIE connectivity

- Testing new methodologies for assessment, including an online tool
- Developing a sophisticated deliverable for reporting assessment information across practices that includes provider-specific information, statistics on connectivity across the region, and visual depictions of assessment results (a template was offered to other RCCOs for their use in reporting to the State as well)
- Coordinating with other RCCOs, as well as the SIM office, to make sure practices were not contacted by more than one entity to be assessed
- Leveraging the CCHA SIM Clinical Health Information Technology Specialist (who is already in the region's ACC PCMP practices providing technical assistance) to help with adoption of clinical health information technology for the HIE Connectivity Assessment

As 1 of only 2 participants conducting the 2017 HIE Connectivity Assessment and also participating in the SIM, CCHA has staffed a Clinical Health Information Technology Specialist who coordinates SIM practice assessments and tests new methodologies, such as the online assessment tool, with the Department.

CCHA *Plus* recognizes the immense value of this role in primary care, and we understand that practices serving Colorado Medicaid Members must adopt EHRs and connect to an HIE to provide a Medical Home-level of care. PHP is a local leader in helping more than 400 PCMPs use sophisticated tools to deliver care that reaches the Quadruple Aim. We will draw on this experience, as well as CCHA's recent experience partnering with the Department, to conduct the first HIE Connectivity Assessment of Network Providers and continue to deliver this assessment and report findings to the Department annually. We are excited to use the results of the assessment, in partnership with the Department, to help more practices adopt EHRs and connect to an HIE.

We applaud CORHIO's recent achievement of reaching 10,000 users, including physicians, nurses, care coordinators, office administrators, BH Providers, emergency rooms, and others to access health information in real time. To support continued growth and evolution of the HIE across Colorado's system of care, we will employ the HIE Connectivity Assessment to understand Providers' readiness and baseline system capability to connect to the HIE. Based on findings, we will work collaboratively with Network Providers to address barriers to connecting to the HIE. We will continue to work with the Department and other stakeholders to create, leverage, and extend the reach of informational communication techniques that deliver a consistent message to Network Providers, encouraging the benefits of EHRs and data sharing through the HIE. This includes continuing ongoing CCHA efforts to incent EHR adoption:

- Employing Practice Transformation Coaches who are regularly in the practices and meet with Network Providers to offer face-to-face training, assistance, and technical support
- Hosting webinars, video-based training, and information sessions
- Partnering with experienced Network Providers who have already adopted EHRs and use HIE services to serve as Physician Champions and help connect new Providers
- Offering incentives, such as an annual award, to recognize Network Providers who demonstrate effective use of EHRs to improve quality scores

CCHA *Plus* is excited to have the opportunity to build upon and continue this work, which includes the delivery of the HIE Connectivity Assessment annually.

CCHA *Plus* Will Meet All Section 6.6 Requirements

In addition to detailing how CCHA *Plus* will meet the requirements that address OR 29, we also affirm that CCHA *Plus* will comply with all the requirements listed in Section 6.6 that are not detailed in our response.

Technical Proposal Attachments

COLORADO COMMUNITY HEALTH ALLIANCE

Attachment 4.2-1

COLORADO COMMUNITY HEALTH ALLIANCE

Letters of Support

Attachment 4.2-1a

COLORADO COMMUNITY HEALTH ALLIANCE

Community Partners

Attachment 4.2-1a: Community Partners

This section includes Letters of Support from the following Community Partners:

- A Precious Child
- Action Center The
- Adams County Human Services
- Adult Care Management, Inc.
- Amberwood Court Care Center
- Arapahoe House
- Benefits in Action
- Boulder County Public Health
- Boulder Valley School District
- Broomfield Early Childhood Council
- Brothers Redevelopment
- Clear Creek County
- Clutter Trucker
- Complete Home Health Care
- Developmental Disabilities Resource Center
- DispatchHealth
- Dominican Home Health Agency
- Eaton Senior Communities
- Emerald Elementary School
- Epic Health Services
- Family Tree
- Intervention Community Corrections Services – Kendall
- Intervention Community Corrections Services – West
- Jefferson County Aging Well Project
- Jefferson County Head Start
- Jefferson County Human Services
- Jefferson County Options for Long Term Care
- Jefferson County Public Health
- Laurie Fowler, Trainer High Fidelity Wraparound
- Mann Method Physical Therapy and Fitness
- Metro West Housing Solutions
- Mile High Health Alliance
- Mount Evans Home Health Care
- Nurturing Newborns
- Prime Health
- Rocky Mountain Children's Health Foundation
- Rocky Mountain Crisis Partners
- Sensory Parenting
- UnitedHealthcare

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July 1, 2017

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

Dear Ms. Miller:

The Action Center is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA has partnered with The Action Center to provide Thanksgiving meals for more than 3,000 families in Jefferson County. Additionally, CCHA staff have volunteered to pack school supplies, work in our grocery store, sort clothing, and pack Thanksgiving food boxes. And, a CCHA Health Partner is co-locating at the Action Center one day a week. We believe this collaboration will provide additional services, particularly in the access of health care services, that our clients so desperately need.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Mag Strittmatter
Executive Director,
The Action Center, Inc.

Human Services Department
Children and Family Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

7401 North Broadway
Denver, Colorado 80221
PHONE 303.412.8121
FAX 303.412.5335

July 11, 2017

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

Dear Ms. Miller:

Adams County Human Services is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC). Colorado Community Health Alliance has served as a community consultant in our Permanency Roundtable meetings. A Permanency Roundtable is a professional consultation on a youth's case who has been in out of home placement for over a year or who has been assigned a permanency goal of Other Planned Permanency Living Arrangement. Permanency Roundtables are a structured, in-depth meeting process developed to meet the goals of: increasing the number of youth's permanent connections, expediting permanency for children and youth, stimulating thinking and learning about new ways to accelerate permanency and Identifying and addressing systematic barriers to timely permanency.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jennifer Alvarado

Jennifer Alvarado, MA, LPCC, NCC
Adams County Department of Human Services
Permanency Round Table Coordinator/Facilitator

Arapahoe House

Comprehensive Alcohol, Drug and Behavioral Health Services

8801 Lipan Street ● Thornton, CO 80260 ● Main 303.657.3700 ● Fax 303.657.3727 ● ArapahoeHouse.org

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

Dear Ms. Rapp:

Arapahoe House is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

As the largest substance use provider in the state, Arapahoe House needs the support of the RAE to expand access to critically needed substance use services to Medicaid Members. We believe CCHA brings a fresh opportunity to make the best use of state resources and collaborate with Arapahoe House and the Managed Service Organizations to connect Members with substance use services quickly and efficiently. We look forward to a more streamlined administrative process with CCHA for delivering these much-needed services. We are happy to participate in their Health Neighborhood Advisory to strengthen coordination among providers and the community and to make recommendations on how best to invest RAE incentive payments in the community.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Mike Butler
President & CEO

BENEFITS IN ACTION
Education • Navigation • Application Assistance

30 June 2017

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

Dear Ms. Miller:

Benefits in Action is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

Benefits in Action is a local organization that provides education, navigation, and application assistance to adults throughout Colorado. As we enroll Coloradans in Health First Colorado, we educate them about the services of the Regional Care Collaborative that serves the county in which they live. Working together with CCHA, we have been able to ensure that our clients are assigned to a primary care provider and that they receive the services appropriate to their need for care. Additionally, we work together with CCHA to ensure that our clients also receive any community supports for which they are eligible.

CCHA's Health Partners provide exceptional service to Health First Colorado members. Health Partners have a great understanding of the communities they serve, are willing to spend time with individuals to ensure they receive the services they need, and have been very effective in attaining specialty appointments for our clients that need them.

We whole-heartedly support CCHA as the continues Accountable Care Organization for Region 6! As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. CCHA's work in the community has brought together groups of stakeholders to work together for common goals.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Laura Boggs
Chief Operating Officer
Benefits in Action

8725 W 14th Ave, Suite 102, Lakewood, CO 80215 *720-221-8354* *www.benefitsinaction.org*

May 28, 2017

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

Dear Ms. Miller:

Boulder County Public Health (BCPH) and the Boulder County Department of Housing and Human Services (BCDHHS) are excited to work closely with whoever is selected for the Region 6 Regional Accountable Entity (RAE). Our commitment to finding ways to collaboratively improve health outcomes, reduce costs, and increase quality in our communities is part of our mission and vision at Boulder County, and we will be an active participant with whoever is chosen to lead the effort.

We have been working with the Colorado Community Health Alliance (CCHA) during the last year on ways to improve the lives of our clients who are served in the Region 6 Regional Care Collaborative Organization (RCCO). A few of those examples include:

- We developed a data sharing agreement so we can cross reference clients within the RCCO that are receiving, or need services, within our safety net system.
- We continue to look for opportunities to improve client services.
- CCHA has committed to supporting one-year funding for BCPH, and we are working with CCHA to develop a contract between CCHA and BCPH to provide services to our pregnant and parenting teen clients.
- BCPH is participating on CCHA's Health Neighborhood Advisory Committee.

We have appreciated a closer working relationship with CCHA during the last year, and are enthusiastic about the positive opportunities we will have in Accountable Care Collaborative 2.0. We look forward to working with the successful incumbent as a partner in serving the Colorado Medicaid population in Region 6!

Sincerely,

DocuSigned by:
Jeff Zayach
E95D96BCC6B7498...
Jeff Zayach, MS
Executive Director
Boulder County Public Health

DocuSigned by:
Frank Alexander
EE05E7CE8E614F2...
Frank Alexander, MPA
Executive Director
Boulder County Department of Housing and Human Services

Boulder Valley School District
Excellence and Equity

School Medicaid Office
6500 E. Arapahoe Road
Boulder, Colorado 80303
Office: 720-561-5571

May 23, 2017

Sarah Miller

Colorado Department of Health Care Policy and Financing

Purchasing and Contracting Services Section

1570 Grant Street

Denver, CO 80203-1818

Dear Ms. Miller:

The School Medicaid Department of Boulder Valley School District is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. We have partnered in many aspects to provide services to children in our region.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Elizabeth Clark MSN RN NCSN

Elizabeth Clark MSN RN NCSN

School Medicaid Coordinator

BROOMFIELD
Early Childhood Council
PO Box 573 | Broomfield, CO 80038 | www.broomfieldecc.org | info@broomfieldecc.org

May 19, 2017

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

Dear Ms. Miller:

Broomfield Early Childhood Council is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

Broomfield is historically a county with limited resources within the county proper. Therefore, having CCHA to support the access to different resources across counties is instrumental in achieving improved health outcomes and success for our families and children.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jessica Jones, MBA
Council Director
Broomfield Early Childhood Council

June 14, 2017

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

Dear Ms. Miller:

Brothers Redevelopment Inc. (BRI) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

BRI is a longstanding and reputable non-profit that provides housing and housing related services in the metro area. Because housing is a social determinant of health, which means it is an underlying, contributing factor to health outcomes, CCHA has made great strides in building a collaborative relationship in bringing the community together to expand access to services and improve coordination of care to treat the whole person.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jeff Martinez
President
Brothers Redevelopment

Clear Creek County
POST OFFICE BOX 2000
GEORGETOWN, COLORADO 80444
TELEPHONE: (303) 679-2300

July 13, 2017

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

Dear Ms. Rapp:

Clear Creek County is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to continue serving as the Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Medicaid members in region 6, CCHA has been an invaluable partner to our county and the approximately 1175 men, women and children who are eligible and enrolled in Medicaid programs and services. Since its inception in 2011, CCHA has helped to improve access to basic care as well as providing care coordination; a difficult feat at times for our county residents who have been without Primary Care since October of 2011.

Clear Creek County will achieve the perfect platform for health care when "Centura Health Care" opens its doors on July 17, 2017. CCHA generously provided financial support as we pursued our dream to bring quality sustainable health care back to our communities. Access to local health care and our continued relationship with Colorado Community Health Alliance's numerous partners gives us the ability to coordinate care in order to treat the "whole person".

Clear Creek County is looking forward to our continued association with Colorado Community Health Alliance. Through this partnership we have accomplished a great deal, but there is much more to do. A continuous positive presence in our communities by CCHA's partners as well as the support of Elizabeth and her staff is critical as we move forward. Our county will continue to look to Colorado Community Health Alliance for their focused community involvement and for additional collaborative relationships.

Sincerely,

Clear Creek Board of County Commissioners

Timothy J. Mauck

Randall Wheelock

Sean Wood

"Honoring Our Past, While Designing Our Future"

May 17, 2017

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

Dear Ms. Miller:

DispatchHealth is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. We have been pleased to be working with CCHA on a project to reduce unnecessary Emergency Room utilization among CCHA members.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Dr. Mark Prather
CEO
DispatchHealth

dispatch™ HEALTH

303.500.1518 | INFO@DISPATCHHEALTH.COM | DISPATCHHEALTH.COM

DOMINICAN
Home Health Agency, Inc.

June 27, 2017

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

Dear Ms. Miller:

Dominican Home Health Agency (DHHA) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, DHHA believes CCHA will bring invaluable perspective, knowledge, and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to strengthen services for this vulnerable population. We are confident in their abilities to serve any of the Medicaid ACC regions.

DHHA is enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Daniel Grey

Daniel Grey, MS, RN
Administrator and Clinical Director
Dominican Home Health Agency, Inc.

2501 Gaylord St., Denver, CO 80205 • 303-322-1413 • www.dominicanhha.org

epic HEALTH SERVICES

06/09/2017

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

Dear Ms. Miller:

Epic Health Services located in Denver, Colorado is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

The care and compassion that CCHA has towards patients is apparent on a daily basis, and the patient's best interest is always their primary focus. As a homecare company, we work with many patients who do not have access to this program and see first hand the benefits this brings to the community.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Erica Wagner
RD/Client Relations Director
Epic Health Services – Denver, CO

3805 Marshall St., Suite 100
Wheat Ridge, CO 80033
(p) 303.422.2133
(f) 303.422.5707
www.thefamilytree.org

July 3, 2017

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

Dear Ms. Miller:

Family Tree, Inc. is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

At Family Tree we are excited to be exploring the possibility of working with CCHA to provide enhanced support and expertise for our clients through the utilization of CCHA's care coordination services and willingness to co-locate staff at our Women in Crisis domestic violence emergency shelter, as well as work with children and families in our Safe Care and Homelessness programs.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Scott Shields
Chief Executive Officer
Family Tree, Inc.

EMPOWERING CHANGE. TRANSFORMING LIVES.

Together we build the path to success!
Jefferson County Head Start

June 14, 2017

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

Dear Ms. Miller:

Jefferson County Head Start is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We have been working together with CCHA to provide services to the families of children in Jefferson County who attend our Head Start program. CCHA has a seat on our Health Advisory Committee and provides information to families who are Colorado Health First members.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cat Nash, RN

Cat Nash BSN, RN | Head Start Nurse
Jefferson County Department of Human Services | Head Start
5150 Allison Street | Arvada, Colorado 80002
720.497.7909 office | 720.898.0664 fax
http://jeffco.us/head/ | cnash@jeffco.us

JEFFERSON COUNTY COLORADO | Human Services
Steps to a better, safer life

Human Services
Director Lynn Johnson
303.271.1388 | jeffco.us
humanservices@jeffco.us

June 22, 2017

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

Dear Ms. Miller:

Jefferson County Human Services is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

CCHA and our Aging & Adult Services have a robust collaboration. Their care managers and our case managers conduct joint home visits with identified members, which is a great benefit to customers who need resources and supports beyond the scope of our Single Entry Point (SEP). We have conducted joint trainings and meet & greets with both of our full staffs, in order to build more collaboration. We have developed and diagramed effective processes so that we can streamline the referrals between our agencies.

Additionally, our manager sits on the CCHA Health Neighborhood Advisory Committee, and their Community Liaison sits on our SEP Community Advisory Committee. She participates in two Aging Well workgroups. Our manager attended their external audit to provide in-person feedback on the value and benefits of our collaborative efforts.

We work closely with CCHA to provide continuity of service to our community members. Our members are well served and receive needed services much more quickly.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we are supportive of continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Lynn Johnson
Executive Director
Jefferson County Human Services

900 Jefferson County Parkway, Golden, Colorado 80401

June 28, 2017

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

Dear Ms. Miller:

I am pleased to offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC). I have met with staff from CCHA on several occasions to discuss the High Fidelity Wraparound Model of intensive case management. We have agreed that the benefit to youth and families with complex needs within their service system would be of great benefit. I would be honored to train and coach the staff responsible for implementing the model with fidelity. A rigorous certification process is the result of the coaching.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Laurie Fowler Beckel

Laurie Fowler Beckel, MA/LPC, President
Laurie Fowler Beckel, PC
National Trainer and Coach of High Fidelity Wraparound

Mann Method
PT and Fitness, PLLC

8565 Five Parks Drive Suite 240
Arvada, CO 80005

June 15, 2017

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

Dear Ms. Miller,

My name is Sarah Mann. I am the owner of Mann Method PT and Fitness, PLLC in Arvada, CO. I have been a Medicaid provider since 2015. In my short time as a Medicaid provider – even prior to the March 1, 2017 changeover - I have encountered a variety of different patient issues, billing issues, and coverage questions. With each challenge, I have had the great opportunity to meet more of the individuals who truly keep Medicaid going to help our patients. Jillian White, and the team at the Region 6 Regional Care Collaborative Organization are some of the most helpful individuals I have had the good fortune to work with in the Medicaid system.

In January 2016, I had a prior authorization in place for a patient for physical therapy services, but for some reason, we could not get reimbursement for the PT services. Over the course of the year, my billing team and I could not figure out why Medicaid was not working for this patient. I spoke to people at HCPF, and I spoke to people at Xerox. I tried for 10 months to find someone to help me help this patient. It was not until October that a very circuitous route brought me through to Jillian White at the Region 6 Regional Care Collaborative Organization. Jillian and her team at the RCCO were outstanding. I felt like they mobilized every resource they could to reach out to the family, the providers, the ombudsman office, HCPF, and Xerox to truly get to the bottom of the issue. It turned out that there had been an accidental error on the system side that had retroactively cancelled my patient's Medicaid benefits. Because of the RCCO's advocacy for my patient, they were able to help get the error rectified and help her access her Medicaid benefits not only for PT, but also for serious medical issues that occurred a mere month later.

Because of the diligence, collaboration, professionalism, and perseverance of Jillian and her team at the Region 6 RCCO, we were able to truly serve the community. As a provider who has seen firsthand the exceptional level of service provided by this team, I full heartedly offer my support to the Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

If you have questions or would like to further discuss my very positive experience with this team, please reach out to contact me!

With thanks,

Dr. Sarah Mann, PT, DPT, MBA, NSCA-CPT
Mann Method Physical Therapy and Fitness, PLLC

8565 Five Parks Drive, Suite 240 | Arvada, CO 80005
Phone: 720.524.4659 | Fax: 303.256.0572 | sarah@mannmethodpt.com
www.mannmethodpt.com

Mile High Health Alliance

June 20, 2017

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

Dear Ms. Miller:

The Mile High Health Alliance is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity (RAE) for the next iteration of the Accountable Care Collaborative (ACC). The Mile High Health Alliance (MHHA) formally launched in 2015, one of the newest health alliances in Colorado, serving the City and County of Denver. The strong support and active participation of CCHA as a board and executive committee member has been instrumental to our success, and demonstrates one of the many ways in which they have formed important partnerships in the communities they serve.

