

Colorado
Accountable Care Collaborative

**FY 2014–2015
ACCOUNTABLE CARE COLLABORATIVE
SITE REVIEW AGGREGATE REPORT**

August 2015

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.



3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545
Phone 602.801.6600 • Fax 602.801.6051

1. Overview	1-1
Background	1-1
Methodology	1-1
2. Statewide Summary of Results	2-1
Summary of Compliance Findings	2-1
Year-to-Year Comparison of Care Coordination Record Reviews	2-1
Summary of Activities and Progress by Focus Area	2-2
3. Trends Related to Discussion Themes	3-1
Delegation of Care Coordination	3-1
RCCO Coordination With Other Agencies/Provider Organizations	3-4
Care Coordination	3-7
4. Conclusions and Overall Recommendations	4-1
Conclusions	4-1
Overall Opportunities for Improvement and Recommendations	4-5

Background

The Colorado Department of Health Care Policy & Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011 as a central part of the Department's plan for Medicaid reform. The ACC Program was designed to improve the client and family experience, improve access to care, and transform incentives and the healthcare delivery system into a system that rewards accountability for health outcomes. Central goals for the program are improvement in health outcomes through a coordinated, client-centered system of care and cost control by reduction of avoidable, duplicative, variable, and inappropriate use of healthcare resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. The ACC Program was designed to allow each RCCO to develop customized programs to address the variations in populations, community providers and agencies, and member needs in diverse geographic areas across the State. The RCCOs provide care management for medically and behaviorally complex clients, coordinate care among providers, and provide practice support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign.

Methodology

Between February and May 2015, Health Services Advisory Group, Inc. (HSAG), performed a site review of each RCCO to assess progress toward implementing the ACC Program during its fourth year of operations. The site review process consisted of a focused evaluation of these domains: Delegation of Care Management, RCCO Coordination With Other Agencies/Provider Organizations, and Care Coordination. The purpose of the site reviews was to document compliance with selected ACC Program contract requirements, evaluate each RCCO's progress toward implementation of the ACC model of patient care, explore barriers and opportunities for improvement, and identify activities related to the integration of the Medicaid expansion populations. The site review process included a desk review of key RCCO documents prior to the site visit, on-site review of care coordination records, and on-site interviews of key RCCO personnel. This report documents the aggregate findings and recommendations to provide a statewide perspective of RCCO operations and progress toward ACC Program goal achievement.

HSAG performed care coordination record reviews on five adults with complex needs and five children with special needs for each RCCO. The Department selected the sample from a list of members with complex care coordination needs provided to the Department by each RCCO, and included cases from entities delegated to perform care coordination as well as cases for which the RCCO performed care coordination. Compliance with the contract requirements for the care coordination record review was documented using a score of *Met*, *Partially Met*, or *Not Met* for each requirement. For each case, HSAG provided observations and comments, some of which were related to addressing *Partially Met* or *Not Met* scores. Care coordination record scores are summarized by

RCCO in Table 2-1. A year-to-year comparison of record review scores is summarized in Table 2-2, and statewide trending of record review scores is summarized in Table 2-3.

HSAG conducted the focused review of Delegation of Care Coordination and RCCO Coordination With Other Agencies/Provider Organizations using a qualitative interviewing methodology to elicit information concerning activities and progress related to requirements outlined in the ACC contract. Results of these discussions were not scored. Discussion and pertinent observations were included in individual RCCO data collection tools. Section 2 includes the summary of the RCCOs' activities and progress related to each of the focus areas.

HSAG analyzed information obtained during the on-site interviews to identify common experiences or concerns across RCCO regions, and developed statewide recommendations for continued successful implementation of Colorado's ACC Program. The trended results of discussions related to Delegation of Care Coordination, RCCO Coordination With Other Agencies/Provider Organizations, and Care Coordination are documented in Section 3, "Trends Related to Discussion Themes." HSAG's observations and recommendations related to statewide themes and discussions are documented in Section 4, "Conclusions and Overall Recommendations."