MHHA members include 24 dues-paying organizations, as well as ex-officio members and interested individuals, who represent key healthcare and community leaders in Denver and throughout the surrounding metro area. Together we are building a strong cross-sector coalition focused on collaboratively solving the most urgent community-identified health challenges in our region for low-income residents: access to specialty care, high utilizers, and integrated care. These priority areas align closely with the role of the current Regional Collaborative Care Organizations (RCCOs) and future RAEs.

As the incumbent RCCO serving Health First Colorado members in Region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of its members. They have also made great strides in building 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.

We are enthusiastic about the positive impact of the work of CCHA and the ACC to date, as well as the HCPF's vision for the future of this program. As a partner of CCHA in working with low-income populations, we look forward to continued collaboration and combining efforts toward care transformation.

Please do not hesitate to contact me if you have any questions or would like additional information about the relationship and collaborative efforts between MHHA and CCHA.

Sincerely,

Dede de Percin
Executive Director

dede@milehighhealthalliance.org
303.503.2899

MOUNT EVANS
HOME HEALTH CARE & HOSPICE

3081 Bergen Peak Drive • Evergreen, CO 80439 • 303-674-6400 • MountEvans.org

June 12, 2017

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

Dear Ms. Miller:

Mount Evans Home Health & Hospice is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. Our social workers feel this partnership truly helps our patients.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Sallie Wandling, MSW
Sr. Director of Support Services
Mount Evans Home Health & Hospice
swandling@mtevans.org
303-674-6400

PRIME HEALTH

June 1, 2017

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

Dear Ms. Miller:

Prime Health is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. As a member of Prime Health's Safety Net Advisory Board, they have contributed to defining the key needs of underserved communities and barriers to implementation that exist in the adoption of digital health technologies. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Steve Adams
CEO
Prime Health

ROCKY MOUNTAIN
CHILDREN'S HEALTH
FOUNDATION.

June 15, 2017

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

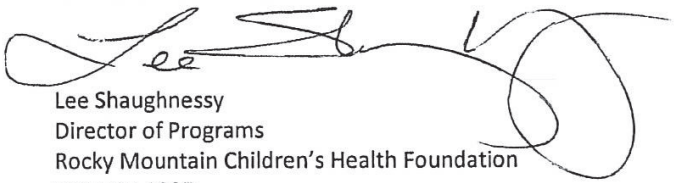
Dear Ms. Miller:

Rocky Mountain Children's Health Foundation is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships, including with our organization, and bringing the community together to focus on solutions for expanding access to services and improving coordination of care to treat the whole person.

We feel very happy to have met and begun work with many CCHA Health Partners, and we are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals. I hope that you will contact me with any questions about RMCHF's work with CCHA to improve the lives of pediatric patients and their families in our community.

With my sincere regards,



Lee Shaughnessy
Director of Programs
Rocky Mountain Children's Health Foundation
720-507-0907
Lee.shaughnessy@rmchildren.org

5394 Marshall Street, Suite 400, Arvada, CO 80002 | **Main:** 303.839.6782 | **Fax:** 303.839.6783 | **Web:** www.rmchildren.org

UnitedHealthcare
MEDICARE & RETIREMENT

July 13, 2017

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

Dear Ms. Rapp:

UnitedHealthcare has worked with Colorado Community Health Alliance's managing owner, Physician Health Partners (PHP), for 21 years in our Medicare Advantage products. Along with their primary care IPA clients, we delegate care coordination and medical management activities in a professional risk contract for nearly 30,000 AARP MedicareComplete Medicare Advantage members. PHP provides inpatient and outpatient care coordination, practice transformation, risk adjustment factor coding education, provider relations and network management, prior authorization and referral services, data and analytics support, open enrollment communications, and formerly processed and paid claims for this population. The primary care physicians coordinate outpatient behavioral health services utilizing the UnitedHealthcare Medicare Advantage network.

After two decades of working together in the Medicare Advantage sector, we look forward to continuing our strong working relationship.

Sincerely,

George Young
Colorado Health Plan CEO
UnitedHealthCare Medicare &Retirement

June 5, 2017

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

Dear Ms. Miller:

A Precious Child is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Courtney Wickberg
VP of Programs and Services
A Precious Child

APreciousChild.org | 303.466.4272 | 557 Burbank Street, Unit E | Broomfield, CO 80020

ACMI
Since 1986

Care Management for Seniors, Children, and Disabled Adults
"Providing Choices for Independence"

May 19, 2017

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

Dear Ms. Miller:

As the Single Entry Point agency administering the HCBS-EBD, HCBS-BI, HCBS-CMHS, HCA and Childrens' HCBS programs in Boulder, Broomfield, Clear Creek and Gilpin counties, Adult Care Management, Inc (ACMI) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Barb Wilkins- Crowder, Executive Director
bcrowder@acmicolorado.org
303-964-2441

1455 Dixon Ave Ste. 105 * Lafayette, Colorado 80026
Inquiries: 303.439.7011 * Fax: 866-931-0763

AMBERWOOD COURT
CARE CENTER

6/14/2017

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

Dear Ms. Miller:

Amberwood is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Ken Kerver
NHA
Amberwood Court a Vivage Community

Phone: 303.756.1566 | Fax: 303.756.5261
4686 East Asbury Circle | Denver, Colorado 80222

June 1st

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

Dear Ms. Miller:

Clutter Trucker is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jennifer Hanzlick

Jennifer Hanzlick
President
Clutter Trucker
info@cluttertrucker.com
www.cluttertrucker.com

Complete Home Health Care

June 6, 2017

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

Dear Ms. Miller:

Complete Home Health Care is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cathy Kaufman
CEO, President
Company/Organization>Complete Home Health Care, LLC.

Developmental Disabilities Resource Center

D D R C

Helping PEOPLE with intellectual and developmental disabilities….

11177 W. 8th Avenue, Suite 300 Lakewood, CO 80215-5503 303.233.3363 FAX 303.233.4622 www.ddrcco.com

May 23, 2017

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

Dear Ms. Miller:

Developmental Disabilities Resource Center (DDRC) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings experience, knowledge and proven success with managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of care.

We are enthusiastic about the positive work that the CCHA has accomplished and how we can work together toward a shared vision for future health care coordination. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving mutual goals.

Sincerely,

Beverly Winters

Beverly Winters
Executive Director
Developmental Disabilities Resource Center

JEFFERSON COUNTY SUMMIT COUNTY CLEAR CREEK COUNTY GILPIN COUNTY

May 20, 2017

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

Dear Ms. Miller:

Eaton Senior Communities is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Kate West

Kate West
Resident Services Coordinator
Eaton Senior Communities

Emerald Elementary
755 W. Elmhurst Place
Broomfield, Colorado 80020
720-561-8500

Samara Williams
Principal

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

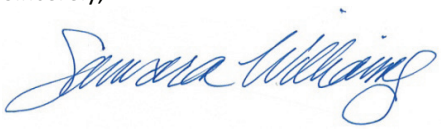
Dear Ms. Miller:

Emerald Elementary School is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,



Samara Williams
Principal
Emerald Elementary School

intervention
community
corrections
services

June 5, 2017

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

Dear Ms. Miller:

Intervention Community Corrections Services-Kendall is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cassi Sattazahn
Program Director
Intervention Community Corrections Services
1651 Kendall Street
Lakewood, CO 80214

intervention community corrections services
phone: (303) 232-4002 1651 kendall st. lakewood, co 80214 fax: (303) 232-4392

intervention
community
corrections
services

June 6, 2017

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

Dear Ms. Miller:

Intervention Community Corrections Services-West is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Kristin Heath
Program Director
Intervention Community Corrections Services
11500 W Security Ave
Lakewood, CO 80215

intervention community corrections services
phone: (303) 407-6200 11500 w. security ave. lakewood, co 80215 fax: (303) 407-6201

June 7, 2017

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

Dear Ms. Miller:

Jefferson County's Aging Well Project is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Karin Stewart

Karin Stewart
Project Coordinator
Jefferson County Human Services, Aging Well

900 Jefferson County Parkway Golden, Colorado 80401
303 271 1388 http://jeffco.us

Jefferson County
Human Services
Steps to a better, safer life

Community Development & Criminal Justice Planning
Children, Youth & Families
Workforce Development
Community Assistance
Justice Services
Head Start

June 7, 2017

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

Dear Ms. Miller:

Jefferson County Options for Long Term Care is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Karin Stewart

Karin Stewart
Program Manager
Jefferson County Human Services, Options for Long Term Care

900 Jefferson County Parkway Golden, Colorado 80401
303 271 1388 http://jeffco.us

metrowest HOUSING SOLUTIONS

June 5, 2017

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

Dear Ms. Miller:

Metro West Housing Solutions is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Daniela Dillon
Resident Services Supervisor
Metro West Housing Solutions

Alternative Formats of this Document are Available Upon Request

575 Union Boulevard, Suite 100 ◄ Lakewood, Colorado 80228
303-987-7580 ◄ Fax: 303-987-7693 ◄ www.mwhsolutions.org

Nurturing Newborns and Families

June 21, 2017

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

Dear Ms. Miller:

Nurturing Newborns is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Susan K. Huebner

Susan Huebner
Owner/Operator
Nurturing Newborns, LLC

ROCKY MOUNTAIN
CRISIS PARTNERS
.....leaders in 24/7 support

June 5, 2017

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

Dear Ms. Miller:

Rocky Mountain Crisis Partners is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Bev Marquez
Chief Executive Officer
Rocky Mountain Crisis Partners

PO Box 460695, Denver, CO 80246 Business: 303.928.7100 Crisis Line: 1.844.493.TALK www.RMCrisisPartners.org

6/27/17

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

Dear Ms. Miller:

Britt Collins, Occupational Therapist is pleased to offer support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Britt Collins M.S. OTR/L

Britt Collins M.S. OTR/L
Sensory Parenting
www.sensoryparenting.com

Jefferson County Public Health
jeffco.us/public-health

June 19, 2017

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

Dear Ms. Miller:

Jefferson County Public Health (JCPH) looks forward to working closely with the Colorado Community Health Alliance (CCHA), or whomever is selected for the Region 6 Regional Accountable Entity (RAE). We are committed to working collaboratively to find ways of improving health outcomes, reducing costs and increasing the quality of healthcare services in our community. We realize that selecting the RAE is a competitive process, and as a governmental agency we will actively participate with whomever is chosen to lead this work in our region.

Over the past year we have significantly improved our working relationship with the CCHA, and believe that the clients and residents who live in Region 6 and are served by the Regional Care Collaborative Organization (RCCO) have seen real improvement in their lives as well. We have joined CCHA's Health Neighborhood Advisory Committee, and have a strong memorandum of understanding by and between our organizations whereby we have a data sharing agreement for protected health information to help us each better coordinate and serve the health needs of our clients.

We are excited about the possibilities that exist under the Accountable Care Collaborative 2.0, and we look forward to working closely with CCHA if they are successful in their application to become the RAE for Region 6 as we partner to serve the Colorado Medicaid population in Jefferson County!

Sincerely,

Mark B. Johnson, MD, MPH
Executive Director
Jefferson County Public Health

Mission: Promoting and protecting health across the lifespan through prevention, education, and partnerships.

Lakewood Offices/Clinic	645 Parfet Street	Lakewood, CO 80215	phone: 303.232.6301	fax: 303.239.7088
Environmental Health	645 Parfet Street	Lakewood, CO 80215	phone: 303.232.6301	fax: 303.271.5760
Vital Records	800 Jefferson County Pkwy	Golden, CO 80401	phone: 303.271.6450	fax: 303.271.6451

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Attachment 4.2-1b

COLORADO COMMUNITY HEALTH ALLIANCE

Members

Attachment 4.2-1b: Members

This section includes Letters of Support from the following Members:

- Bruce Gorman
- Carrie Hauptman
- Carrie Hullett
- Cathy Duffy
- Dana Ann Wallingford
- Debra Blessinger
- Debra Schramm
- Diane Dworkin
- Diane Smith
- Erin Zalesky
- Gaylene Lopez
- Gail Johnston
- Gilbert Granado
- Jennifer Remington
- John Velasquez
- Kacie Krug
- Kathleen Rogge
- Kelly Bethurem
- Marie Updike
- Melissa Porter
- Michael Powell
- Michelle Finney
- Nicole Stinson
- Sarah Cleary
- Savannah Croy
- Shondra Baublitz
- Yvette Poirier

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June 14, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since September 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped my father by advocating for his medical needs, assisting our family with locating a skilled nursing facility for respite care, setting up a meal delivery service and collaborating with all of the agencies involved in our family's life. The Health Partner has also assisted us with various community resources. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Bruce Gorman, son to CCHA Member Ryan Gorman

July 13, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with Michelle Blady with CCHA since February of 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care around my son's complex physical and behavioral health needs. This has made a huge impact on my son's overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Cathy Duffy
Current Mother CCHA Member

June 8, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since June 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with get connected with home health services that I needed, keep more regular appointments, and connect with resources . If it wasn't for working with my Health Partner, a lot of the things I'm doing and working on now wouldn't be happening. Working with my Health Partner has been awesome! This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Carrie Hullett Carrie Hullett 6-12-17
Current CCHA Member

06/12/2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 07/29/2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with getting Occupational Therapy in the home for Isaiah, his language therapy in the home. Getting the assessment done for getting his diagnosis has been a great help and will be of great help for him getting help at school in the following years. Getting help to get him funded for activities has also been helpful. The services have been a support to me as well as to Isaiah. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,
Carrie Hauptman

Carrie Hauptman, Grandmother of Isaiah Bradley
Current CCHA Member

June 26, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since December 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with being able to get off of meds and talking about the way I feel about the meds being not to strong and the support I like the way they helped me This has made a huge impact on my overall health and well-being. to feel good about myself too

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Debra Blessinger

Current CCHA Member

Debra Blessinger

June 28, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since January of 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care to address my physical and behavioral health needs. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Diane Dworkin

Diane Dworkin
Current CCHA Member

6-14-2017

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

Dear Ms. Miller:

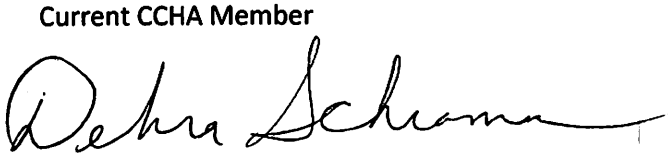
As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 04/2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with respite care, searching for supportive services and ABA therapy for my autistic son. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Debra Schramm
Current CCHA Member



June 13, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with Michelle Blady with CCHA since October of 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care around my behavioral and physical health needs. Michelle has been incredibly supportive for me emotionally and mentally. I am not sure what I would do without her. Michelle has gone above and beyond by helping me out with my mother's care even though it was not her responsibility. Also, she is always checking on me on a regular basis and providing support. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Diane (Laree) Smith
Current CCHA Member

722 Cardinal Dr
Lafayette, CO 80026
19 June, 3017

Sarah Miller
Colorado Dept. Health Care Policy and Financing
Purchasing and Contracting Services Section
1570 Grant St
Denver, CO 80203-1818

Dear Ms. Miller:

I am currently a Health First Colorado member, and have been receiving support from the Colorado Community Health Alliance (CCHA) since April of this year. Ms. Diana Lin in particular has been most helpful to me in working with my medical provider, Health First Colorado, as well as most-recently with your department. She and I are hopeful for a positive outcome in providing the medical services I require.

I have been very impressed with the personal service I have received while working with CCHA. Ms. Lin has been quite proactive in her approach to my issue, and has been very dependable in staying in contact, and with keeping me apprised of progress. It pleases me to have the opportunity to offer my support to CCHA, as they work to continue serving as the Regional Accountable Entity (RAE). I am hopeful that they may be able to continue to offer their high-quality services going forward.

Thank you for considering my personal experience with CCHA as you move toward making a decision regarding the RAE appointment.

Sincerely yours,

Dana Ann Wallingford

Dana Ann Wallingford

June 9, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since February 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with getting my son into therapy, obtaining durable medical equipment not covered by insurance which was recommended by my son's occupational therapist and has provided my family with community resources . This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Erin Zalesky, mother to Camden Zalesky
Current CCHA Member

June 9, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since April 18, 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with ALL my Dental Needs. And has found me A really good Dr. for my health needs. And is currently helping me with Seeing An Optometrist
This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely, gilbert granados

Current CCHA Member

June 13, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with Michelle Blady with CCHA since March of 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care around my son's behavioral and physical health needs. I can't imagine navigating the coordination of services without Michelle's help. At one point my son's Medicaid benefits were accidently dropped. Without Michelle's support I would have been lost in the process of unraveling what happened and how to fix it. In a state where behavioral health services are far from plentiful, Michelle provides information and research in finding and using what is possible. Beyond specific help, Michelle is a constant support for me in the role of caregiver. I cannot begin to express how absolutely invaluable this support is in maintaining my own health as well as caring for my disabled son. Michelle has made a huge impact helping me manage my son's overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Gail Johnston

Gail Johnston (mother of member)
Current CCHA Member

June 13, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with Michelle Blady with CCHA since June of 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care around my daughter's behavioral health needs. This has made a huge impact on my child's overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Gaylene Lopez (mother of member)
Current CCHA Member

June 9, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since April 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care for my son, specifically requesting and advocating for in home therapy services as well as providing us with community resources. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

John Velasquez father to Vincent Clark
Current CCHA Member

5-12-17

June 9, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since June 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with getting my son connected with the CES waiver through DDRC, enrolling my son into therapy, has collaborated with my son's providers, advocating for his needs and has referred our family to community resources. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Kacie Krug

Kacie Krug: Mother to Hunter Krug
Current CCHA Member

June 23, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since July 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with organizing, learning about new ideas and new resources. And I liked my Health Partner checked in with me regularly and talks with my home health agency. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely, K. Rogge
KATHLEEN ROGGE

Current CCHA Member

6-28-17

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since September of 2015 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with, I don't even know where to begin, getting therapy, helping me know where to go to get appointments, where to get resources, help and information. Since diagnosis being able to start therapies with my son Xander has been a huge improvement for him. This has made a huge impact on our overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Michelle Finney
Current CCHA Member

June 28, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since April 24, 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me get transported from Michigan to Colorado and assisted me in finding placement. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Michael "Scooby" Powell
Current CCHA Member

June 16, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with Michelle Blady with CCHA since December of 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordinating care around my son's physical and behavioral health needs. I appreciate all the work that Michelle has done to help with my family and she has provided a tremendous amount of support. Michelle is always making sure that we know about resources/support and on top of it to assure our needs are being met. This has made a huge impact on my son's overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Melissa Porter
Current Mother CCHA Member

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since April 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with so many things. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes withthe ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Marie updike
Current CCHA Member

Sent from my iPhone

6/27/2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since August 2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me accomplish a healthy pregnancy, found support in areas I needed it, was there to help me through certain life issues, went to doctor appointments with me and overall made me feel good about myself and my pregnancy. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Nicole Stinson
Current CCHA Member

June 9, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since February 2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with advocating for my daughter's educational, behavioral and medical needs. Our health partner has assisted with finding a school for my child that meets her needs, has coordinated durable medical equipment and physical therapy with my daughter's primary care provider. Our health partner has also provided us with requested community resources. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Shondra Lee Baublitz (M.O.C.)

Shondra Baublitz mother to Aliana Baublitz
Current CCHA Member

June 28, 2017

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

Dear Ms. Miller:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since May 2017 and have fist-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with implementing ABA services into my home, applying for waiver services through the CCB, has coordinated with my PCP regarding my child's needs and has connected my family with community resources. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Sarah J. Cleary

Sarah Cleary: Mother to Logan Cleary
Current CCHA Member

06/26/2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 04/17/2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with getting formula for my daughter, with getting counselors, with a bunch of resources and getting my son the help he needs to get. Because you've helped me with that, I've been able to get other resources as well. It's just a chain of help. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Savannah Croy

Savannah Croy
Mother of a Current CCHA Member

July 12, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 2015 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with coordination of my Long Term Care Medicaid benefits, which is the lifeline for me staying in my home! I cannot express enough how much help Sheryl has provided me by helping me navigate through the complicated process every year! If it were not for CCHA, I believe that I may be in a nursing home. Sheryl has helped me find accessibility contractors to keep me safe in my home, provided lists of specialty doctors, dentist and even if contacted my county works department to advocate for curb cutouts in my neighborhood so that I could travel safely in my wheelchair. This has made a HUGE impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Jennifer Remington
Current CCHA Member

July 12, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 6/22/2017 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me better understand my benefits and how to utilize them. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Kelly Bethurem
Current CCHA Member

July 12, 2017

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

Dear Ms. Rapp:

As a current Health First Colorado member receiving care coordination services from Colorado Community Health Alliance (CCHA), I am pleased to offer my support to CCHA in their bid to serve as the Regional Accountable Entity (RAE). The care coordination CCHA provides has been very valuable to me and my family, and it is important that they continue to provide this work in the years to come.

I have been working with CCHA since 1/1/2016 and have first-hand experience of the person-centered, comprehensive services their Health Partners provide. The CCHA Health Partners team has helped me with numerous needs as well as resources for hearing aids. This has made a huge impact on my overall health and well-being.

I am excited about the positive work that CCHA and the ACC have accomplished and am happy to live in a state that wants to continue this program. I look forward to continued changes with the ACC to better meet the medical and non-medical needs of members like me.

Sincerely,

Yvette Poirier
Current CCHA Member

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Attachment 4.2-1c

COLORADO COMMUNITY HEALTH ALLIANCE

Providers

Attachment 4.2-1c: Providers

This section includes Letters of Support from the following Providers:

- Arbor Family Medicine, PC
- Arvada Pediatric Associates
- Aspen Park Pediatrics
- Aurora Family Medicine Center
- Aurora Internal Medicine Clinic, PC
- Boulder Community Health
- Boulder Valley Women's Health Center
- Broomfield Family Practice
- Broomfield Pediatrics & Internal Medicine
- Carin' Clinic
- Centennial Family Care, PC
- Centura Health Littleton Adventist Hospital
- Centura Health Longmont United Hospital
- Centura Health Parker Adventist Hospital
- Centura Health Penrose Hospital
- Centura Health Porter Adventist Hospital
- Centura Health St. Anthony Hospital
- Centura Health St. Anthony North Campus
- Centura Health St. Francis Medical Center
- Centura Health Physician Group Primary Care Golden
- Centura Health Physician Group St. Anthony Health Center Evergreen
- Chaffee Family Physicians
- Children's Hospital Colorado
- Clinix Health Center
- Denver Family Medicine
- Denver Health
- Denver Osteopathic Clinic
- Developmental FX
- Dinh V. Nguyen, MD
- Douthit Family Medicine
- Elizabeth Bassow-Scheve, MD, PC
- Exempla Good Samaritan Medical Center
- Family Medicine Associates, PC
- Family Medicine Clinic, PC
- First Health Family Medicine, LLC
- Foothills Women's Clinic
- Garrison Family Physicians, PC
- Gordon Fleischaker, MD and Yelena Khayut, MD
- Green Mountain Pediatrics
- Harvard Avenue Internal Medicine, LLC
- Highlands Family Medicine
- Internal Medicine Associates of Wheat Ridge, PC
- Internal Medicine Associates Southwest, PC
- Jackie L. McCollum, MD, PC

- John D. McLaughlin, II, MD, PC
- Kaiser Permanente
- Kids First Pediatrics
- Kipling Physicians, PC
- Lakewood Internal Medicine
- Littleton Internal Medicine Associates
- Maria Ivashchenko, MD, PC
- Maurine C. Onat, MD, PC
- Michael J. Guese, MD
- Michael J. Willig, MD, PC
- Mile High Family Medicine
- Mile High Primary Care, PC
- Morel Laronn, MD
- NextCare Urgent Care Arvada
- NextCare Urgent Care Aurora, Centennial and Thornton
- NextCare Urgent Care Longmont
- Our Lady of Hope Medical Clinic, Inc.
- Partners in Health Family Medicine
- Peak Pediatrics
- Peak Primary Care
- Peak to Peak Family Medicine, PC
- Pediatrics West, PC
- R. Brian Aikin, MD
- Rocky Mountain Family and Urgent Care
- Rocky Mountain Pediatrics, PC
- Rocky Mountain Primary Care
- Rocky Mountain Youth Clinics
- Senior Health First at Lakewood
- South Federal Family Practice, PC
- Southeast Family Practice
- St. Anthony North Family Medicine Center
- The Women’s health Group
- Westminster Medical Clinic
- Westside Women’s Care
- Wheat Ridge Internal Medicine
- Wheatridge Family Clinic

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

Boulder Valley Women's Health Center
2855 Valmont Rd, Boulder & 82 21st Ave, Longmont
Phone: 303-440-5160

June 27, 2017

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

Dear Ms. Miller:

Boulder Valley Women's Health is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by coordinating a streamlined referral process for our patients to receive mental health services. She navigated the systems of two separate not-for-profit health clinics to help us develop an internal system of communication that has helped us provide improved patient navigation services. She also is crucial in helping us navigate the changing reporting and quality requirements that Medicaid is developing. We could not maintain our Medicaid compliance without her assistance, and she is transparent, patient and excellent at her job.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Heather Goodchild, CNM
Clinical Director
Boulder Valley Women's Health

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

Boulder Valley Women's Health Center
2855 Valmont Rd, Boulder & 82 21st Ave, Longmont
Phone: 303-440-5160

June 27, 2017

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

Dear Ms. Miller:

Boulder Valley Women's Health is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA consistently collaborates with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by helping us coordinate with other partner organizations in the community. For example, we have been able to streamline our mental health referral procedures, with Mindy's help. It has been an ongoing process but we would not be where we are without her. She is very knowledgeable and happy to tackle any task we may need help with. Due to her coaching, we have been able to close to referral loop that so many patients fall through, in terms of mental health care. Her persistence and dedication is unmatched and she is a joy to work with. I always look forward to our monthly check in meetings and acknowledge all the help we have received.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cassidy Winchip, B.S.S.W
Patient Advocate
Boulder Valley Women's Health

Carin' Clinic

5150 Allison Street *Phone: 303-423-8836*
Arvada, CO 80002 *Fax: 303-403-0592*

www.carinclinic.info

June 13, 2017

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

Dear Ms. Miller:

As Executive Director of Carin' Clinic in Arvada, CO, I am pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

It has been a pleasure and very helpful to work with CCHA. They have helped us to track quality care measures and continual quality improvement projects. Seeing that they are the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, it makes sense to me that their experience and success would make them the best choice for the future.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Margo Sobocinski, NP
Executive Director
Carin' Clinic

The Carin' Clinic is a not-for-profit 501(c)3
IRS EIN 84-1331444.

Centura Health Physician Group
Centura Health

750 Warner Drive Golden, CO 80401

June 14, 2017

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

Dear Ms. Miller:

CHPG Primary Care Golden is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

Our CCHA RCCO 6 nurse social worker works closely with our care coordinators and brings invaluable experience, knowledge and proven success working directly with our members providing resources and programs to improve the overall health and well-being of the members. Our practice transformation coach assists the practice in goal setting, currently, obtaining VFC designation and standardized behavioral health screenings along with other initiatives to assist in meeting KPIs. Our CCHA partners possess an obvious dedication to our Health First Colorado members.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Corrie Catron

Corrie Catron
Clinic Supervisor
CHPG Primary Care Golden

DEVELOPMENTAL FX
The Developmental &
Fragile X Resource Centre

June 15, 2017

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

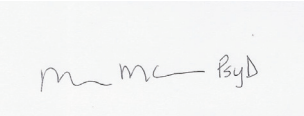
Dear Ms. Miller:

Developmental FX is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. CCHA has proven to be an invaluable resource for many of the families Developmental FX works with by connecting them with needed community supports, facilitating treatment recommendations, and helping them to navigate the complicated school system. Without CCHA's support, these families would be lost and without many needed services.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,



Meade McCue, Psy.D.
Clinical Psychologist
Developmental FX

www.developmentalfx.org • 7770 East Iliff Avenue • Denver, Colorado 80231
Phone ~ 303-333-8360 • Fax ~ 303-333-8380

Family Medicine Associates, PC
1022 Depot Hill Road
Broomfield, CO 80020
303-465-2323
fax: 303-465-1260

8853 Fox Drive Suite 200
Thornton, CO 80621
303-487-8817
fax: 303-487-0497

Elisabeth Kandel, MD
Nick Senna, DO
Meighen Purk, NP
Edward Stambaugh, PhD
David Leistikow, MD
Amy Hulstrom, PA
Jill Brogdon, NP

June 29, 2017

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

Dear Ms. Miller:

Family Medicine Associates, PC is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals. They have worked closely with our office assisting us in many best practices. They meet with our office regularly to help us with pulling reports, understanding those reports and what we can do to make sure we are meeting the needs of us patients.

Sincerely,

Shannon Dux
Office Manager
Family Medicine Associates, PC

KAISER PERMANENTE®

July 14, 2017

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

Dear Ms. Rapp:

Kaiser Permanente Colorado (KPCO) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, we are submitting this letter to affirm that should CCHA win the RAE bid for Region 6, we will actively work with CCHA on behalf of our Medicaid members who are served by KPCO's primary care medical providers in the Region 6 area.

KPCO staff worked with CCHA as the RCCO for Region 6 over the last three years to address care coordination issues for our members to ensure members received the care they needed to maintain or improve their health. CCHA was a very good partner by keeping in regular communication with our team, focusing on solutions to expand access to services, and strengthening their care coordination program to treat the whole person.

As a current partner of CCHA in serving the Colorado Medicaid population in region 6, we would expect our positive relationship to continue in ACC Phase II.

Sincerely,

Kathleen Westcoat

Kathleen Westcoat, MPH
Senior Director for Medicaid and Charitable Programs

10350 E. Dakota Avenue
Denver, CO 80247

96 Wadsworth Blvd.
Suite 100
Lakewood, CO 80226

KIDSFIRST PEDIATRICS
Comprehensive Pediatric Care
Infants, Children & Adolescents

T: 303-239-8327
F: 303-239-9946
Website: www.kfpeds.com

June 20, 2017

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

Dear Ms. Miller:

KidsFirst Pediatrics, in Lakewood, Colorado, would like to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge, and proven success with effectively managing funding, resources, and programs to improve the overall health and well-being of their members. CCHA, as an organization, has made it their mission to build collaborative relationships within the community. With their assistance, our practice has been able to improve the quality of care that KidsFirst Pediatrics provides to all of our patient's.

CCHA consistently collaborates with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by assisting in keeping our QI projects on task. Our practice has done well with meeting certain Key Performance Indicators, which assist in lowering overall healthcare costs for Medicaid patient's.

As part of the State Innovation Model, Cohort 1, KidsFirst Pediatrics requested to change our Technical and QI assistance team to CCHA for year 2. We felt that our strong relationship and mutual goals with CCHA would be a necessity to making sure the project was successful. Our Clinical Health Information Technology Specialist has brought great knowledge and assistance to our practice with Clinical Quality Reporting, and Meaningful use support.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Farah Broomandi, MHA
Practice Manager
KidsFirst Pediatrics

NextCare®
URGENT CARE
When Feeling Great Can't Wait!
NextCare Urgent Care – 7380 W. 52nd Ave Suite I – Arvada, CO 80002 (303)-463-5941

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

Dear Ms. Miller:

NextCare Urgent Care 52nd is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach offers support with building our Primary care Practice. We are always up to date on different options to better serve our patients. With the help of our coach we have implemented scheduling initiatives, Behavior Health Co-location, and streamlined our referral process. Our Health Partners aid us in bridging the gap with specialists in our area to better serve the needs of each individual patient and our Clinical Health Information Technology Specialist (Ben) acts as a great resource for data needs in an effort to monitor patient needs via claims data for all of our key performance indicators.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Casey Young
Clinic Manager III
NextCare Urgent Care

Erick Gomer MD
PCP Medical Director
NextCare Urgent Care

NextCare®
URGENT CARE
When Feeling Great Can't Wait!

June 20, 2017

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

Dear Ms. Miller:

NextCare Urgent Care is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach supports us by helping our practices to improve our KPI's especially our ED utilization and Well-Child checks. Our Clinical Health Information Technology Specialist (Mindy) has been meeting with our group in group and individual settings in establishing best practice for our Urgent Care as well as our newly developed Primary Care program. I am a manager of a clinic outside of CCHA's territory, but do have members that see our clinic from them. Not only is Mindy helping with region 6 members, but my patients and practice in region 3. I have implemented all of our initiatives from our meetings to that region as well.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Kim Taylor

Kim Taylor, Center Manager III
Aurora, Centennial and Thornton
NextCare Urgent Care

NextCare®
URGENT CARE
When Feeling Great Can't Wait!

June 28, 2017

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

Dear Ms. Miller:

NextCare Urgent Care Longmont is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

CCHA consistently partners with our practice to successfully deliver comprehensive, patient-centered care and achieve performance goals. Our Practice Coach (Mindy Riordan) supports us by streamlining our Primary Care practice. She has helped us initiate many new programs which focus on improving patient care and continuity, these initiatives in turn have help us to reach our KPI's. Our Health Partners have been key in getting referral programs running to improve access for our patients, as well as help us to get a colocation set up for behavioral health and our Clinical Health Information Technology Specialist (Ben) has been instrumental in our efforts to educate staff on our EHR system in order to process referrals and track data to improve our KPI's.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Scott Householder RT(R) ARRT
Clinic Manager III
Longmont/Greeley/Cheyenne

NextCare Urgent Care
-A Nextcare Holdings Company

Longmont
2144 North Main St Suite 8
Longmont, CO 80501

Mark Engelstad, MD • Karen Burnett, MD • Morgan Campbell, DO •
Aaron Shupp, MD •Lisha Barré, MD
Jeff Hilburn, PA-C • Heather Gray PA-C • Kathleen Slater, PA-C • Alison Ruble, PA-C •
Sarah Kleinschmidt, PA-C •Andre Neitzel, LCSW •
3520 West 92nd Avenue, Suite 104
Westminster, CO 80031

Phone: (303) 429-6601
Fax: (303) 429-6600
www.partnersinhealthfm.com

PARTNERS IN HEALTH
FAMILY MEDICINE

June 12, 2017

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

Dear Ms. Miller:

Partners in Health Family Medicine, PC is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC). As a CPC Classic, CPC+ and SIM participant we have many occasions to work closely with CCHA and have found them to be far superior to the other RICCO that we work with, Colorado Access.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Janet Stephenson, Practice Manager
Partners in Health Family Medicine, PC

PEAK PEDIATRICS

Wheat Ridge
3555 Lutheran Pkwy #340
Wheat Ridge, CO 80033
Phone: 303-996-6005
Fax: 303-420-8831

Thornton
12774 Colorado Blvd #141
Thornton, Colorado 80241
Phone: 303-996-6005
Fax: 303-420-8831

6/7/17

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

Dear Ms. Miller:

My name is Brian Gablehouse and I am a physician and owner of Peak Pediatrics which is located in both Wheat Ridge and Thornton. I am pleased to offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As a practice with multiple locations throughout the Denver metro area our patients come to us from a variety of RCCOs throughout the area and we work regularly with multiple organizations. Our work with CCHA, who currently serves Colorado Medicaid members in region 6, has truly been invaluable. Together they have supported multiple initiatives in our office that have helped expand access to resources and programs. The help and resources our patients and our office receive from other RCCOs throughout the area is quite frankly nonexistent and disappointing.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals. I know the restructuring and bidding process is likely competitive but truly hope we will have the opportunity to continue the work we have begun with CCHA in the years to come.

Sincerely,

Brian Gablehouse, M.D., FAAP
Owner Peak Pediatrics

BARBARA GABLEHOUSE, M.D. BRIAN GABLEHOUSE, M.D.
PEAK PEDIATRICS

June 16, 2017

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

Dear Ms. Miller:

My name is Dr. Yamini Rao, a primary care pediatrician at Peak Pediatrics, and I actively support the Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

In my primary care practice, I see the direct benefit and impact that the CCHA program has made in our patient's and family's lives. I work directly with Laurel Glickman, CCHA's social worker and she has become an invaluable member of provider team. I have had multiple families in crisis or on the verge of crisis that are now receiving services through CCHA. Thanks to Laurel and CCHA, these families are finally making progress when they thought there were no other options. I see how this positively impacts the overall health and well-being of the child and family.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

MD

Yamini Rao, MD
Peak Pediatrics

3555 LUTHERAN PKWY SUITE 340 WHEATRIDGE, CO 80033 PHONE (303)996-6005 FAX (303)420-8831

BARBARA GABLEHOUSE, M.D. BRIAN GABLEHOUSE, M.D.
PEAK PEDIATRICS

June 6, 2017

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

Dear Ms. Miller:

I would like to personally offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. As a pediatric primary care provider , i have had the wonderful opportunity to interact directly with CCHA and its associated staff and have been blown away with the services they provide our patient population. The positive changes in comprehensive patient care, and addressing the whole patient - medical, social and psycosocial-has resulted in truly enhanced care.

I am enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jessica Johnson
MPAS PA-C
Peak Pediatrics

3555 LUTHERAN PKWY SUITE 340 WHEATRIDGE, CO 80033 PHONE (303)996-6005 FAX (303)420-8831

BARBARA GABLEHOUSE, M.D. BRIAN GABLEHOUSE, M.D.
PEAK PEDIATRICS

June 6, 2017

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

Dear Ms. Miller:

I would like to personally offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. As a pediatric primary care provider it is important to approach each patient from not only a medical perspective, but a social and psychosocial one as well. CCHA and the ACC have helped improve care to countless children and families as they have facilitated this comprehensive approach to care.