2. Statewide Summary of Results

Summary of Compliance Findings

Table 2-1—Summary of 2014–2015 Care Coordination Record Review Scores							
RCCO	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Region 1	80	63	59	4	0	17	94%
Region 2	71	57	45	8	4	14	79%
Region 3	82	65	59	6	0	17	91%
Region 4	80	60	60	0	0	20	100%
Region 5	80	54	33	16	5	26	61%
Region 6	80	57	41	13	3	23	72%
Region 7	80	62	48	13	1	18	77%
Total	553	418	345	60	13	135	83%

Year-to-Year Comparison of Care Coordination Record Reviews

Table 2-2 and Table 2-3 provide a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Although most contract requirements remained the same for the two review periods, scores may have changed due to reformatting and clarifications in the record review tool.

Table 2-2—Year-to-Year Comparison of Care Coordination Record Review Scores			
RCCO	2013–2014 Score (% of Met Elements)	2014–2015 Score (% of Met Elements)	Year-to-year % Change in Score
Region 1	99%	94%	- 5%
Region 2	64%	79%	+ 15%
Region 3	43%	91%	+ 48%
Region 4	100%	100%	-0-
Region 5	59%	61%	+ 2%
Region 6	69%	72%	+ 3%
Region 7	98%	77%	- 21%
Total	79%	83%	+ 4%

Table 2-3—Statewide Trending of Care Coordination Record Review Scores							
Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Care Coordination 2013–2014	1,044	858	679	97	82	186	79%
Care Coordination 2014–2015	553	418	345	60	13	135	83%

Summary of Activities and Progress by Focus Area

Delegation of Care Coordination

Region 1— Rocky Mountain Health Plans (RMHP)

- ◆ Community Care Teams (CCTs) in five geographic locations across the region and RMHP staff perform care coordination for all RCCO members with complex needs. CCT staff members are employed by local health partners that developed each CCT. In 2014, RMHP supplemented the CCTs with RMHP-employed care coordinators in order to manage the expansion populations.
- ◆ Each CCT is uniquely configured according to the resources in each community, and CCTs provide care coordination for many primary care medical providers (PCMPs) in the region. Each CCT is accountable to RMHP to perform care coordination functions and reporting as outlined in the Community Integration Agreement (delegation agreement).
- ◆ A local Community Oversight Committee, composed of leadership from the community partnership organizations and RMHP, conducts oversight of each CCT’s performance.
- ◆ RMHP based its pre-delegation assessment on an overall evaluation of the leadership and resources available in the community, while conveying a clear message of the RCCO’s expectations for care coordination activities. In preparation for delegation, RMHP meets with community leadership and staff to assess gaps and training needs, and offers resources to assist in filling any identified gaps. Prior to initiation of delegated functions, RMHP conducts extensive training of care management staff regarding care coordination policies, processes, and resources.
- ◆ RMHP provides ongoing tools and resources to CCTs to help guide the care coordination processes, including an option to use RMHP’s Essette care management software. CCT staff members are required to participate in quarterly cross-CCT meetings, and provide RMHP with quarterly care coordination metrics.
- ◆ RMHP management staff members are highly integrated with the CCTs and hold CCTs accountable through expeditious use of data to monitor and facilitate care coordination outcomes. The delegation agreement allows RMHP to conduct annual audits, although RMHP had not yet identified the need to implement a detailed performance audit.
- ◆ The CCT model of care coordination enables care coordination to be community-based across a widespread geographic region, yet still focused on a manageable number of entities. While processes are not standardized, care coordination record reviews demonstrated that CCTs are consistently performing the ACC Program comprehensive care coordination requirements. The CCTs identify and resolve care