I am enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cindy Nugent RN CPNP

Cindy Nugent
RN, CPNP
Peak Pediatrics

3555 LUTHERAN PKWY SUITE 340 WHEATRIDGE, CO 80033 PHONE (303)996-6005 FAX (303)420-8831

PEAK PEDIATRICS

6/7/17

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

Dear Ms. Miller:

My name is Laura Johnson and I am the Clinical Manager at Peak Pediatrics. I am pleased to offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. Peak Pediatrics has worked very closely with CCHA over the last two years, and we have been so impressed with the support they have provided to our patients through social work and nursing support, as well as through quality improvement coaching for our practice as a whole. Their dedication to improving the overall health of their members has been impressive and we strongly support their bid to serve as a Region Accountable Entity in 2018. As a registered nurse, I strongly believe they have utilized state funding in a way that meets the needs of our Colorado Medicaid patients and through their support, we have been able to provide excellent care!

Peak Pediatrics patient population is comprised of mostly Colorado Medicaid patients (almost 70%), as a result, our two locations works with two different Regional Care Collaborative Organizations under the current ACC contract. The care provided to our families who receive services from CCHA is far superior on many levels to that of Colorado Access. Ultimately, no care coordination or practice support is provided to our patients who are served by Colorado Access. Additionally, their communication with us and ability to respond to our requests for care coordination services for our patients have been ignored and gone unmet. This is has caused additional stress to our practice as we try to determine, on our own, how to provide the support that Colorado Access patients need and deserve.

In conclusion, I am very enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

L Johnson, RN

Laura Johnson, BSN, RN
Clinical Manager
Peak Pediatrics

Larissa Applegate, M.D., F.A.A.P.
Nicki Bacon, M.D., F.A.A.P.
Cynthia Frederick, M.D., F.A.A.P.
Susan Fudge-Erickson, M.D., F.A.A.P.
Shen Nagel, M.D., F.A.A.P.
Eric Shaw, M.D., F.A.A.P.

Betsy Barringer, PA-C
Candace DiRezza, PA-C
Katie Gruel, CPNP
Dana Jundt, CPNP
Anneka Landgraf, CFNP
Stephanie LeBlanc, PA-C
Brittany Schaffer, PA-C
Sarah Sizemore, CPNP

pediatrics west, p.c.
health care for the growing years

3555 Lutheran Parkway, Suite 200 • Wheat Ridge, CO 80033
ph. 720.284.3700 fax 303.467.0525
13402 West Coal Mine Avenue, Suite 200 • Littleton, CO 80127
ph. 303.973.9300 fax 303.973.9308

June 9, 2017

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

Dear Ms. Miller:

As the physician president of Pediatrics West, I am pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. For instance, the high risk/high need care support and coordination involving CCHA's social worker, Laurel Glickman, has been of tremendous benefit to a number of our patients and their families, allowing them to better access support services in the community.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Shen Nagel, MD
President
Pediatrics West, PC

ROCKY MOUNTAIN YOUTH CLINICS
connecting kids to healthy lives

June 22, 2017

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

Dear Ms. Rapp:

Rocky Mountain Youth Clinics (RMYC) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

Over the years, RMYC has grown to trust and rely on the CCHA team of experts to help us with practice transformation initiatives. We regularly meet to share best practices related to care coordination services and over time we have seen our care navigators become essential and integrated members of the clinical teams and more impactful in their ability to help patients and families. Moreover, RMYC recently decided to expand its clinical services in the Lakewood community and CCHA provided timely support using data analytics to help us identify where there are gaps in pediatric care in the region. They also advised RMYC about approaches to target outreach efforts to connect Medicaid patients that do not have a usual source of care with our services. These are the kinds of supports practices need now and in the future through the Regional Accountable Entities to really move the needle on population health and streamline precious resources. CCHA has demonstrated they can play that role effectively.

As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Jessica Dunbar
Executive Director
Rocky Mountain Youth Clinics

Administrative Office
9197 Grant Street
Suite 100
Thornton, CO 80229
Phone: 303.450.3690
Fax: 303.962.1511

Aurora Clinic
1550 South Potomac Street
Suite 130
Aurora, CO 80012
Phone: 303.360.8111
Fax: 303.360.8088

Denver Clinic
1601 East 19th Avenue
Suite 6600
Denver, CO 80218
Phone: 303.869.2182
Fax: 303.869.1906

Thornton Clinic
9197 Grant Street
Suite 200
Thornton, CO 80229
Phone: 303.450.3690
Fax: 303.450.3699

facebook.com/TheRMYC | twitter.com/TheRMYC | rmyclinics.org

Centura Health Physician Group
Centura Health.

St. Anthony's Health Center Evergreen
32214 Ellingwood Trail Suite 210
Evergreen, CO. 80439

June 14, 2017

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

Dear Ms. Miller:

St. Anthony Health Center, Evergreen is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

Our CCHA RCCO 6 nurse social worker brings invaluable experience, knowledge and patience working directly with our members providing resources and programs to improve the overall health and well-being of the members. Our practice transformation coach assists the practice in quality improvement goal-setting, currently, obtaining VFC designation, and other initiatives to assist in meeting our KPIs and ultimately working toward the positive clinical outcomes of our valued members. Our CCHA partners possess an obvious passion and dedication to our Health First Colorado members.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Amanda Jackson
Clinic Supervisor
St. Anthony Health Center Evergreen

The Women's HEALTH GROUP, P.C.

May 25, 2017

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

Dear Ms. Miller:

The Women's Health Group is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. We have worked thru different patient care improvement projects with them, and find their knowledge and support have contributed greatly to the success of the programs.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Vernon Naake, MD
Treasurer/Partner
The Womens Heath Group

VN:dm

9195 Grant Street, Suite 410 • Thornton, CO 80229 • (303) 280-2229 (BABY) • Fax (303) 280-0765
300 Exempla Circle, Suite 470 • Lafayette, CO 80026 • (303) 665-6016 • Fax (303) 665-1933 6363
West 120th Avenue, Suite 202 • Broomfield, CO 80020 • (303) 460-7116 • Fax (303) 460-8240

wheatridge
family clinic

6301 west 38th avenue
wheatridge, colorado 80033
303.940.9118 • fax 1-866-644-5936

6/20/217

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

Dear Ms. Miller:

Wheatridge Family Clinic is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

We have really counted on the services of CCHA for our staff and patients. We feel the Care Coordination provided by CCHA has really improved the quality of our work. We have had nothing but positive feedback in this working partnership with CCHA, am look forward our ongoing relationship in the future.

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Dr. Archuleta
Wheatridge Family Clinic

Arvada Pediatric
ASSOCIATES

Arvada Location
8030 Lee Drive • Arvada, CO 80005
T 303.421.6873 F 303.421.9922

Broomfield Location
3830 W. 121st Place • Broomfield, CO 80020
T 303.410.8041 F 303.410.8044

www.arvadapeds.com

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

Dear Ms. Rapp:

Arvada Pediatric Associates, P.C. is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Veronica Spence CMPE
Practice Administrator
Arvada Pediatric Associates, P.C.

Aspen Park Pediatrics

June 16, 2017

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

Dear Ms. Rapp:

Aspen Park Pediatrics, PC is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Carol Turner MD
President
Aspen Park Pediatrics, PC

25797 CONIFER ROAD • CONIFER,
.DATE
COLORADO • 80433
PHONE: 303-838-3355 • WEB: WWW.ASPENPARKPEDIATRICS.COM

ELIZABETH BASSOW-SCHEVE, MD, PC
FAMILY AND GENERAL MEDICINE
LISA M. BASSOW, MD ◆ KRISTIN L. MOREAU, MD ◆ HOLLY L. ELGAS, MD ◆ SEAN D. FLANNERY, PA-C

June 14, 2017

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

Dear Ms. Rapp:

Drs Bassow and Moreau are pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals. We have had great support from all members we have encountered in working with these groups.

Sincerely,

Kimberley A Gilson
Financial Coordinator/ Billing Manager
Elizabeth Bassow-Scheve MD PC

4045 WADSWORTH BOULEVARD, SUITE 250 ◆ WHEAT RIDGE, COLORADO 80033
303-425-6012 ◆ FAX: 303-467-9211

Broomfield Pediatrics & Internal Medicine
3301 W. 144th Avenue, Suite 200
Broomfield, CO 80023
Ph: 303-438-5522
Fax: 303-438-5686

June 1, 2017

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

Dear Ms. Miller:

Broomfield Pediatrics & Internal Medicine is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Nancy Greer, MD.

Nancy Greer MD
Physician/Owner/SIM Grant Recipient
Broomfield Pediatrics & Internal Medicine

Nancy Greer, MD, PhD **Thomas Pham, MD** **Gene Gonzales, MD** **Debra Greenstein, MD** **Rebecca Barnes, PA-C**

Broomfield Pediatrics & Internal Medicine
3301 W. 144th Avenue, Suite 200
Broomfield, CO 80023
Ph: 303-438-5522
Fax: 303-438-5686

June 1, 2017

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

Dear Ms. Miller:

Broomfield Pediatrics & Internal Medicine is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Lisa Rizzuto
Office Manager/SIM
Broomfield Pediatrics & Internal Medicine

Nancy Greer, MD, PhD **Thomas Pham, MD** **Gene Gonzales, MD** **Debra Greenstein, MD** **Rebecca Barnes, PA-C**

DENVER OSTEOPATHIC CLINIC
1770 S Federal Blvd., Denver, CO 80219 ● Phone: 303.975.0696 ● Fax: 888.615.4224

KHOI D. NGUYEN, D.O.
Specialized in Family Medicine
USCIS Civil Surgeon

23 June 2017

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

Dear Ms. Miller:

Denver Osteopathic Clinic is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Khoi D Nguyen, DO
Medical Director/President
Denver Osteopathic Clinic

1

Gordon H Fleischaker MD & Yelena Khayut MD
4350 Wadsworth Blvd., Ste 301
Wheatridge, CO 80033

June 14, 2017

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

Dear Ms. Rapp:

Drs. Fleischaker & Khayut are pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Barb Heil
Practice Manager
Drs. Fleischaker & Khayut

Foothills Women's Clinic

June 20, 2017

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

Dear Ms. Rapp:

I am pleased to offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

I am enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, I look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Julie Schmidt
Medical Assistant
Foothills Women's Clinic

Green Mountain Pediatrics
255 Union Blvd. Suite 120
Lakewood, CO 80228

6/29/17

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

Dear Ms. Miller:

Green Mountain Pediatrics is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Dr. Francine Paston
Green Mountain Pediatrics

KIPLING PHYSICIANS, P.C.
VERNON M. SMITH, M.D.
1805 Kipling St.
Lakewood, CO 80215
Phone: 303-232-7660 Fax: 303-232-9247

June 27, 2017

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

Dear Ms. Miller:

Kipling Physicians is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Vernon Smith, M.D.

Vernon M. Smith, M.D.
Kipling Physicans

PEAK PEDIATRICS

June 8, 2017

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

Dear Ms. Miller:

Peak Pediatrics is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Maureen Carney, LCSW
Behavioral Health Therapist
Peak Pediatrics

3555 Lutheran Pkwy, Suite200 Wheat Ridge, CO 80033
Phone: 720-284-3700 Fax: 303-467-0525
13402 West Coal Mine Ave, Suite 200 Littleton, CO 80127
Phone: 303-973-9300 Fax: 303-973-9308
Medical Records/Referrals Fax: 303-431-1038

June 14, 2017

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

Dear Ms. Miller:

Pediatrics West, PC, is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Diane Brauch RN

Diane Brauch, RN
Clinical Manager
Pediatrics West, PC

Rocky Mountain Urgent Care

6/27/2017

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

Dear Ms. Miller:

Rocky Mountain Family and Urgent Care is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Brandon Hahn
Clinic Director
Rocky Mountain Family and Urgent Care

Rocky Mountain Pediatrics, PC
2020 Wadsworth Blvd., #16
Lakewood, CO 80214

June 22, 2017

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

Dear Ms. Miller:

Rocky Mountain Pediatrics, PC is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Roseann Zamora
Office Manager

McArthur O. Hill, M.D.
Sharon Schroeder, MN, WHNP-BC

Obstetrics and Gynecology

8550 West 38th Ave. • Suite 303 • Wheat Ridge, Colorado 80033
303-425-8550 • Fax 303-425-2720

June 21, 2017

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

Dear Ms. Miller:

Foothills Women's Clinic is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Sharon Schroeder

Sharon Schroeder, RN, MN, WHNP-BC
Nurse Practitioner
Foothills Women's Clinic

Westside women's care

3555 Lutheran Parkway, Suite 210, Wheat Ridge Colorado, CO 80033; 303-467-2800

June 2, 2017

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

Dear Ms. Miller:

Westside Women's Care is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Julie A. Javernick, CNM, DNP

Julie A. Javernick, CNM, DNP
Clinical Practice Director, Midwifery
Westside Women's Care

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

Littleton Adventist Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Brett Spenst
President & CEO, LAH

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

Longmont United Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Mitchell Carson
President & CEO, LUH

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

Parker Adventist Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Sam Huenegardt
President & CEO, PKR

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

June 5, 2017

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

Dear Ms. Miller:

Penrose Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Margaret Sabin
Group President & CEO, PSF

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

Porter Adventist Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Morre Dean
Group President & CEO, PAH

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

St. Anthony Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Eddie Sim
Group President & CEO, SAH

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

May 22, 2017

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

Dear Ms. Miller:

St. Anthony North Health Campus is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Kevin Jenkins
President & CEO, SANHC

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Centura Health
9100 E. Mineral Circle
Centennial, CO 80112

June 5, 2017

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

Dear Ms. Miller:

St. Francis Medical Center is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Margaret Sabin
Group President & CEO, PSF

Gary Campbell
CEO, Centura Health

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Boulder Community Health

BCH Ambulatory Services
4141 Arapahoe Avenue, Suite 200
Boulder, CO 80303

June 14, 2017

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

Dear Ms. Miller:

I manage the Integrated Clinical Services team for Boulder Community Health, this includes RN Care Managers, Care Coordinators, Behavioral Health Specialists, Transitional Care and our Diabetic Education Program. L am pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

Our CCHA RCCO 6 nurse/health partner provides invaluable experience, knowledge and dedication working directly with our team, and members, providing resources and programs to improve their overall health and well-being. In the last couple of years, we have worked closely with CCHA care coordination and we consider them an extension of our care teams. Our CCHA partners possess a positive force and dedication to our Health First Colorado members in Boulder County.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Betsy Duckett
RN Manager of Integrated Clinical Services
Boulder Community Health - Ambulatory Services

Children's Hospital Colorado

www.childrenscolorado.org

July 14, 2017

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

Dear Ms. Rapp:

Children's Hospital Colorado (CHCO) is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As a nationally recognized center for excellence in pediatric health care, CHCO places great value in partners that understand the specific, specialized needs of the pediatric population in Medicaid to effectuate improved outcomes for patients and families. CHCO has prioritized progressing toward goals around achieving the quadruple aim with key partners in the Medicaid community and beyond. To that end, CCHA has been a proactive, innovative partner that has regularly connected with CHCO to explore how to build the kind of partnerships and mechanisms that will allow providers to participate in creating a seamless, streamlined process for patients and families as they transition between settings across the continuum of care.

CHCO's work with a number of Primary Care Medical Providers (PCMPs) in region 6 has provided CHCO with exposure to candid feedback regarding the appreciation that providers have for how CCHA has provided support and guidance as the current RCCO. Such positive feedback and consistent performance as a RCCO is especially important to CHCO, where over half of patients are covered by Health First Colorado. Also, as CHCO builds a pediatrics-focused collaborative with other Medicaid providers, CCHA will be a valuable partner as an experienced and trusted organization in the region 6 provider community.

Furthermore, CCHA's approaches to building creative, effective collaborations to ensure whole-person care are well aligned with CHCO's work in engaging community partners to address social determinants of health. We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Annie Lee
Senior Director, Medicaid Strategies and Programs
Children's Hospital Colorado

Heidi Baskfield
Vice President, Population Health and Advocacy
Children's Hospital Colorado

Affiliated with University of Colorado Anschutz Medical Campus School of Medicine

Anschutz Medical Campus • 13123 East 16th Avenue, Aurora, CO 80045
(720) 777-1234 (800) 624-6553

Children's Miracle Network Hospitals

Children's Hospital Colorado

6/13/17

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

Dear Ms. Miller:

I am pleased to offer my support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. As a hospital social worker, I can personally attest to the great work they have done in building collaborative relationships between primary care and specialty providers to focus on solutions for expanding access to services and improving coordination of care to treat the whole person.

As a hospital social worker who has had direct experience collaborating with a CCHA Health Partner, I can serve as a witness to the benefits of this incredible service, which provided extraordinary care coordination as well as positive outcomes for the patients served.

I am enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program.

Sincerely,

Ashley Niederhauser
Licensed Clinical Social Worker
Children's Hospital Colorado

www.childrenscolorado.org

Children's Hospital Colorado

6/12/17

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

Dear Ms. Miller:

Developmental Pediatrics clinic at Children's Hospital Colorado is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

LCSW

Sarah McSwegin, LCSW
Developmental Pediatrics
Children's Hospital Colorado
720-777-6869
Sarah.mcswegin@childrenscolorado.org

Affiliated with University of Colorado Anschutz Medical Campus School of Medicine

Anschutz Medical Campus • 13123 East 16th Avenue, Aurora, CO 80045
(720) 777-1234 (800) 624-6553

Children's Miracle Network Hospitals

Children's Hospital Colorado

www.childrenscolorado.org

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

Dear Ms. Miller:

I am pleased to my offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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. Working with representatives from CCHA has improved our ability to provide quality, effective care for families.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Robyn Nolan, MD
Developmental Behavioral Pediatrician
Children's Hospital Colorado

Affiliated with University of Colorado Anschutz Medical Campus School of Medicine

Anschutz Medical Campus • 13123 East 16th Avenue, Aurora, CO 80045
(720) 777-1234 (800) 624-6553

Children's Miracle Network Hospitals

DENVER HEALTH

July 14th, 2017

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

Dear Ms. Rapp:

Denver Health and Hospital Authority is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity in Region 6 for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA has made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and 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

OFFICE OF THE CHIEF FINANCIAL OFFICER
777 Bannock Street, Mail Code 0278 Denver, Colorado 80204-4507 Phone 303-602-4964 pburnette@dhha.org

Longmont United Hospital
Centura Health

1950 Mountain View Avenue
Longmont, CO 80501
303-651-5111 Phone
luhcares.org

05/31/2017

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

Dear Representative;

Longmont United Hospital is pleased to offer our support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Darlene Savage, R.N.