Delegation of Care Coordination

	<p>coordination challenges through local initiatives.</p> <ul style="list-style-type: none"> ◆ CCTs and RMHP care coordination staff are responsible for completing the service coordination plans (SCPs) for Medicare-Medicaid Program (MMP) enrollees. RMHP customized its Essette care management system to capture and report all of the required SCP documentation. The care coordination processes for MMP members are the same as those used with other member populations. Staff stated that a major implication of integrating MMP members into the RCCO was developing relationships with the many organizations that serve this population. ◆ RMHP has admit, discharge, and transfer (ADT) data-sharing arrangements with many hospitals across the region, and is working with the west slope and front range health information exchanges to access timely ADT information from all hospitals.
<p>Regions 2, 3, 5—Colorado Access</p>	<ul style="list-style-type: none"> ◆ Colorado Access had executed written delegation agreements with 13 of the larger PCMP clinic systems across the three RCCO regions, with 10 of the 13 delegation agreements signed prior to 2014. Staff estimated that 45 percent of members across the three regions are attributed to practices delegated for care coordination. Colorado Access provides care coordination services for the remaining 55 percent of its members and, during 2014, significantly increased staffing levels for internal care management. ◆ All 13 delegates perform intensive care management, 12 of 13 perform transitions of care (TOC), and seven of 13 perform MMP care plans, including SCPs. During 2014, Colorado Access revised its delegation agreement to explicitly define expectations related to the current care coordination requirements of the RCCO contract with the Department. However, Colorado Access did not implement the revised agreement with the pre-established delegates, instead amending the previously executed delegation agreement to include the MMP requirements and revised reporting metrics. ◆ Colorado Access continues to have discussions with additional PCMPs concerning their readiness to apply for delegation of care coordination. Colorado Access is also evaluating an alternative model of delegation to accommodate future relationships with local community-based partnership alliances, particularly in the Region 2 rural areas. ◆ Colorado Access updated its predelegation assessment tool to align with the “evolved” understanding of care coordination requirements for which RCCOs are contractually responsible. The new predelegation process, applied to applicants in 2015, will involve evaluation, practice coaching, and a preparatory process that may require a lengthy engagement with the practice prior to delegation. ◆ During 2014, Colorado Access also developed a chart audit tool for an annual assessment of delegate care coordination performance. Colorado Access has applied the chart audit tool to internal RCCO care coordination records and plans to audit all delegated entities before the end of 2015. ◆ Other ongoing oversight activities include reviewing delegates’ monthly care coordination metrics, monitoring enhanced primary care reports, and delegate participation in bimonthly Care Management (CM) Delegation Committee meetings. CM Delegation Committee meetings provide ACC Program updates and education about system-wide changes in RCCO care coordination priorities, stimulate interactive care coordination discussions, and encourage delegates to share best practices. ◆ During 2014, Colorado Access internally implemented a comprehensive member needs assessment tool that incorporated many detailed elements of medical, behavioral, functional, social, and cultural needs. Colorado Access introduced the tool to delegates for