Darlene Savage, RN
Director Case Management
Longmont United Hospital
Centura Health
Darlenesavage2@centura.org
303 678 4958

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Exempla Good Samaritan MEDICAL CENTER

July 3, 2017

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

Dear Ms. Rapp:

Tenaya Pieper, LCSW, a social worker at Good Samaritan Medical Center, is pleased to offer her support to Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As the incumbent Regional Care Collaborative Organization serving Colorado Medicaid members in region 6, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building 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.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population in region 6, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Tenaya Pieper, LCSW

Tenaya Pieper, LCSW
Social Worker
Good Samaritan Medical Center

R. Brian Aikin, M.D., P.C.
8015 W. Alameda Ave., Suite 150
Lakewood, CO 80226

May 30, 2017

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

Dear Ms. Miller:

R. Brian Aikin, M.D. is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

R. Brian Aikin, M.D.

PRIMARY PHYSICIAN PARTNERS

Arbor FAMILY MEDICINE

West Office
10081 Wadsworth Pkwy Ste 200
(101st and Wadsworth Pkwy)
Westminster, CO 80021
P: 303.431.5409
F: 303.453.4994

Arbor Family Medicine, PC
www.arborfamily.com
Suzanne C. Nash, MD
Philip J. Rosenblum, MD
Kenneth W. Hahn, DO
Kent Schreiber, MD

East Office
3655 E. 104th Ave
(104th and Colorado Blvd)
Thornton, CO 80233
P: 303.254.8500
F: 303.453.4994

Thornton PA: Melanie Anderson, PA-C Gina Bolinger, PA-C Diana Keiling, PA-C
Westminster PA: Sara Gallo, PA-C Zachary Amdurer, PA-C

July 7, 2017

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

Dear Ms. Miller:

Arbor Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Philip J Rosenblum, MD
Partner, Arbor Family Medicine, PC

Broomfield Family Practice
FAMILY MEDICINE • OBSTETRICS • PEDIATRICS

1420 W. Midway Boulevard
Broomfield, CO 80020
(303) 466-1866 Phone
(303) 466-4061 Fax
www.broomfieldfp.com

Antonio Escobedo, M.D.
Diplomate, American Board of Family Practice

Julia A. Essig, M.D.
Diplomate, American Board of Family Practice

Shannon Hill, D.O.
Diplomate, American Board of Family Practice

James R. Hill, M.D.
Diplomate, American Board of Family Practice

Susan J. Robertson, M.D.
Diplomate, American Board of Family Practice

Mark Sarinopoulos, M.D.
Diplomate, American Board of Family Practice

Monica Salas-Meyers, D.O.
Diplomate, American Board of Family Practice

Aaron Shupp, M.D.
Diplomate, American Board of Family Practice

Nancy Berg, P.A.-C
Board Certified NCCPA

Darcy Connelly, P.A.-C
Board Certified NCCPA

Jackson Ferguson, P.A.-C
Board Certified NCCPA

Richard D. Hazen, P.A.-C
Board Certified NCCPA

Amy Kinsey, CHA, P.A.-C
Board Certified NCCPA

June 1st, 2017

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

Dear Ms. Miller:

Broomfield Family Practice is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Dr. Susan Robertson
Broomfield Family Practice

CHAFFEE FAMILY PHYSICIANS

Gregory Kaczmarczyk, M.D Mark Vaughn, M.D. Caroline Guillebaud, M.D.

June 9, 2017

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

Dear Ms. Miller:

Chaffee Family Physicians a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Gregory A. Kaczmarczyk, M.D.
Chaffee Family Physicians
President

PRIMARY PHYSICIAN PARTNERS
4720 Tejon Street • Denver, Colorado 80211
Phone 303-433-6563 • Fax 303-433-5614

Denver Family Medicine

July 7th, 2017

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

Dear Ms. Miller:

Denver Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

DeAun Gehring, MD
Provider, Owner
Denver Family Medicine

PRIMARY PHYSICIAN PARTNERS

Douthit Family Medicine

June 14, 2017

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

Dear Ms. Miller:

Douthit Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

John D. Douthit
D.O.
Douthit Family Medicine

PRIMARY PHYSICIAN PARTNERS

Garrison Family Physicians, PC
205 South Garrison Street
Lakewood, Colorado 80226-2843
Telephone (303) 237-2779

June 9th 2017

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

Dear Ms. Miller:

Garrison Family Physicians, PC is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Jeffrey Amundson, MD

John E. O'Connor, MD

Martin B. Thumim, DO

PRIMARY PHYSICIAN PARTNERS

7/6/2017 1:40 PM FROM: Fax Highlands Family Medicine TO: 13036051546 PAGE: 002 OF 002

Highlands Family Medicine

www.highlandsfamilymed.com

Joseph Bednarek, M.D.
Emily Herman, PA-C
Lauren Kolfenbach, PA-C
William LeCoq, PA-C
Lukas McWhorter, M.D.
Miriam Reece, M.D.

4500 West 38th Avenue
Suite 220
Denver, CO 80212
303-420-1297
Fax 303-420-2953

June 30, 2017

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

Dear Ms. Miller:

Highlands Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Joseph Bednarek, MD
Owner/Physician
Highlands Family Medicine

PRIMARY PHYSICIAN PARTNERS

Internal Medicine Associates
of Wheat Ridge, P.C.

1805 Kipling Street
Lakewood, CO 80215
Telephone (303) 422-3727

07-12-2017

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

Dear Ms. Miller:

Internal Medicine Associates of Wheat Ridge is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge, and proven success with effectively managing funding, resources, and programs to improve the overall health and well-being of their members. They also have made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Dr. Susan Schiff
MD
Internal Medicine Associates of Wheat Ridge

Aubrey R. Dobbs, M.D. • Joanne E. Ruch, M.D. • Susan L. Schiff. M.D.
Bridget Forsmark, PA-C • Karen Charland, C-A.N.P.

Lakewood Internal Medicine

7/11/2017

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

Dear Ms. Miller:

Lakewood Internal Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

David Leon MD

Dr. David Leon

Lakewood Internal Medicine

PRIMARY PHYSICIAN PARTNERS

MILE HIGH *Family* MEDICINE

a higher standard of care for your family

July 10, 2017

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

Dear Ms. Rapp:

Mile High Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization serving Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members. They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Tracy Lewis
Office Manager
Mile High Family Medicine

Dinh V Nguyen, MD

7/11/2017

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

Dear Ms. Miller:

The office of Dinh V Nguyen, MD is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Dr. Dinh V Nguyen

Dinh V Nguyen, MD

PRIMARY PHYSICIAN PARTNERS

PEAK PRIMARY CARE

Eric D Barnhart, MD James H Weingart, MD Ann M Imhof, MD
Nancy L Stoudt, MD Laura A Maugel, PA-C Miranda Prejean, PA-C
Peter Koenig, PA-C Kristin Del Negro, PA-C
2200 E. 104th Ave., Suite 115
Thornton, Colorado 80233
Phone: (303) 452-2766 Fax: (303) 252-8694

June 9, 2017

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

Dear Ms. Miller:

Peak Primary Care is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Eric Barnhart MD
Peak Primary Care

PEAK PRIMARY CARE

Eric D Barnhart, MD James H Weingart, MD Ann M Imhof, MD
Nancy L Stoudt, MD Laura A Maugel, PA-C Miranda Prejean, PA-C
Peter Koenig, PA-C Kristin Del Negro, PA-C
2200 E. 104th Ave., Suite 115
Thornton, Colorado 80233
Phone: (303) 452-2766 Fax: (303) 252-8694

June 9, 2017

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

Dear Ms. Miller:

Peak Primary Care is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

James Weingart MD
Peak Primary Care

PEAK PRIMARY CARE

Eric D Barnhart, MD James H Weingart, MD Ann M Imhof, MD
Nancy L Stoudt, MD Laura A Maugel, PA-C Miranda Prejean, PA-C
Peter Koenig, PA-C Kristin Del Negro, PA-C
2200 E. 104th Ave., Suite 115
Thornton, Colorado 80233
Phone: (303) 452-2766 Fax: (303) 252-8694

June 9, 2017

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

Dear Ms. Miller:

Peak Primary Care is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Ann Imhof MD
Peak Primary Care

PEAK TO PEAK
FAMILY MEDICINE, P.C.

7768 Vance Dr., Suite B
Arvada, CO 80003
Ph: 303-427-7700
Fax: 303-427-7709

www.peaktopeakfm.com

May 31, 2017

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

Dear Ms. Miller:

Peak to Peak Family Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

David Yamamoto, MD
Owner
Peak to Peak Family Medicine

ROCKY MOUNTAIN PRIMARY CARE
An affiliate of SCL Physicians

June 16, 2017

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

Dear Ms. Miller:

Rocky Mountain Primary Care, P.C. is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Greg Hirons, MD
Treasurer, Rocky Mountain Primary Care, P.C.
RMPC-92nd Ave.

PRIMARY PHYSICIAN PARTNERS

ROCKY MOUNTAIN PRIMARY CARE
An affiliate of SCL Physicians

June 16, 2017

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

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Sincerely,

John Gordon, MD
President, Rocky Mountain Primary Care, P.C.
RMPC-92nd Ave.

PRIMARY PHYSICIAN PARTNERS

ROCKY MOUNTAIN PRIMARY CARE
An affiliate of SCL Physicians

June 16, 2017

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

Dear Ms. Miller:

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Sincerely,

Martha Ives, MD
Board Member, Rocky Mountain Primary Care, P.C.
RMPC-Arvada

PRIMARY PHYSICIAN PARTNERS

ROCKY MOUNTAIN PRIMARY CARE
An affiliate of SCL Physicians

June 16, 2017

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

Dear Ms. Miller:

Rocky Mountain Primary Care, P.C. is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Brian Wegner, MD
Board Member, Rocky Mountain Primary Care, P.C.
RMPC-Lakewood

PRIMARY PHYSICIAN PARTNERS

ROCKY MOUNTAIN PRIMARY CARE
An affiliate of SCL Physicians

June 16, 2017

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

Dear Ms. Miller:

Rocky Mountain Primary Care, P.C. is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

A Nelson MD

Aimee Nelson, MD
Secretary, Rocky Mountain Primary Care, P.C.
RMPC-Lakewood

PRIMARY PHYSICIAN PARTNERS

Senior Health First
Centura Health

6.27.2017

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

Dear Ms. Miller:

Senior Health First at Lakewood is affiliated with Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Kay Cowell, MS, RN
Practice Administrator
Senior Health First at Lakewood

South Federal Family Practice, P.C.
1930 South Federal Blvd, Suite A
Denver, CO 80219
(303) 934-2202

July 12, 2017

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

Dear Ms. Miller:

South Federal Family Practice, P.C. is a member of Primary Physician Partners. This large practice includes approximately 19 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Roy J. Durbin, MD
South Federal Family Practice, P.C.

PRIMARY PHYSICIAN PARTNERS

July 12, 2017

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

Dear Ms. Miller:

St. Anthony North Family Medicine Center is a member of Primary Physician Partners. This large practice includes approximately 19 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Karen Martin
Assistant Administrator
St Anthony North Family Medicine Center

PRIMARY PHYSICIAN PARTNERS

May 30, 2017

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

Dear Ms. Miller:

Westminster, Inc. dba Westminster Medical Clinic is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Robin Smith, DO
Physician, President
Westminster Medical Clinic

WHEAT RIDGE INTERNAL MEDICINE

"We Cultivate Good Health"

June 8, 2017

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

Dear Ms. Miller:

Wheat Ridge Internal Medicine is a member of Primary Physician Partners. This large Independent Practice Association includes approximately 140 primary care physicians who serve patients in the northern and western portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Stanton R. Elzi, MD
President
Wheat Ridge Internal Medicine PC

PRIMARY PHYSICIANS

STANTON ELZI, M.D. - WILLIAM ELZI, M.D. - W. SCOTT ALLAN, M.D. - GERARD FEDERICO, D.O.
L. SCOTT WILNER, M.D. - JENNIFER MIX, D.O. - MARK HUMES, D.O. - ELIZABETH COWAN, N.P.
CRYSTAL CULBERT, PA-C - MATTHEW A. DHIEUX, PA-C - EMILY L. PIALA, PA-C - MELISSA RIDER, PA-C - JENNA HANNAN, PA-C
7821 West 38th Avenue • Wheat Ridge, Colorado 80033 • (303) 422-2343

Richard A. Patt, M.D. ■ Barry R. Sundland, M.D. ■ Bruce Zieger, PA-C ■ Andrea P. Moon, PA-C ■ Megan Thoms, PA-C

Aurora Family Medicine Center, P.C.

1421 South Potomac, Suite 320 ■ Aurora, Colorado 80012 ■ Phone (303) 750-1920

July 14, 2017

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

Dear Ms. Rapp:

Aurora Family Medicine Center is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who service patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to service as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

As an incumbent Regional Care Collaborative Organization servicing Colorado Medicaid members, CCHA brings invaluable experience, knowledge and proven success with effectively managing funding, resources and programs to improve the overall health and well-being of their members . They have also made great strides in building collaborative relationships and bringing the community together to focus on solutions for expanding access to services and improving coordination of whole person care.

We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely

Richard A. Patt, M.D.

Aurora Internal Medicine Clinic, PC

13111 E. Briarwood Avenue
Suite 250
Centennial, CO 80112

303-805-1800
FAX: 303-805-9323
www.aimcpc.com

T. Scott Gilmer, MD
Alan P. Aboaf, MD, FACP
Arthur A. Burroughs, MD
Lisa Lumley, FNP-C
Jennifer Lueb, PA-C

June 30, 2017

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

Dear Ms. Miller:

Aurora Internal Medicine Clinic is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Alan P. Aboaf MD

Alan Aboaf, MD
T. Scott Gilmer, MD
Arthur A. Burroughs, NMD
Aurora Internal Medicine Clinic, PC

SM PC SOUTH METRO PRIMARY CARE

Centennial Family Care PC
7261 S. Broadway Suite 101A
Littleton, CO. 80122
Ph. 303-471-6066

07/10/2017

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

Dear Ms. Rapp:

Centennial Family Care PC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

A Poturalski MD

Angelique Poturalski, M.D.
Centennial Family Care PC

SMPC SOUTH METRO PRIMARY CARE

CLINIX HEALING CENTER

July 5, 2017

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

Dear Ms. Rapp:

Clinix Health Services of Colorado is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Cindy Stillman
Director of Operations

7030 South Yosemite Street | Centennial, CO 80112 | TEL: 303.721.9984 | www.clinixusa.com

FAMILY MEDICINE CLINIC, P.C.
6179 S. Balsam Way Suite 110
(303) 948-1570 **Littleton, CO 80123** Fax (303) 972-6871
Steven Singer, M.D., Madelyn Palmer, M.D.
Michael Corcoran, RN FNP-C, Shannon Dyer, RN FNP-C
Giovanna Salerno, PA-C, Sarah Dueber, PA-C

10 July 2017

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

Dear Ms. Rapp:

Family Medicine Clinic, P.C. is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Steven A. Singer, M.D.
Medical Director
Family Medicine Clinic, P.C.

FIRST HEALTH FAMILY MEDICINE, LLC
1411 South Potomac Street • Suite 170 • Aurora • CO 80012 • Tel: (303) 755-8100 • Fax: (303) 755-8101

July 5, 2017

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

Dear Ms. Rapp:

First Health Family Medicine is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

Julia E. Jung, M.D.
First Health Family Medicine, LLC

SOUTH METRO PRIMARY CARE

Michael J. Guese, MD
850 East Harvard Avenue, Suite 455
Denver, CO 80210
(303) 722-2724

July 13, 2017

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

Dear Ms. Rapp:

Michael J. Guese, MD is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Michael J. Guese, MD

SM PC SOUTH METRO PRIMARY CARE

Harvard Avenue Internal Medicine, LLC
850 East Harvard Avenue, Suite 455
Denver, CO 80210
(303) 722-2724

July 13, 2017

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

Dear Ms. Rapp:

Harvard Avenue Internal Medicine, LLC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Edward Ho, MD
Harvard Avenue Internal Medicine, LLC

SM PC SOUTH METRO PRIMARY CARE

Internal Medicine Southwest, P.C.

Swedish Healthpark Southwest · 6169 S. Balsam Way, # 190 · Littleton · CO 80123 · Office (303) 933-8240 · Fax (303) 933-8205

July 6, 2017

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

Dear Ms. Rapp,

Internal Medicine Southwest, P.C. is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Yours sincerely,

Roger E. Bowles, M.D.

Gerald D. Brown, M.D.

Kristin R. Brown, M.D.

George M. Frank, M.D.

Roger E. Bowles, M.D. • Gerald D. Brown, M.D., F.A.C.P. • Kristin R. Brown, M.D. • George M. Frank, M.D. • Jeffrey Douglass, ANP • Sara Schneider, P.A.-C

Marina Ivashchenko MD PC
9892 Rosemont Avenue Ste 201
Lone Tree, Co 80124

July 11, 2017

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

Dear Ms. Rapp:

Marina Ivashchenko MD PC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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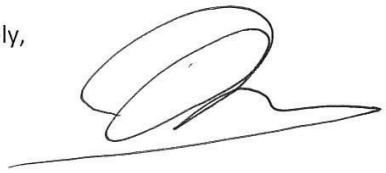
Sincerely,



Marina Ivashchenko MD PC

SM PC SOUTH METRO PRIMARY CARE

Morel Laronn, MD
1610 S. Girard Place, Suite F
Englewood, CO 80113
(303) 794-6357

July 13, 2017

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

Dear Ms. Rapp:

Morel Laronn, MD is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Morel Laronn, MD

SM PC SOUTH METRO PRIMARY CARE

LITTLETON INTERNAL MEDICINE ASSOCIATES
7780 S. Broadway
Littleton, CO 80122

July 3, 2017

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

Dear Ms. Rapp:

Littleton Internal Medicine Associates is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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We are enthusiastic about the positive work CCHA and the ACC have accomplished and the State's vision for the future of this program. As a partner of CCHA in serving the Colorado Medicaid population, we look forward to continued collaboration and sharing of best practices toward achieving the ACC goals.

Sincerely,

David R. Conway, MD
Chief Executive Officer
Littleton Internal Medicine Associates

SMPC SOUTH METRO PRIMARY CARE

Jackie L. McCollum, M.D., P.C.
12101 E 2nd Ave Suite 105
Aurora, CO 80011

July 12, 2017

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

Dear Ms. Rapp:

Jackie L. McCollum, M.D. is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Jackie L. McCollum, M.D., President

Jackie L. McCollum, M.D., P.C.

Phone (720) 535-6204 Fax (720) 949-0540

John D. McLaughlin II MD, P.C.

July 12, 2017

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

Dear Ms. Rapp:

John D. McLaughlin is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

John D. McLaughlin II
MD
John D. McLaughlin II MD, P.C.

SM PC SOUTH METRO PRIMARY CARE

Mile High Primary Care PC
2230 S. Fraser St Unit #1
Aurora, Co 80014

July 11, 2017

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

Dear Ms. Rapp:

Mile High Primary Care PC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Mile High Primary Care PC

SM PC SOUTH METRO PRIMARY CARE

Maurine C. Onat, MD, PC
1501 South Gaylord Street, Suite B
Denver, CO 80210
(303) 733-3660

July 13, 2017

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

Dear Ms. Rapp:

Maurine C. Onat, MD, PC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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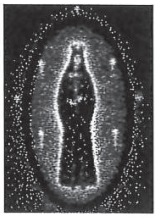
Sincerely,

Maurine C. Onat, MD

SMPC SOUTH METRO PRIMARY CARE

Our Lady of Hope Medical Clinic, Inc.