Delegation of Care Coordination

	<p>educational purposes, and made it available to all delegates for optional implementation.</p> <ul style="list-style-type: none"> ◆ Colorado Access allows each delegate to stratify members for referral to care management based on internal systems and data available within the individual practice, and processes varied across PCMPs. ◆ Staff stated that coordination with external community organizations and agencies is a relatively new concept in PCMP-based care coordination and remains a challenge for most delegates. Colorado Access hosted a cross-systemic care coordination conference to explore care coordination relationships among multiple external entities. Colorado Access had business associate agreements (BAAs) that enable data sharing and shared client lists with 22 community agencies and providers, and implemented several care coordination pilot projects with select organizations. ◆ Colorado Access provides care coordination, including SCP completion, for all unattributed MMP members and those members attributed to nondelegated MMP practices. Colorado Access designated a specialized SCP team and developed a web-based SCP tool used by delegates and Colorado Access staff. Colorado Access anticipates the SCP team’s experiences will be valuable in informing care coordination for other ACC populations. ◆ Colorado Access had ADT data sharing arrangements with many independent hospitals and (effective in 2015) access to Colorado Regional Health Information Organization (CORHIO) data. Colorado Access passes ADT data for RCCO members to the applicable delegate. In 2014, Colorado Access established the TOC Team to develop and implement improved TOC mechanisms that may be transferable to the delegates. ◆ Colorado Access’ goal is to create a more robust system of care coordination through individual practice coaching and group trainings. Staff stated that increased delegate training and support can be accomplished as the frequency of major ACC Program changes is diminished.
<p>Region 4— Integrated Community Health Partners (ICHP)</p>	<ul style="list-style-type: none"> ◆ ICHP has aligned a care coordinator from each community mental health center (CMHC) with a care coordinator from each federally qualified health center (FQHC) to create seven care coordination teams, and delegates all core functions of care coordination to these seven partner teams. Each team is responsible to coordinate care for RCCO members attributed to its own organization as well as provide care coordination support for other PCMP practices within its service area. ◆ ICHP signed delegation agreements with each of the seven entities that delineated the overarching goals of RCCO care coordination and the delegated entity’s specific responsibilities. ICHP updates the agreements annually, and has incorporated the requirement to complete SCPs for the MMP population. ◆ ICHP’s management oversees the region-wide care coordination program, and care coordination teams participate in monthly care coordination workgroup meetings. The collaborative workgroup is responsible for developing care coordination procedures, reviewing performance indicators, and resolving gaps in care coordination, which enhances consistency and increases standardization of processes. ◆ ICHP has expanded the role of care coordination teams to support communications and implement RCCO objectives and projects in the local communities. ICHP’s operational philosophy is to augment local care coordination efforts by supporting local systems of care.

Delegation of Care Coordination

	<ul style="list-style-type: none"> ◆ ICHP staff anticipated that, in 2015, all care coordination teams will implement the Crimson care management system, which will integrate care coordination documentation by allowing all care coordinators, providers, and ultimately community agencies to consolidate care coordination information. ◆ Prior to delegating care coordination to the existing FQHC/CMHC teams, ICHP evaluated the organizations’ care coordination capabilities and systems. ICHP has a well-defined predelegation assessment process for evaluating PCMP care coordination capabilities that has been incorporated into the more comprehensive activities of the practice transformation team. ◆ ICHP also implemented annual auditing of delegated care coordination functions, using a detailed record review tool that addresses the comprehensive care coordination requirements specified in the RCCO contract. ICHP also regularly monitors each delegated entity’s key performance indicators (KPIs) and care coordination metrics. ◆ ICHP has not modified its core care management processes to accommodate any special populations, including MMP members. However, ICHP does expect that a large proportion of MMP members will require complex care coordination, will impact the types of resources required, and will stimulate new relationships with community organizations and agencies. Completion of the SCPs and attribution of MMP members have dominated care coordination resources. ICHP intends to integrate the SCP document into the Crimson care management system. ◆ ICHP continues to have issues related to lack of consistent and timely reporting of ADT information from hospitals. ICHP has identified that access to information in the CORHIO system is the best solution to this issue. ◆ Staff members stated that ICHP may not be able to capture some of the eligibility category information required in the Department’s revised care coordination report. Ultimately, ICHP intends to automate the Department’s care coordination report through the Crimson care management system.
<p>Region 6— Colorado Community Health Alliance (CCHA)</p>	<ul style="list-style-type: none"> ◆ CCHA has delegated care coordination activities to five PCMPs that represent 35 percent of the members attributed to Region 6. CCHA retains the responsibility for complex care coordination for the remaining 65 percent of the members in the region. ◆ CCHA is not pursuing delegation with additional PCMPs, but may consider implementing partial delegation of care coordination functions with some of the more robust practices. ◆ CCHA has a formal delegation agreement with each entity that delineates, in broadly-defined terms, the care coordination requirements outlined in the CCHA contract with the Department. CCHA stated it was limited in its ability to be prescriptive with the methodologies or systems used by each delegate to perform care coordination, due to cross-RCCO affiliations of the PCMPs and the political implications of working with the major provider network PCMPs. ◆ CCHA broadly defined the performance expectations of delegates related to RCCO care coordination requirements in the delegation agreement and monitored performance at a high-level. CCHA performed a predelegation assessment of the infrastructure and systems capabilities within each PCMP to meet the requirements of the delegated care coordination agreement. ◆ CCHA met monthly with delegates to share best practices, review outcome data (e.g.,