Edwin T. Anselmi MD
Britney Mach, PA-C
Katie Masters, PA-C
7960 S. University Blvd. #203
Centennial, CO 80122
Phone 720-344-2680
Fax 720-344-2681



July 10, 2017

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

Dear Ms. Rapp:

Our Lady of Hope Medical Clinic is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Edwin T. Anselmi MD

Edwin T. Anselmi MD
Family Physician
Our Lady of Hope Medical Clinic

SOUTH METRO PRIMARY CARE

SOUTHEAST FAMILY PRACTICE

John D. Morrison, M.D.
Lindsey Mulder, N.P.

July 10, 2017

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

Dear Ms. Rapp:

Southeast Family Practice is a member of South Metro Primary Care. This large independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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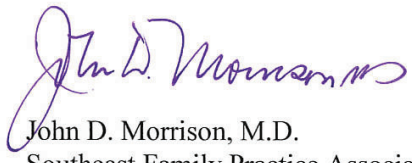
Sincerely,



John D. Morrison, M.D.
Southeast Family Practice Associates, P.C.
JDM,MD/kmj

950 E. Harvard Avenue, Suite 110, Denver, CO 80210 Phone: 303-777-0577 Fax: 303-777-1197

Michael J. Willig, MD, PC
1421 South Potomac, Suite 210
Aurora, CO 80012
(303) 923-3831

July 13, 2017

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

Dear Ms. Rapp:

Michael J. Willig, MD, PC is a member of South Metro Primary Care. This large Independent Practice Association includes approximately 60 primary care physicians who serve patients in the south and east portions of the Denver metro area. As a primary care driven organization, we are very invested in supporting Colorado Community Health Alliance (CCHA) in their bid to serve as a Regional Accountable Entity for the next iteration of the Accountable Care Collaborative (ACC).

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Sincerely,

Michael J. Willig, MD

SOUTH METRO PRIMARY CARE

Attachment 5.2-1

COLORADO COMMUNITY HEALTH ALLIANCE

Resumes

WILLIAM G. WOOD, M.D., Ph.D.

RFP Job Title: Chief Clinical Officer

Majority of Work Experience in Behavioral Health: Yes

Summary of Experience:

Physician Executive with 34 years of extensive senior leadership experience in public and private mental health care with a focus on integrated care and mental illness recovery. Effective communicator through presentations and multiple media. Interest in the development of innovative solutions in the current health care environment.

Career History

RVP Behavioral Health South Region, Medicaid Behavioral Health, Anthem
2014 – PRESENT

- Responsible for Medicaid Behavioral Health Programs in 8 States.
- Duties include program development and standardization, utilization management, government relations, quality standards, and provider relationship development.
- Supervise Behavioral Health Medical Directors in each program.
- Led the expansion of the BH program in 4 of the 8 states.

Chief Medical Officer Tennessee Behavioral Health, Medicaid Behavioral Health, Anthem
2008 – 2014

- Developed and improved Behavioral Health program for Medicaid population for Tennessee.
- Decreased inpatient costs by 58% through improved utilization of community resources, diversion to outpatient alternatives, and case management.
- Introduced Rising Star program for Seriously Mentally Ill who were frequently hospitalized. Increased community tenure, reduced costs, and improved their long-term outcomes.
- Developed program for discharge planning from hospital which resulted in decreased readmissions and improved outpatient follow-up.
- Reduced length of stay in and number of admissions to long-term residential care for adolescents and children by developing wraparound services in the community. Reduced census by 75%.
- Developed close working relationship with TennCare and other Managed Care Organizations resulting in program and policy development.
- Reduced long-term state hospital census by 50% by providing supported community living alternatives with a focus on recovery from their disability.

Senior Vice President and Medical Director, Behavioral Health, Anthem
2003 – 2008

- Developed Behavioral Health program for Amerigroup.
- Served as Acting Chief Medical Officer for Amerigroup for interim period.
- Developed Integrated Behavioral Health/Physical Health program for Amerigroup.
- Developed Integrated Case Management program to treat the whole person physically, mentally, and socially.
- Developed Rising Star program for Seriously Mentally Ill as a Provider-Payer Collaboration to improve community tenure and outcomes. Enthusiastic reception by providers and dramatic improvement in member ability to remain in the community resulting in significant cost savings and improved outcomes for members.

Consultant, William Wood, MD PLLC
2001 – 2003

- Consultant to Minister of Health, New Zealand on Behavioral Health Program for Hawkes Bay Region from 2002-2003. Analysis of services and process in working with indigenous population as well as substance abuse and interface with primary care providers.
- Developed education program and medication management program for Homeless Co-occurring population in Virginia Beach VA as part of grant funded homeless program.
- Developed structure for LME program in North Carolina as state moved from local FFS to having CMHCs become managing entities, contracting for services in lieu of developing a managed care program for Medicaid.
- Consultant with APS Healthcare on CHAMPUS program for which Humana was primary contractor.
- Performed clinical utilization reviews and audits for selected managed care entities.
- Served as consultant to CHCS on adolescent project.

Education

Baylor College of Medicine, Houston, TX

Degree/Program: M.D. degree	1974
Child Psychiatry	1977-1978
General Psychiatry Residency	1975-1977

University of North Carolina, Chapel Hill, NC

Degree/Program: Ph.D., Biochemistry	1968

Georgia Southern College, Statesboro, GA

Degree/Program: B.S., Chemistry	1963

Certifications/Licensure

- Active, Medical Licensure, Texas, Florida, Tennessee, Virginia, Louisiana
- Psychiatry by American Board of Psychiatry and Neurology 1985

ANDRÉE M. MICELI

RFP Job Title: Utilization Management Director

Majority of Work Experience in Behavioral Health: Yes

Summary of Experience:

Behavioral Health professional with more than 25 years of post-master's degree experience and skilled in clinical therapy, administration, supervision, quality improvement, and program development. Diverse background includes managed care; care management; individual, marital, family and group therapy; domestic violence and child abuse treatment; and crisis intervention.

Career History

Business Change Manager, Behavioral Health Department, Anthem
2016 – PRESENT

- Lead the Government Business Division Substance Use Disorder program.
- Lead Behavioral Health Housing Initiatives for Government Business Division.
- Work with Behavioral Health Case Management on collaborative initiatives related to Substance and Abuse and BH/PH Integration.
- Develop process for regular data reporting for BH in each Health Plan.
- Participate in Cost of Care Initiatives for Behavioral Health.

Director, Behavioral Health Department, Anthem
2013 – 2016

- Director for all clinical and administrative UM operations for all of Behavioral Health, including Commercial, National, and Local Integrated Health Model accounts.
- Implemented the Behavioral Health program for the largest employer group at Anthem (State of GA): developed a dedicated Behavioral Health team to manage this group.
- Implemented a dedicated UM and Case Management team for second largest employer group in GA.
- Developed "Build A Better WellPoint" programs focused on efficiency of service delivery.
- Responsible for all BH UM activities and 50 staff members.
- Interface daily with members, providers, Account Managers, employer groups.
- Participated in accreditation audits and ensures compliance with NCQA and URAC regulations.
- Lead department and staff meetings weekly.
- Worked directly with BH Case Management Directors to provider integrated services to Integrated Health Model groups.
- Worked with Medical Director and Physician Advisors to ensure efficient peer review and appeal process is in place.
- Met regularly with Network facilities.
- Developed a Field Advocate program with high volume facilities.
- Oversaw implementation of National Accounts.
- Interfaced with Account Managers to assist with complex cases and service provision.
- Ensured all Behavioral Health operations are in compliance with federal mental health parity.
- Created an Exercise Physiology program for BH with goal of improving health and reducing utilization.

Manager II, Behavioral Health Department, Anthem
2007 – 2013

- Provided clinical and administrative supervision to Behavioral Health department comprising of 14 Care Managers and 9 Utilization Management Representatives, and 3 Outreach Care Specialists. The department managed BH for Georgia members and 90 National Accounts.
- Hired and trained new staff; training included benefits, policies and procedures, and systems.
- Oversaw implementation of new National Accounts.
- Developed and ensured adherence to all policies and procedures for the department and participated in all accreditation audits.
- Was responsible for all Human Resources tasks for the department.
- Worked with Account Managers to educate groups regarding BH treatment; assist with complex cases.
- Interfaced regularly with members, providers, account managers, and assist with any problems.
- Led weekly staff meetings, clinical case presentations, and participate weekly in managers meetings with Medical Director.
- Developed Case Management program for GA Behavioral Health.

Lead Care Manager, Behavioral Health Department, Anthem
2006 – 2007

- Provided clinical and administrative supervision and guidance to 12 Specialty Care Managers daily.
- Completed monthly chart audits and phone audits.
- Led trainings for Care Managers regarding insurance and case management.
- Interfaced with members and facility staff to manage problems.
- Provided individual, daily rounds with Care Managers as requested by Medical Director.
- Acted on behalf of Behavioral Health Manager in his absence.
- Attended NCQA meetings with Behavioral Health Manager as scheduled.
- Co-edited Behavioral Health newsletter monthly.
- Trained new staff members regarding systems, policies and procedures, and daily workflow.
- Updated facility assignments to Care Managers as needed.
- Assisted manager in ensuring compliance with NCQA, URAC, and AUMSI regulations.
- Monitored WMDS Letter Error List daily and corrected errors to ensure compliance.
- Participated in department “Mentoring Group” and helped develop BH orientation manual.

Behavioral Health Care Manager, Behavioral Health Department, Anthem
2005

- Authorized inpatient and outpatient psychiatric and substance abuse treatment for members.
- Reviewed members’ clinical information and authorized based on medical necessity criteria.
- Acted as a Senior Care Manager, providing clinical and systems related assistance to other Care Managers; delegated daily assignments as needed.

Licensed Clinical Social Worker, Health Services, Lawrence Joel Army Health Clinic
2002 – 2005

- Completed assessments and provided therapeutic services for victims and offenders of domestic violence and child abuse in military families.
- Provided counseling for individuals, families, couples, and groups in a military setting.
- Taught Anger Management and Stress Management classes to military personnel.
- Supervised graduate students.

Education

Colgate University, Hamilton, New York
Degree/Program: Bachelor of Arts, Sociology and Anthropology

University of Georgia, Athens, Georgia
Degree/Program: Master of Social Work

Certifications/Licensure

- 1996, Licensed Clinical Social Worker

ELIZABETH M. BASKETT

RFP Job Title: Program Officer

Majority of Work Experience in Behavioral Health: No

Summary of Experience:

During my long career in health care policy and administration, I have served at the Arizona Legislature, two Medicaid departments, and the Arizona and American Hospital Associations. Currently, I am the Executive Director of RCCO 6: Colorado Community Health Alliance. CCHA is passionate about serving Medicaid Members and providers. We are a respected partner with the community and a collaborative partner with the Department. We are innovative, flexible, and financially sound. CCHA is currently the highest performing RCCO in the state (as defined in the ACC Management Report). Throughout my career, I have had extensive experience working to overcome barriers between behavioral and physical health that exist in the health delivery system on the state and national level. In Arizona, I led the development of health-related legislation that included many behavioral health policy issues like mental health parity and increasing access to care for Medicaid members. At the Arizona and Colorado Medicaid departments, I facilitated innovations to the state delivery system, working closely with stakeholders and policymakers to integrate physical and behavioral health and worked with providers to help Medicaid members receive care in community-based settings and reduce inappropriate utilization of the emergency department. In Washington, DC, I contributed to the passage and implementation of the Affordable Care Act, with a special emphasis on hospital and overall system reforms like the Accountable Care Organizations and Bundled Payment Demonstrations.

Career History

Executive Director, Colorado Community Health Alliance
2015 – PRESENT

The Colorado Community Health Alliance (CCHA) is a collaboration formed in 2010 between Centura Health System, Physician Health Partners, and Primary Physician Partners to focus their combined expertise and efforts on improving the quality, efficiency, and delivery of health care for Coloradans. As the designated Regional Care Collaborative Organization (RCCO) for Colorado Medicaid Region 6, CCHA helps guide care and improve outcomes for Medicaid members living in Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties. As Executive Director of CCHA, Elizabeth is responsible for development and implementation of new and ongoing strategies that guide contracting, community partnerships, and care coordination efforts to optimize success of CCHA.

Manager, Program Innovations Section, Colorado Department of Health Care Policy & Financing
2013 – 2016

- Led the Program Innovations team in designing and implementing all aspects of Colorado's Medicaid reform.
- Served as an expert on innovations to the health care delivery system, including primary care and care coordination, integrating public health, behavioral health and social services, telehealth, client engagement, payment and quality reforms, provider accountability, and alignment with other health care payers.
- Identified, designed, implemented, and evaluated new Medicaid innovations. Collaborated with key Department staff and leadership on complex operational aspects of new programs and policies, including budget, actuarial analysis, quality measurement, systems, data analysis, enrollment, and provider and client outreach.

- Worked closely with external stakeholders including clients, advocates, providers, payers, and the federal government. Facilitated numerous stakeholder meetings and committees.
- Managed contracts and program budgets of over $11M and oversee a team of ten employees.
- Successfully implemented Medicaid Expansion, the Medicare-Medicaid Program, Project ECHO, eConsult, Colorado Opportunity Project, and myriad other policies designed to support and enhance the state's Accountable Care Organization as the primary Medicaid delivery system.

Professional Sabbatical
2012 – 2013

- Traveled to twelve countries (Mexico, Guatemala, Nicaragua, Honduras, Costa Rica, Panama, Columbia, Ecuador, Peru, Bolivia, Argentina, and Chile) in Latin America.
- Studied Spanish, volunteered in local villages, and immersed myself in the Latin American culture.
- Refined my ability to think on my feet, adapt to unexpected situations, and communicate with people who do not speak my language or share my cultural norms.

Senior Associate Director, Policy, American Hospital Association
2009 – 2012

- Assumed a leadership role in high priority policy issues affecting hospitals and post-acute care to develop, advocate, and articulate policy positions that enabled the AHA to have a positive impact on the political and policy environment facing its members.
- Balanced an array of high-visibility responsibilities under continuous time and performance pressures, including influencing policymakers in meetings; presenting key concepts and ideas representative of the AHA policy agenda; preparing comment letters and advisories.
- Assessed the impact of legislative and regulatory proposals on hospitals and produced issue and option analysis in oral and written formats instantaneously and over time.
- Managed research projects across the continuum of care from the development of the RFP, to oversight of contractor, to public dissemination of the final product. Responsible for managing over $400,000 in projects.
- Developed and maintained excellent relationships with staff, members, external organizations, federal agencies, and other organizations interested in healthcare related issues.

Director, Government Affairs & Policy, Arizona Hospital and Healthcare Association
2006 – 2009

- Managed the association's state legislative advocacy affairs by researching, analyzing, and monitoring legislation, lobbying state lawmakers, legislative staff, and other policymakers, and testifying at legislative hearings.
- Identified key issues and strategies for the association's advocacy agenda by collecting and analyzing quantitative and qualitative data and information regarding issues affecting hospitals and the state's health care system, including the state's Medicaid program.
- Drafted legislation, amendments, and policy briefs and prepared correspondence to legislators on issues affecting hospitals.
- Assisted in coordinating the association's press strategy to influence the legislative process. Drafted press releases and provided radio, television, and print interviews.
- Managed a joint state and federal political action committee; filed state and federal campaign reports.

Chief Legislative Liaison, Arizona Health Care Cost Containment System
2005 – 2006

- Served as the liaison between the state's Medicaid agency and the Arizona State Legislature. Developed and maintained positive relationships between lawmakers and agency staff and responded to legislative inquiries regarding the agency's policies and programs.
- Developed and advanced the agency's legislative agenda by identifying key issues, researching, and monitoring all health care-related legislation, lobbying lawmakers, legislative staff, and other stakeholders and testifying in legislative hearings.
- Educated legislators, staff, and stakeholders regarding Medicaid and Medicare, the State Children's Health Insurance Programs, health insurance, prescription drugs, and other relevant health care issues.
- Monitored federal health care related legislation and assisted agency staff with implementation of new state and federal health care laws and regulations.

Education

Arizona State University, Tempe, Arizona
Degree/Program: Master of Public Administration

University Of Arizona, Tucson, Arizona
Degree/Program: Bachelor of Science in Family and Consumer Sciences

JOELLE KERNITZKI

RFQ Job Title: Chief Financial Officer

Majority of Work Experience in Behavioral Health: No

Summary of Experience:

Member of the executive management team for a physician-owned management services organization with primary responsibility for all aspects of the financial affairs of the business including financial reporting, budgeting, forecasting, and treasury. Fully responsible for financials for seven related organizations with combined revenues in excess of $150 million annually.

Career History

Physician Health Partners, LLC 1998 – PRESENT

2009 – Present

Senior Vice President, Finance and Administration

Responsible for all shared services including information technology, project management, accounting, audit and finance, cash management, facilities management, human resources, payroll, marketing and communications, and overall business operations. Finance-related initiatives include:

- Reporting to seven boards of directors and related finance committees quarterly to review financial status and make recommendations.
- Lead banking relations for transactional and investment activity across multiple banks.
- Preparation of all documentation for partnership and corporate tax returns and communication to partners.
- Implementation of Lean procedures to maximize efficiency.
- Management of independent annual audits, resulting in clean opinions every year
- Replacement of financial reporting software.

2000 – 2009

Controller

Responsible for planning, organizing, and directing all aspects of the accounting department consistent with generally accepted accounting principles, including the development and administration of accounting and financial policies and procedures.

- Participation in senior management team. Responsible for direction of Finance and Accounting activities to include: financial statements, budgets, taxes, payroll, insurance, employee benefits, leases, banking, and investment activities.
- Reviewed departmental financial statements with administrators, provided assistance, and presented information at meetings as requested. Monitored budgetary performance and internal controls.
- Directed and coordinated general accounting, including general ledger accounting (accounts payable, cashiering, etc.).
- Reviewed performance and ensures compliance with governmental reporting requirements, including tax reports.

1998 – 2000

Senior Accountant

Responsible for managing, maintaining, and analyzing accounting information including developing manual and automated accounting processes.

- Prepared monthly journal entries, financial statements, and account reconciliations.

- Analyzed, reviewed, and adjusted income and expense information to ensure accurate and reliable financial statements.
- Analyzed and explained variances in account balances.
- Maintained payroll records, processed biweekly payroll, and maintained employee personnel records.
- Coordinated and administered health, dental, and life insurance plans.
- Prepared annual budget and monthly forecasts.
- Processed accounts receivable and made cash deposits within established timeframes.
- Prepared documents for annual audit.

Education

University Of Colorado, Denver, Colorado
Degree/Program: Master of Science, Accounting

Baker University, Baldwin City, Kansas
Degree/Program: Bachelor of Science, Finance and Economics

GLENN M. SMITH

RFQ Job Title: Health IT and Data Director

Majority of Work Experience in Behavioral Health: No

Summary of Experience:

Business professional with over 17 years of experience in the health care industry including managed care, health IT systems, implementation, and operations. Strong team leader with exceptional problem-solving and communication skills that bridge the gap between business operations and technical experts. Solutions-driven innovative thinker with a proven track record of generating and retaining customer loyalty and satisfaction. Speaker at industry events at both the local and national level including Medical Management Group Association (MGMA), Colorado Department of Public Health and Environment (CDPHE), and several national ACO-specific conferences.