Delegation of Care Coordination

	<p>KPI's), and provide information about any anticipated ACC Program developments. CCHA management also tracked and trended each delegate's care coordination activities using the metrics submitted in the care coordination report to the Department.</p> <ul style="list-style-type: none"> ◆ CCHA staff stated that it intends to perform an annual audit of each PCMP, including care coordination record reviews, to ensure compliance with care coordination requirements. At the time of review, effective audit mechanisms for determining compliance with current ACC contract requirements were not in place. CCHA had audited each PCMP once since inception of the program, has revised its audit approach, and plans a second audit in 2015. ◆ Processes for stratification of members for referral to care coordination varied by delegate. CCHA is working with its delegate partners to determine the best methods for identifying the categories of members to which care coordination resources may be most effectively applied. ◆ CCHA remains committed to conducting home-based assessments as an effective mechanism for engaging members in comprehensive care coordination. CCHA also co-locates CCHA care coordinators in some high-volume Medicaid practices. ◆ Delegation agreements require all delegates, except Kaiser, to complete SCPs for MMP members. CCHA completes the SCP for all members attributed to nondelegated PCMPs and Kaiser. Staff stated that completing SCPs is time-consuming for care coordinators and needs to be integrated into the Essette care management software in the future. ◆ Effective April 1, 2015, CCHA was receiving daily ADT information from 28 regional hospitals through the Department's affiliation with CORHIO.
<p>Region 7— Community Health Partnership (CHP)</p>	<ul style="list-style-type: none"> ◆ CHP stakeholder leadership, including major Medicaid providers, determined at the inception of the RCCO that care coordination should be delivered at the PCMP level whenever possible. CHP signed a Delegation of Care Coordination Memorandum of Understanding (MOU) with eight PCMPs, including five that account for approximately 50 percent of the attributed RCCO enrollment. CHP employed care coordinators and health navigators to assist delegates with complex care coordination and provide outreach to unattributed members. ◆ Each delegation MOU described a high level of core requirements for performing basic and complex care coordination and deliverables for RCCO members but did not define specific operational approaches. Each PCMP has a slightly different model of care coordination driven by the funding streams of its total patient population as well as its resources and system capabilities. Staff described delegation as a matrix of different levels of care coordination across the delegate PCMPs. ◆ CHP performed predelegation assessments for each of the eight PCMPs with which it has delegation agreements; however, prior to 2014, the practice assessment tools used were not consistent across practices and were more closely aligned with an assessment of medical home standards than with the comprehensive care coordination requirements outlined in the ACC contract. Beginning mid-2014, CHP implemented a more thorough assessment of specific care coordination functions that align with the requirements in the delegation MOU for any new PCMP practices seeking delegation. ◆ CHP's ongoing assessment of delegated practices included review of monthly care coordination metrics and a biannual audit of care coordination charts for each PCMP.

Delegation of Care Coordination

However, examples of chart audit tools applied to PCMPs were variable from practice to practice and did not include the comprehensive care coordination characteristics outlined in the RCCO contract.

- ◆ PCMP-based care coordination trended toward the traditional clinical model of needs assessment, referral management, and follow-up rather than addressing comprehensive medical, behavioral, social, and cultural factors.
- ◆ CHP holds a bimonthly care coordination meeting to share best practices among delegates and to obtain input regarding system-wide care coordination issues. However, the primary interaction between PCMPs and the RCCO is through the practice transformation teams, which assist PCMPs with improving care coordination processes.
- ◆ Care coordination activities for MMP members are the same as those for other Medicaid members. CHP has not delegated the responsibility for completing SCPs to the PCMPs. CHP has designated staff to complete SCPs.
- ◆ CHP invested in the Crimson care management software to be pilot tested with Peak Vista, RCCO coordinators, AspenPointe, and the Community Assistance, Referrals, and Education Service (CARES) program. CHP plans to expand access to the Crimson system to other PCMPs and community providers.

RCCO Coordination With Other Agencies/Provider Organizations

**Region 1—
Rocky
Mountain
Health Plans**

- ◆ RMHP had numerous formal agreements with agencies and provider organizations and described many examples of both community-based and region-wide initiatives with community organizations or agencies.
- ◆ RMHP has committed significant staff resources to developing and nurturing multiple partnerships.
- ◆ Many of RMHP’s relationships with community organizations are associated with integrated care coordination functions. RMHP also participates in or facilitates community-driven special projects and pilot programs to meet community health and member needs. Relationships may be either informally aligned or formally defined through a BAA or MOU.
- ◆ RMHP supports various community partnership initiatives by providing funding, data, or expertise in building structured processes. Community organizations also value the RCCO as a conduit for information flow with the Department.
- ◆ RMHP has established relationships with CMHCs, county public health agencies, departments of human services (DHS), Aging and Disability Resource Centers, community health alliances, single entry points (SEPs), and community-centered boards (CCBs). RMHP secures the mutual commitments of the agency and the RCCO through formal written agreements.
- ◆ Staff members stated that successful interagency relationships are realized when a need is defined by more than one stimulus source, or financial incentives have been implemented to encourage agencies to work with the RCCOs. RMHP also acknowledged the Department’s efforts to align RCCOs with other State-wide agencies and to facilitate solutions to cross-RCCO challenges.
- ◆ RMHP addressed the continuing need to promote the use of technology to support coordination efforts among multiple organizations, and has been collaborating with the Quality Health Network (QHN) information exchange to facilitate integration and timely access of information from multiple health partner sources.
- ◆ RMHP and the CCTs have interfaced with the Colorado Department of Public Health and Environment (CDPHE) and the Colorado AIDS Project regarding services for members with HIV. Colorado AIDS Project provides services and programs that address the comprehensive needs of members with HIV in the region.
- ◆ RMHP has developed a working relationship with the two prisons in the region to develop a program to connect criminal justice involved (CJI) members to primary care upon release from prison. RMHP staff members began navigating through some of the 22 county jail systems in the region and have determined that the approach to working with CJI members being released from county jails will best be defined through small pilot projects. RMHP has engaged in a CJI performance improvement project (PIP) with the CCTs and parole offices in Mesa and Larimer counties.
- ◆ RMHP has established relationships with numerous agencies and organizations associated with management of MMP members, including all of those outlined in the ACC contract. Most relationships are focused on data-sharing and cooperative care coordination activities, and address the State-defined protocols for managing MMP members. Staff described the relationships with most skilled nursing facilities (SNFs), home health agencies, and hospice organizations during 2014 as “introductory.” The Area Agencies on Aging and RMHP’s participation in community-based healthcare