Career Highlights:

- Over 200 successful Practice Management and Electronic Health Record implementations nationwide.
- Assisted 150 Primary Care Providers secure over $6 Million in performance-based incentives over the past 4 years.
- Developed a data aggregation strategy across 10 EHR systems and over 30 physician practice sites.
- Implementation of a data analytics system that gave providers a view of clinical and claims data together for the first time.
- Developed patient matching algorithm with the State Health Information Exchange (HIE) to drive successful delivery of Admit, Discharge, and Transfer (ADT) messages throughout the health care community.

Career History

Director Technical Program Management, Physician Health Partners
2014 – PRESENT

Drive organizational strategy as it relates to Health Information Technology including interoperability between 85 physician practices, 11 EHRs systems, 15 hospitals, and the state-designated HIE. Analyze and make decisions regarding business intelligence tools that facilitate the organizational goal of achieving the Triple Aim as well as facilitate the implementation of such tools using Agile methodologies.

- Drive Health Information Technology strategies across the business.
- Lead vendor procurement processes.
- Provide project management resources to drive successful implementation of Health Information Technology Information Systems including Electronic Health Record systems, Care Management and Utilization Management systems, Business Intelligence, Analytics, and Interoperability between all of these disparate sources of data.
- Manage third party vendor relationships as well as community partner relations to ensure that the required participation and support is being provided in a timely manner to support organizational goals.
- Ensure physician practices and individual providers are successful in implementing technology, utilize data and reports in order to successfully measure quality performance to facilitate practice improvement activities including Meaningful Use, NQF, HEDIS, and IPA specific reporting goals.
- Facilitate Physician Quality Reporting System (PQRS) through the Group Reporting Option (GPRO). Serve as the Security Official for such activities which encompasses ensuring the all GPRO users are successfully registered, able to conduct data entry, and ultimately responsible for submission of quality data to CMS.

- Successfully implemented a new Care Management and Utilization Management system that is considered mission critical for the organization's managed care operations including implementation of a new referral authorization system that spans over 1,200 web portal users across the state.
- Referral authorization response times went from 24 minutes to less than 1 minute, which resulted in increased end user experience and customer satisfaction. The sophisticated rules engine now facilitates automatic authorizations and has resulted in fewer FTEs required to review and process requests.
- Facilitate the creation of training materials as well as training sessions including in person, online, as well as recorded sessions.

ACO Program Manager, Physician Health Partners
2011 – 2014

Manage ACO operations for Physician Health Partners Pioneer/MSSP ACO. Initially awarded through the CMS Innovation Center, PHP became one of 32 the Pioneer ACOs and in 2014 successfully made the transition to the Medicare Shared Savings Program (MSSP) ACO program. This contract encompasses 25,000 Medicare lives and includes an up and down side risk bearing model.

- Managed relationship with CMS and ensure compliance with contractual obligations.
- Assembled an ACO advisory board including PCPs, specialists, hospital partners, beneficiaries, and a patient advocate.
- Provided regular updates and presentations to IPA boards as well Physician Health Partners board of directors in order facilitate the decision making process.
- Oversaw ACO data warehousing and aggregation strategy to ensure reporting requirements are met in a timely manner.
- Collaborated with statewide HIE to connect 10 EHR systems across the ACO.
- Evaluated third party tools and vendors including population health, predictive modeling, and risk stratification solutions.
- Clinical quality improvement team guidance on clinical documentation requirements in order to meet quality goals and successfully report HEDIS and NQF measures.
- Utilized data from multiple sources to manage overall program, set goals, develop provider messaging, and program priorities.
- Care management team coordination and deployment based on chronic care models.
- Managed relationships with 3 hospital organizations to ensure successful patient identification and coordination across the continuum of care.

Program Manager – Regional Extension Center Services, Physician Health Partners
2010 – 2011

Manager Regional Extension Center (REC) services and HIT connectivity initiatives. Consult physician practices on overall technology strategies including the use of electronic medical record software solutions.

- Program development from inception through the entire program life cycle.
- Realized $1.2 million dollars in grant funding over 2 years based on program performance.
- Assisted over 100 primary care providers achieve meaningful use incentives accounting for over $1.5 million in revenue.
- Managed and trained clinical quality coaching staff to provide technical consulting services and assist practices with IT solutions as they relate to the overall quality improvement and data aggregation strategy of the IPA.
- Development of program toolkit and materials.

- Provided education and outreach on electronic medical record software, health information exchange, and meaningful use.
- Manage practice software and IT vendor selection process including RFP, demonstrations, reference checks, and contracting.
- Provided workflow analysis and process redesign.
- Conducted HIPAA Security Risk Analysis
- Assisted practices in working towards meaningful use of an EHR through gap analysis tools, data collection, and process redesign.
- Worked closely with the CORHIO, the statewide designated entity, to provide the Colorado HIE in preparing practices statewide data exchange.
- Leveraged technology to assist practices in achieving NCQA recognition as well as patient centered medical home (PCMH) initiatives.

Senior Project Manager, APRIMA Medical Software
2006 – 2010

Serve as liaison among project stakeholders at all levels, both employees and clients, during the implementation of Aprima products. Organize and manage all phases of the project from initiation to completion, keeping project within scope and budget and on target for completion date.

- Managed more than 15 national projects simultaneously while consistently meeting deadlines thus speeding revenue generation.
- Created detailed project plans including critical paths, and milestones.
- Was instrumental in launching a new product, a hosted application model (ASP). Negotiated pricing, and led implementation team.
- Oversaw the purchase and installation of hardware and network systems.
- Managed multiple cross functional teams, including a software development team in India.
- Conducted onsite workflow analysis at physician offices to identify inefficiencies as they related to the overall implementation and revenue cycle.
- Oversee third party interface development including custom HL7, e-prescribing, and laboratory interfaces.
- Managed clearinghouse and payer enrollments for electronic claim submissions to ensure cash flow is consistent throughout the implementation process.

Education

Regis University, Denver, Colorado
Degree/Program: Master of Business Administration

University of Phoenix, Salt Lake City, UT
Degree/Program: Bachelor of Business Administration

ZULA SOLOMON, MBA
RFP Job Title: Quality Improvement Director

Majority of Work Experience in Behavioral Health: No
Worked with internal and external partners to integrate behavioral health services in the primary care setting. Currently sitting on the State SIM workgroup to help inform practice transformation efforts.

Summary of Experience:
A highly motivated health care professional skilled at developing and implementing strategic and quality improvement plans that guide the growth and development of health systems changes. Effective team builder who is skillful at establishing a strategic vision and gaining buy-in from all levels of an organization, customers, and community to achieve organizational success. Analyzes and effectively presents outcome data at local and national conferences. Selected areas of expertise include strategic and Organizational Planning, Planning and Budgeting, New Business Development, Employee Engagement and Recruitment, Healthcare Reform Advocacy, Software Development and Training, Clinical Systems Implementations, Process and Quality Improvement, Patient Centered Medical Home, and Community/National Care Delivery Interventions.

Career History
Director, Quality and Clinical Programs, Physician Health Partners
2012 - PRESENT
Responsible for providing leadership, oversight, and coordination of the clinical programs, performance improvement, patient experience, at PHP for all lines of business. Designs systems and processes to measure and increase quality and efficiency of existing services to increase quality outcomes, patient safety, decrease cost, reduce clinical variation, and increase customer service to the network providers. Develops and evaluates health care programs to determine effectiveness, value, and alignment with PHP's business objectives.

Health Systems Director, Colorado Department of Public Health and Environment
2011 - 2012
Provided expertise to the Prevention Services Division on how to affect policy and systems change in the health system setting that promotes prevention and disease management. Supplied necessary support and services to internal and external partners on how to assess and engage the different aspects of the healthcare systems (patients, benefit plans, hospitals, providers, and worksites). Responsible for following the Affordable Care Act (ACA) rules and regulations to understand how it will impact public health and public health programs and create intervention plans to mitigate negative impact. Served as the primary liaison for CPDHE and Health Care Financing and Policy (Medicaid) and represents the department in the Accountable Care Collaborative advisory committees. Accountable for managing health systems' unit operations and budget, including development and tracking of budget, hiring, training, mentoring , and evaluating staff.

Patient Centered Medical Home Manager, HealthTeamWorks (formerly Colorado Clinical Guidelines Collaborative)
2009 - 2011
Provided vision, leadership, and management for locally and nationally grant-funded health care system quality improvement programs. Provided direct oversight of the Multi-payer Patient Centered Medical Home and the Texas Medical Home initiatives and provided the organization and the practices with the background, framework, and support to implement the initiatives successfully. Participated in leadership

role to create Coach University that included the development of the curriculum and providing the trainings for internal and external coaches. Designed and monitored intervention plan for health system change with hands-on assistance and education. Worked with stakeholders to assess needs and determine program strategy and direction. Served as Medical Home faculty member and expert speaker at conferences held nationally and locally. Co-authored a Medical Home workbook with a practicing physician for primary care practices seeking National Committee for Quality Assurance (NCQA) recognition as Patient-Centered Medical Homes. Coached practices to establish efficient workflows that would help them achieve health outcome goals. Worked closely with practice leadership to develop effective quality improvement teams that fostered team-based care and empowered staff to challenge the status quo. Worked closely with Reach My Doctor (software vendor) in the development and implementation of several clinical guidelines at primary care practices. Accountable for managing the PCMH initiatives' operations and budget, including hiring, mentoring, training, and evaluating staff.

Quality Improvement Coach, HealthTeamWorks (formerly Colorado Clinical Guidelines Collaborative)
2006 - 2009
Served as the lead coach for Improving Performance in Practice (IPIP) initiative in Colorado. Helped with the planning, development, implementation, and evaluation of evidence based quality improvement programs at Colorado Clinical Guideline Collaborative that was geared towards Primary Care Physicians. Met regularly with senior leadership and external partners and effectively communicated successes and barriers to the program implementation. Worked with quality improvement teams to create a customized improvement plan that included workflow improvements, accountability plan, organizational structural changes, and quality improvement tactics. Worked closely with practice leadership to develop effective quality improvement teams that fostered team-based care and empowered staff to challenge the status quo.

Education

University of Colorado, Denver, CO
Degree: Master of Business Administration, Health Administration

University of Colorado, Denver, CO
Degree: Bachelor of Science, Biology

Regional Institute for Health and Environmental Leadership, Denver, CO
Degree/Program: Leadership Training

America's Health Insurance Plans, Online Course
Program: Basics of Health Insurance

BMGI, Online Course

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Attachment 5.9-1

COLORADO COMMUNITY HEALTH ALLIANCE

Population Health Management Plan

Attachment 5.9-1: Population Health Management Plan

This attachment includes the following documents:

- Attachment 5.9-1a: Population Health Management Plan — Adult
- Attachment 5.9-1b: Population Health Management Plan — Pediatric
- Attachment 5.9-1c: Population Health Management Plan — Descriptions

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APPENDIX I

Population Health Management Plan

RAE Name: CCHA *Plus* **Region: _____** **Date Submitted: _____**

ADULT INTERVENTIONS

Stratification Level	**INSTRUCTIONS** for completing the table below: 1) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 2) Place a checkmark in the cell indicating which interventions will be used for each stratification level.									
	Integrated Complex Care Coordination	Wellness Website	Crisis Center Follow up	Outreach Trigger Follow up	Tobacco Cessation	Wellness Mailings	Tele-Town Hall	Influenza Vaccination Campaign	Gaps in Care	Community nutrition, exercise, and obesity initiatives
Low Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity		✓			✓	✓	✓	✓	✓	✓
High Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓		✓	✓	✓	✓	✓	✓	✓
Low Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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APPENDIX I

Population Health Management Plan

RAE Name: CCHA *Plus* **Region: _____** **Date Submitted: _____**

PEDIATRIC INTERVENTIONS

Stratification Level	**INSTRUCTIONS** for completing the table below: 1) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 2) Place a checkmark in the cell indicating which interventions will be used for each stratification level.										
	Integrated Complex Care Coordination	Wellness Website	Crisis Center Follow up	Outreach Trigger Follow up	Wellness Mailings	Tele-Town Hall	Influenza Vaccination Campaign	Gaps in Care	Community nutrition, exercise, and obesity initiatives	Post residential discharge follow-up for Child Mental Health Treatment Act	Well Child Outreach
Low Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity		✓			✓	✓	✓	✓	✓		✓
High Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓		✓	✓	✓	✓	✓	✓		✓
Low Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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APPENDIX I
Population Health Management Plan
Description of Interventions

Name of Intervention: Integrated Complex Care Coordination

Description: Our Integrated physical health (PH) and behavioral health (BH) Care Coordination Program is a promising practice that targets our adult and pediatric populations that have been stratified as both high physical health risk and high behavioral health risk. Members with complex PH and BH co-morbid conditions work collaboratively with an assigned Lead Care Coordinator to establish meaningful goals and develop a tailored plan of care to address and prioritize health-related concerns identified by the Member, his/her family/caregivers/significant others, legally authorized representatives and Providers. The Lead Care Coordinator communicates with the Member, Provider, and any other Care Coordinators conducting routine follow-up communications and tracking progress toward meeting goals. The Complex Care Coordination program encourages Member education and self-care, using empowerment techniques centered on Motivational Interviewing and meeting Members where they are in their care and recovery for both PH and BH conditions.

To effectively coordinate services for Members with high physical and behavioral risk/complexity, we co-locate Care Coordinators in the community, and in the same office, to function as a cohesive team. At least monthly, our PH and BH clinical staff will discuss if the Members stratifies as high physical and behavioral health risk/complexity during joint case rounds. The Lead Care Coordinator may elect to discuss these Members more frequently if it is beneficial to the Member.

Please check one of the following three options

☒Promising Practices
☐Evidence Based
☐Other

How the frequency of intervention will be determined: Through our Integrated Complex Care Coordination model, we holistically identify and address our Members' needs. For Members who live with co-occurring BH and chronic medical conditions, we use integrated screening processes and the individualized care team model. Whenever more than one Care Coordinator is involved with a Member, we will designate a Lead Care Coordinator based on the Member's primary treatment needs. This allows us to complete a whole-person assessment and facilitate continually evolving, integrated support processes that emphasize Member engagement and education, facilitate lifestyle change, and promote personal resiliency as the foundation of improving health and quality of life.

How the method of delivering the intervention will be determined: Members with complex, PH and BH co-morbid conditions work collaboratively with an assigned Lead Care Coordinator to establish meaningful goals and develop a tailored plan of care, which is guided by evidenced based assessment, to address and prioritize health-related concerns identified by the Member, his/her family/caregivers/significant others, and Providers. The Lead Care Coordinator communicates with the Member, Provider, and any other Care Coordinators conducting routine follow-up communications and tracking progress toward meeting goals.

APPENDIX I
Population Health Management Plan
Description of Interventions

Potential outcomes: We wrap our services around Members to improve treatment outcomes. We designed our Integrated Care Coordination program to help Members learn how to navigate the health care system to enhance their personalized treatment plan. In addition, the program aims to reduce re-admissions in higher levels of care by connecting Members to appropriate services in community-based settings wherever possible. Through this program, Members will be able to manage their own health care and become better advocates for their own care.

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Name of Intervention: Wellness Website

Description: CCHA *Plus* will offer an evidence-based Wellness Websites Intervention program targeting our adult and pediatric populations that have been stratified as low risk. The Wellness Websites Intervention is part of our comprehensive wellness and education program, which includes Member mailings, tele-health town halls, and the use of evidenced-based Member education materials distributed through our Care Coordination programs. Through this program, we will offer Members access to several wellness and disease-based education websites, which provide video and written self-management support content in English and Spanish on managing chronic diseases like hypertension, diabetes, and depression as well as risk factor reduction programs on nutrition and weight loss, smoking cessation, reducing drug and alcohol use, and stress management. For example, our Online Well-Being program is an evidence-based, online tool that helps individuals manage their mental health conditions and modify behavioral risk factors.

Please check one of the following three options

☒Evidence-Based
☐Promising Practices
☐Other:

How the frequency of intervention will be determined: Wellness websites will be available on an ongoing basis. We will solicit Members' input on their experience with the website approximately every two to four months. This frequency will help us target most of the important risk factors and chronic conditions once a year and will remind Members about the availability of these websites regularly. If response to the campaigns begins to decrease, we will consider revising their frequency.

How the method of delivering the intervention will be determined: Wellness and disease management websites make intervention available to a large portion of our Members. It has been estimated that more than 75% of Medicaid recipients have access to a smartphone or other devices that provide access to the Internet. We will use campaigns to promote engagement with the website and focus our website on important wellness/disease management activities.
We will track the number of Members who use the available websites and their frequency of usage. We will ask participating Members to complete baseline and monthly follow-up assessments using well-validated tools to assess success in reducing risk factors or improving disease control.

Potential outcomes: Our Wellness Websites provide a platform from which Members can query and learn about health care conditions. The goal is to engage Members to research conditions they or their family might be experiencing. As they gather information about these conditions, we hope they become better consumers of care because they have more knowledge and facts about the condition that they can review with treatment Providers.

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Name of Intervention: Crisis Center Follow-Up

Description: CCHA *Plus* is keenly aware of the suicide rate for Colorado, and we will collaborate with organizations focusing on suicide prevention. Based upon recent work with the Zero Suicide Institute and the National Action Alliance for Suicide Prevention, we know that the period immediately following discharge from a facility when one was admitted for suicidal ideation or the period immediately following contact with a crisis team is a very vulnerable time, with high rates of death, suicide attempts, and readmissions. With this knowledge we will implement our Crisis Center Follow Up program.

Our Crisis Center Follow-up Program is a best practice that targets adults and pediatrics stratified as high behavioral health risk and low physical health risk. *CCHA Plus* Care Coordinators will follow-up with Members upon release from a Crisis Center. Through this outreach, we will reconnect the Member to his or her circle of care and Lead Care Coordinator. This intervention also provides the Care Coordinator to create or revise the Member's Care Plan, if necessary.

Please check one of the following three options

☐Evidence-Based
☐Promising Practices
☒Other: Best Practice

How the frequency of intervention will be determined: After the initial contact with the Member, the frequency is determined by the Member and the Care Coordinator. Frequency will range from daily to weekly; the duration is determined on a case-by-case basis and tailored to the Member's needs.

How the method of delivering the intervention will be determined: To be effective, we will build a formal agreement and a data exchange process with the Crisis Centers so that we know when our Members have requested their assistance and when they are discharged from the Centers. Upon the crisis resolution, our efforts will support the discharge plans created by the Crisis Center. We will collaborate with the Crisis Center by assigning a Care Coordinator to facilitate the connection between each Crisis Center to a Care Coordinator appropriate to the Members needs and geographic region. This Care Coordinator will stay in contact with the member for a minimum of 72 hours, or longer as indicated by the Member's condition and compliance with the prescribed discharge plan. The goal of this intervention is to make sure the Member is engaging with the aftercare treatment plan provided, as well as reconnecting to his or her circle of supports. The Care Coordinator will also reconnect the Member to his or her PCMP to facilitate getting all gaps in care filled.