RCCO Coordination With Other Agencies/Provider Organizations

	<p>coalitions serve as conduits for building relationships with other long-term services and supports (LTSS) providers.</p> <ul style="list-style-type: none"> ◆ RMHP described several initiatives for identifying and managing Medicaid members who are pregnant, including use of claims and other data sources to identify and refer pregnant members to the obstetrics case manager, an established relationship with the B4 Babies & Beyond program in Mesa County, and referral of first-time mothers to the Nurse Family Partnership programs in the region. ◆ Since the inception of the RCCO program, the CCTs and community oversight committees have integrated with community organizations and agencies for care coordination, and continue to provide a solid foundation for expanding community partnerships. RMHP has positioned the RCCO as “a good community partner” while maintaining a focus on meeting the goals of the ACC.
<p>Regions 2, 3, 5—Colorado Access</p>	<ul style="list-style-type: none"> ◆ Colorado Access listed 180 community organizations and agencies in Regions 3 and 5 and 98 community organizations and agencies in Region 2 with which it has relationships of varying degrees—from introductory RCCO presentations to formal MOUs and/or BAAs. Colorado Access secured care coordination partnerships or other relationships that involve sharing member information, relationships that involve financial payments, or collaborative project agreements with BAAs or MOUs. ◆ Colorado Access had implemented an all-inclusive approach to develop a broad foundation of relationships from which partnerships may be defined. Colorado Access targeted priority relationships through a variety of mechanisms including data sources, care coordinators, community organization networking, and strategic objectives. ◆ Colorado Access established a Health Neighborhood Division to managerially focus oversight and organization of community partnerships across all regions and initiated bimonthly Health Neighborhood meetings in all regions. Colorado Access invites all agencies/organizations with which the RCCOs have contact to attend these meetings. Health Neighborhood meetings in Region 2 are held in three geographic sub-regions in partnerships with other community health groups. ◆ Colorado Access described a number of collaborative pilot projects implemented with community providers and agencies. However, relationships with the majority of organizations have been limited primarily to high-level discussions and presentations. ◆ Colorado Access is implementing a customer relationship management (CRM) database and developing a Health Neighborhood Directory to assist with tracking and managing numerous organizational relationships. ◆ Colorado Access identified these factors that contribute to a successful community partnership: mutually aligned missions and goals, the RCCO’s growing reputation in communities, financial incentives, providing needed data for initiatives, and persistent staff attention to build trust. Colorado Access stated that Department initiatives such as introducing RCCOs to statewide industry groups (e.g., CCBs, SEPs, and Health Facilities Advisory Council) and implementing contract or financial incentives are very helpful. ◆ Significant challenges to developing relationships with community organizations and agencies included organizations’ limited understanding of RCCO roles and responsibilities, legal review and Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns that impede execution of formal agreements, political and operational environments within various health industry groups (e.g., CCBs, SEPs, and

RCCO Coordination With Other Agencies/Provider Organizations

home health providers), shifting priorities of both Colorado Access and a partnering organization, fears that agencies may be replaced by the RCCO or that the State may impose rate adjustments, and different contracted mandates and purposes of the RCCO and agencies.

- ◆ Other challenges specific to Region 2 included adversity to engaging in any perceived government-driven changes to local healthcare systems, some healthcare systems are owned and governed by county governments, and many rural communities are faced with a shortage of or financially strained healthcare resources. Region 2 staff members are participating in local collaborative partnerships that are emerging to address concerns about how to sustain health services in rural communities.
- ◆ Colorado Access noted that creating and maintaining relationships with a multitude of community organizations requires a substantial amount of staff time and resources.
- ◆ Colorado Access executed a data sharing/care coordination agreement with the Colorado AIDS Project, applicable to all three RCCO regions; however, the functional relationship had not been defined. Colorado Access hired a care manager specifically for the HIV population in 2015. Colorado Access is attempting to contract with four infectious disease clinics in Regions 3 and 5 to enable attribution of members to an appropriate PCMP. Within Region 2, The Northern Colorado AIDS Project is the primary provider of services to members with HIV and takes responsibility for coordinating services. The major issue in Region 2 is attributing members to appropriate PCMPs.
- ◆ Colorado Access noted that the Department’s initiative with the Department of Corrections (DOC) concerning CJI members has not progressed; therefore, Colorado Access has not made further progress regarding engagement of prison-paroled CJI members. Arapahoe, Douglas, and Denver counties have processes in place for ensuring that persons being released from jails are efficiently enrolled in Medicaid. Within Region 2, RCCO staff began contacting every local county parole/probation office to discuss mechanisms to connect CJI members to local mental health centers, but the process of working through each county proved too cumbersome. Colorado Access has been working with the Access Behavioral Care (ABC) behavioral health organizations (BHOs)—in which Medicaid clients are passively enrolled—to identify collaborative mechanisms for engaging CJI members soon after release from jail. Effective mechanisms have not yet been defined to close the gap between the member’s release from prison or jail and his or her assignment to the RCCO.
- ◆ Colorado Access was using existing data resources and pursuing MOU relationships with community organizations to identify pregnant Medicaid enrollees to the RCCOs. Once identified, Colorado Access outreaches to unattributed members and messages PCMPs of attributed members to ensure they are receiving obstetrical care. Colorado Access has a specialized care management team for pregnant women with complex needs. Care managers refer members to both the Healthy Mom/Health Baby program and to Nurse-Family Partnership programs for specific needs. Colorado Access is also pursuing relationships with local Women, Infant, and Children (WIC) agencies.
- ◆ Colorado Access developed relationships and/or care coordination/data sharing MOUs with numerous organizations involved in caring for MMP members, including the BHOs, hospitals, SEPs, and CCBs in each region. (Colorado Access serves as the BHO in Regions 2 and 5 and the SEP in Regions 3 and 5.) Colorado Access invites hospitals, SEPs, CCBs, home health agencies, and hospice organizations in each region to attend