Potential outcomes: The potential outcome is a stabilized environment and no repeat crisis center intervention is needed.

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Name of Intervention: Outreach Triggers

Description: Our Outreach Triggers program is an evidence-based intervention targeting our adult and pediatric populations stratified as low behavioral health risk and high physical health risk. We will use data from a variety of sources, including: the Department's Health Needs Survey, Colorado Regional Health Information Organization (CORHIO) data feeds, eligibility and Member data, their integrated data sets, and Behavioral Health Risk Factor Surveillance System (BRFSS). This data, together with lists from Providers provided in response to our outreach requests, will trigger identification of Members will PH and BH issues that align with Population Health issues identified in the data and/or changing needs of the ACC 2.0 program. Specific triggers for care coordination include:

- Four Quadrant Risk Classification
- Inappropriate or high use of health resources, such as emergency rooms (ER)
- Re-admissions to the hospital or other facility
- High total cost of care
- High risk chronic diseases
- Multiple co-morbidities
- Children involved in the child welfare system
- Involvement in the criminal justice system
- Medicare-Medicaid Program Members
- Non-adherence to a treatment regimen
- Complex medical issues or treatment plans
- Impaired mental status, such as with dementia
- Members with insufficient support systems or community resources
- Pregnant
- Serious mental illness
- Serious emotional disturbance
- Chronic substance use disorder
- Residential care
- Crisis center services
- Newly diagnosed chronic conditions
- First psychosis diagnosis
- Homelessness
- Polypharmacy

Through these methods and triggering events, we will identify Members who may benefit from care coordination upon enrollment and throughout their time with CCHA *Plus*.

Please check one of the following three options

☒Evidence-Based
☐Promising Practices
☐Other

How the frequency of intervention will be determined: Initial outreach will be triggered by

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an event, including those in the bulleted list, above. We will determine frequency and duration on a case-by-case basis, dependent upon Member need.

How the method of delivering the intervention will be determined: All identified Members will receive outreach calls and a structured phone assessment to help identify opportunities and barriers to addressing these problems. Members with potentially more serious or complex triggers like a hospital admission, homelessness, or new depression diagnosis will receive face-to-face visits.

Potential outcomes: We designed these interventions to reduce hospital readmissions, ER visits, improve pregnancy and depression outcomes, enhance medication adherence, and address a significant social determinant of health.

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Name of Intervention: Tobacco Cessation

Description: CCHA *Plus* will provide PCMPs and other community-based organizations education materials and posters designed to educate and motivate Members to refrain from tobacco use. We will also offer primary care practices resources and support to help Members who want to quit succeed in that goal. We will offer training to PCMPs and their office staff on Motivational Interviewing and how to address common barriers to quitting. Our website will include links to provide smoking cessation programs and information on how to access Colorado's Quitline. We will also work with local governments to advocate for public policies that have shown smoking cessions quit rates.

We will also create smoking cession clinics within interested PCMP practices. CCHA *Plus* will pilot this approach by working with a few of our practices to identify Providers and other staff who are interested in receiving advance training on evidence-based smoking cession interventions. CCHA *Plus* practice transfer team will work with these practices on logistics of creating a smoking cessation clinic within PCMP practices and strategies to increase reimbursement for these services.

Please check one of the following three options

☒Evidence-Based
☐Promising Practices
☐Other

How the frequency of intervention will be determined: We will provide poster and educational materials annually, or more frequently as needed or requested. We will contact those who receive these resources quarterly to see if replacement materials are needed. We will notify all Members annually about how to access smoking cessation resources and Colorado's Quitline. We will encourage PCMPs and other Providers to refer members who are smokers to CCHA *Plus* for outreach.

How the method of delivering the intervention will be determined: We will tailor the delivery of these interventions to needs and preferences of our Providers and Members. We will offer Providers a menu of resources (posters, education materials, training) from which to choose. Members can access smoking cession resources and programs at any time through our website. We will use mailings to inform our Members about the availability of this content on our website and incentivized campaigns will take place at least twice a year to motivate members to quit smoking and use the available resources to do so. All Members engaged in our Care Coordination programs will also be screened for tobacco use.

Potential outcomes: These interventions have been shown to be effective in helping Members quit using tobacco. As a result, a potential outcome is a lower rate of Members who use tobacco products. We will track the number of Members who have used tobacco cessation content on our website annually and will work with the Quitline to identify Members who have contacted them each year. Identified Members will be contacted 3 times: the first time to determine the baseline, the second time at 3 months, and the third time at 6 months, to determine if they been able to quit or cut down on their tobacco use.

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Name of Intervention: Wellness Mailings

Description: We will provide targeted Members with wellness and disease management educational materials in English and Spanish at a 5th through 6th grade reading level. Covered topics include: self-management support for chronic conditions such as hypertension, diabetes, and depression; and risk factor reduction programs on nutrition and weight loss, smoking cessation, reducing drug and alcohol use, and stress management. We will conduct targeted seasonal and as needed wellness mailings that support Colorado's Winnable Battles, including healthier air, clean water, obesity, and safe food. The valuable information we provide will be connected to the season during which it is mailed. For instance, during the summer months when people are outdoors a lot, we will provide information regarding air quality, the importance of staying hydrated, and protecting oneself against overheating and sunburn. We will use "postcard-type" mailings to convey this information and will provide CCHA *Plus*'s contact information. These mailings will also be provided in our Network Providers' offices to distribute to patients. Providers can request additional hard copy materials on the CCHA website.

Please check one of the following three options

☒Evidence-Based
☐Promising Practices
☐Other

How the frequency of intervention will be determined: Members may access or request hard copies of wellness educational materials on an ongoing basis. We will solicit Member input on their opinion on the materials approximately every 2 to 4 months. This frequency will enable us to target most of the important risk factors for chronic conditions at least once a year and remind members about the availability of support regularly. Wellness Mailings will coincide with seasonal events and holidays, or in response to unique Colorado wellness events and/or general public movements or trends, including preventable disease outbreaks. CCHA *Plus* will use the Member Advisory Committee to evaluate the Member perception of wellness mailings, including the frequency and timing of the mailings. If response to the campaigns begins to decrease, we will consider revising their frequency.

How the method of delivering the intervention will be determined: We will make this intervention available to a large portion of our Members. CCHA *Plus* will measure the number of mailings sent and returned (for example, a wrong address) to determine the effectiveness of the delivery method. CCHA *Plus* will also measure the number of mailings requested by our contracted PCMPs to determine how many materials are being distributed outside of postal mail.

Potential outcomes: We will track the number of Members who request self-management support mailings and their frequency of usage. We will track the outcomes of the Members we engage as a result of the wellness mailings. Self-reported success in reducing risk factors or improving disease control will be assessed by asking participating Members to complete baseline and monthly follow-up assessments using well validated tools. We expect health literacy to improve as a result of wellness outreach.

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Name of Intervention: Tele-Town Hall

Description: The purpose of a town hall meeting is for leaders, organizations, or influencers to hear the community's views, provide an opportunity for individuals to ask questions, present ideas, and feel heard. CCHA *Plus*'s Tele-Town Hall is similar, but will be conducted by phone to connect with a larger audience of Members and families. These tele-town halls will engage Members to help educate about CCHA *Plus* and Medicaid benefits, promote general health literacy, and inform about community resources. Additionally, the town hall may target a specific demographic or subset of our population to address Member-specific needs and questions, such as maternity Members, young families, or Medicaid-Medicare Program Members. CCHA *Plus*, together with Providers and community partners, will provide education and answer Member questions. During the Tele-Town Hall, CCHA *Plus* will encourage Members to ask questions as we educate about a specified topic area, including benefits and resources. Participants will have the option of attending meetings in English and Spanish. Prior to the event, CCHA *Plus* will conduct mailing and conduct interactive voice response (IVR) calls to specified populations (such as pregnant women and children ages 3-9). This outreach will occur one to two weeks before the town hall meeting, with follow up 2-3 days before the event as a courtesy reminder and to confirm attendance.

Please check one of the following three options

☒Evidence-Based:
☐Promising Practices:
☐Other:

How the frequency of intervention will be determined: Initially, the intervention will be performed annually, and biannually thereafter. We will solicit Members' input regarding their experience of the Tele-Town Hall by conducting follow up surveys. This way, Members inform future iterations and we confirm the intervention is effective and relevant. We will also measure care coordination activity resulting from the town hall and modify or adjust our activities and outreach accordingly.

How the method of delivering the intervention will be determined: Given that Tele-Town Halls are conveniently conducted by phone, they are available to a large portion of Members. Plus, multiple family members can listen to the call at the same time. We will determine topics through analysis of multiple data sources and will align topics to the region's demographic determinants, and State's priorities such as Winnable Battles. CCHA *Plus* will monitor engagement and may revise this approach based on Member feedback and engagement.

Potential outcomes: We expect this intervention will help reduce gaps in care including post-partum visits, well child visits, and vaccine administration. Additional potential outcomes include improve engagement with Members who self-direct their own care, increased health literacy, and increased Member engagement with the Health Neighborhood.

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Name of Intervention: Influenza Vaccine Outreach

Description: One month before the beginning of flu season, CCHA *Plus* will mail Members flu vaccine reminder postcards. These will provide written education about the importance of the flu vaccine and CCHA *Plus* contact information for help finding a Provider and scheduling an appointment to obtain the flu vaccine. CCHA *Plus* will also conduct IVR outreach one month prior the start of flu season to provide an opportunity for Members to listen to information regarding the importance of the flu vaccine and to speak to a Care Coordinator for assistance scheduling an appointment for the flu vaccine. For Members at higher risk for the flu (such as children aged 5 and under, adults age 65 and over, pregnant women, and/or those with certain chronic medical conductions such as asthma, lung disease, and heart disease), CCHA *Plus* will develop tailored scripting. Care Coordinators will also receive specialized training regarding how to engage differently with the most "at risk" population. Care Coordinators will outreach all medium to high risk Members enrolled in Care Coordination programs one month prior to the influenza season to educate on the importance and help with barriers to care as needed.

Please check one of the following three options

☐Evidence-Based
☒Promising Practices
☐Other

How the frequency of intervention will be determined: The flu mailings and flu IVR outreach will be performed seasonally at the time of flu season, specifically 1 month before and during the first through third months of flu season. CCHA *Plus* will conduct analyses of the effectiveness of the flu outreach campaigns by comparing outreach statistics to claims payments made within the 30-90 days after outreach is completed. For instance, CCHA will compare Member outreach data to primary care visits and immunization/vaccine claims data to determine the extent to which flu outreach may have contributed to vaccination rates and primary care visits. CCHA Plus will also analyze other benefits of the flu outreach campaigns, through Member engagement with care coordination, connection to resources such as transportation, and appointment scheduling and adherence.

How the method of delivering the intervention will be determined: The use of mailings and IVR phone calls allows us to make this intervention available to the majority of Members. CCHA *Plus* will measure the number of mailings sent and returned (for wrong address) to determine the effectiveness of the delivery method. We will use the Member Advisory Committee to elicit feedback regarding our flu outreach efforts, the effectiveness of language and scripting, and the Member experience of IVR outreach and mailing materials. Whenever possible CCHA *Plus* will structure incentives to encourage Members to receive their vaccine.

Potential outcomes: We will track the outcomes of the Members with which we engage. Some the potential of this Intervention include: improved health literacy, increased vaccination rates, increased primary care appointments, visits at health clinics offering flu vaccines, and evidence of successful care coordination efforts (e.g. connection to transportation resources). We will work with or provider network to ensure that these visits are coded for the intended reason (e.g. vaccination instead of a sick visit). We will track: the number of Members who contact CCHA after receiving flu outreach; the number of Members who transfer to a Care Coordinator after

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an IVR phone call; the number of Care Coordination cases that result from flu outreach.

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Name of Intervention: Gaps in Care

Description: Our Gaps in Care Program follows the recommendations of the United States Prevention Services Task Force (USPSTF) and designed to remind adult and pediatric Members who have been identified as not receiving services pursuant to recommended clinical guidelines. Our Gaps in Care program will focus on goals identified by the ACC Program and is appropriate for all Members, regardless of risk level. To achieve these goals, we will deploy strategies to close clinical gaps that include the following:

- Our Practice Transformation Team will work with the assigned PCMP to conduct outreach to Members and make sure the care gaps are addressed when Members are seen in the practice. In addition, we share gaps in care reports and practice level Key Performance Indicator reports with the PCMPs to educate Providers on their populations' overall health outcomes and to identify those Members who have not been seen.
- Our Care Coordination team proactively screens for gaps in care for all Members enrolled in one of our many Care Coordination programs. The Care Coordinators work with the Members to educate them on the importance of receiving the recommended care, assess barriers to seeking care, and assist as needed to resolve them.
- Our Population Health management tools will reach large targeted subsets of Members, including auto-generated Member mailing and scripted IVR calls. By deploying a combination of strategies, we can reach a larger audience, track gap closures, and direct care coordination follow up support, as needed, if gaps in care are not completed within as specified timeframe.

Please check one of the following three options

☐Evidence-Based
☒Promising Practices
☐Other

How the frequency of intervention will be determined: Monthly gaps in care reports and IVR campaigns will be conducted using the ACC 2.0 goals and/or targeted disease-specific evidenced-based care guidelines. Care Coordinators will monitor and intervene in gaps in care on all active Members enrolled in Care Coordination on an ongoing basis.

How the method of delivering the intervention will be determined: Interventions will occur at three levels: regional population for mailing & IVR outreach to a targeted subgroup, PCMP practice level to engage Member's Medical Home outreach and inform Member visits, and individual outreach for mid to high risk Members enrolled in care coordination programs.

Potential outcomes: Improved clinical prevention and chronic care outcomes, KPI performance and preventive screenings

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Name of Intervention: Nutrition and Weight Loss

Description: CCHA *Plus* will provide PCMPs, schools and other community-based organizations with posters and other patient education materials to motivate Members to eat healthy and, when necessary, lose weight. We will offer PCMPs access to additional resources to support the success of Members who want help in losing weight. Our website will provide links to effective online nutrition and weight loss resources and programs. We will also work with local governments to advocate for public policies shown to reduce obesity. CCHA *Plus* will survey the communities in our regions to access the availability healthy food choices and other resources to aid in weight reduction. We will make this information available through posters, patient education materials posted in the community and our primary care practices as well as mailings.

When healthy food choices are inadequately available in communities, we will work to increase access to food resources as well as resources to allow our Members to be more active.

In addition, we will offer training to PCMPs and their office staff on Motivational Interviewing and how to address common barriers to weight loss. These interventions have been shown to be effective in helping Members loss weight. We will train our Care Coordination staff to offer nutrition and weight loss counseling to Members identified as needing those services.

Please check one of the following three options

☒Evidence-Based
☐Promising Practices
☐Other

How the frequency of intervention will be determined: We will offer PCMP practices posters and educational materials annually. Those who receive these resources will be contacted quarterly to see if replacement materials are needed. We will notify all Members annually about the availability of nutrition and weight loss information on the CCHA *Plus* website. At least twice a year, we will review our claims data monthly to identify Members who are diagnosed as obese, so that they can receive more tailored information on the benefits of losing weight and resources available to them. We will also encourage our Network Providers to refer Members who need nutrition and weight loss coaching to us for outreach.

How the method of delivering the intervention will be determined: CCHA *Plus* will tailor the delivery of these interventions to needs and desires of our PCMPs, Members, and community organizations. We will offer Providers a menu of resources (posters, education materials, and training) to choose from. Members can access nutrition and weight loss resources and programs at any time through our website. We will use mailings to inform our Members about the availability of this content on our website.

Potential outcomes: We anticipate Members will report healthier habits and weight loss. We will track the number of Members who have used nutrition and weight loss content on our website annually. Identified Members will be contacted 3 times; once at baseline, the second time at three, and a third time at six months, to determine if they been able to lose weight.

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Name of Intervention: Well Child Outreach

Description: We will conduct IVR phone calls during the birthday month of our pediatric Members who have not had a well child visit within the last year. The automated message will allow parents and guardians the option to transfer to CCHA *Plus* to speak with a Care Coordinator about the well child visit and will encourage listeners to transfer to CCHA *Plus* if they need help addressing barriers to a visit. Care Coordinators are trained to find a pediatrician and facilitate a three-way phone call to get the well child visit scheduled. They will also work with the Member and/or the parent/guardian to identify additional care coordination needs.

Please check one of the following three options

☐Evidence-Based:
☒Promising Practices:
☐Other:

How the frequency of intervention will be determined: The intervention performed is monthly and on an ongoing basis. CCHA *Plus* will conduct annual, or more frequently and as needed, analyses of this outreach campaign to evaluate effectiveness and determine the specific results of these efforts.

How the method of delivering the intervention will be determined: This intervention is available to the entire population of children for targeted age groups who have not had a well child visit within the last year (using the demographic data provided by Colorado Medicaid). The automated message is concise and provides parents and guardians the option to speak with a Care Coordinator at their convenience.

Potential outcomes: Potential outcomes include increased well child visit rates and follow-up appointment adherence, reduced burden on Members to schedule appointments, and connecting Members to transportation resources to increase adherence to appointments. We will track the outcomes of the Members we engage. We will work with Network Providers to verify these visits are coded for the intended reason; for example: well child visit instead of a sick visit.

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Name of Intervention: Post residential discharge follow-up for Child Mental Health Treatment Act children

Description: This Pediatric CCHA *Plus* Care Coordination program targets adolescent and children with mental health, substance abuse, or co-occurring conditions that have been admitted to residential care. We understand that residential care is very disruptive on everyone in the family; the family has to adjust to having the adolescent/child living outside the home and – when care has completed – they need to make adjustments for the adolescent/child to return to the family unit. We assign Care Coordinators with specialized training to facilitate the process of re-integrating the family. We also recognize that in some instances the adolescent/child does not return to the family unit. We will tailor our approach to address those situations as well.

The program comprises all care coordination activities. We will implement a comprehensive approach to the transition home process, assuring coordination and collaboration among all elements in the adolescent/child's life. This confirms that the child's service needs are met across multiple health care, social service, criminal justice, education, and recreational programs. Our Care Coordinator will make sure that the family and adolescent/child are included in all aspects of treatment planning. Through this collaboration, the Member is more likely to maintain gains achieved during the course of treatment.

Please check one of the following three options

❑Evidence-Based
❑Promising Practices
☒Other: Best Practice

How the frequency of intervention will be determined: After the initial contact, the frequency is determined by the Member / family and the Care Coordinator. Frequency may range from daily to weekly, and is determined on a case-by-case basis, based on Member needs.

How the method of delivering the intervention will be determined: The Follow Up – After Residential Care program starts before the Member is discharged with targeted outreach to the family. CCHA *Plus* will collaborate with the facility discharge planner upon the Member's admission.

Potential outcomes: Potential outcomes include: reduced readmission to inpatient and or residential care. The goals of the residential treatment program will be re-enforced after discharge when the Care Coordinator serves as a liaison during the re-entry into the family.

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