RCCO Coordination With Other Agencies/Provider Organizations

	<p>the Health Neighborhood meetings. Colorado Access is outreaching to all home health agencies to gather information on services provided. Home health agencies seem receptive to a relationship with the RCCOs, but have expressed concern about State rate reductions for MMP members. Colorado Access was in the preliminary stages of exploring relationships with SNFs and had made only limited RCCO introductory presentations. Within Region 2, staff stated that the RCCO needs to explore ways it can support the financial survival needs of nursing homes in rural communities.</p>
<p>Region 4— Integrated Community Health Partners</p>	<ul style="list-style-type: none"> ◆ ICHP developed relationships with numerous community organizations and agencies—including all of those specified in the RCCO contract—concerning services for RCCO members or with which there are mutual interests of improving the long-term health of communities. Much of the region is rural with limited resources, yet has a community-oriented culture that is highly invested in local health systems. Staff stated that care coordination teams have been invaluable for identifying key relationships within their communities. ◆ ICHP cited major success factors in building community partner relationships as positioning the RCCO to assist others with their self-identified needs, participating in improving the wellness of individual communities over the long term, and bringing resources (such as data systems or funding) to organizations in order to facilitate mutual goals. ICHP’s participation in State and federal demonstration grants has brought needed resources to communities through specific initiatives. ◆ Staff reported that receptivity to the RCCO varies by organization. The perception of the RCCO has evolved to include recognition of the RCCO as a key component of the Medicaid system, and that the RCCO may have value in coordinating resources related to mutual objectives. Agency relationships are more complex, include more barriers, and require a more formal approach than those with community organizations. A particular challenge with establishing relationships with publicly funded agencies is the “silo” effect created by separate funding sources and contractual responsibilities that may not always align. ◆ ICHP focused initial outreach efforts on the larger agencies in the region, but has since been driven by the initiatives and requirements of the RCCO, such as integration of the MMP and CJI expansion populations into the RCCO. Staff noted that it is challenging to manage the time and staff resources needed to develop relationships and participate in programs with multiple community organizations across the region; therefore, ICHP developed a strategic plan for aligning RCCO resources with identified high-priority needs of the region. ◆ The Ryan White program and related services for members with HIV were established in the region prior to initiation of the ACC Program. The Ryan White program provides effective care coordination for members in need of HIV services, and an ongoing referral relationship exists among providers, care coordinators, and the Ryan White program. ◆ ICHP has partnered with the regional BHO to conduct a joint, region-wide PIP to address care coordination and linking CJI members to Medicaid providers. All 19 counties in the region had been contacted to participate, and data-sharing agreements were being pursued. ICHP and the BHO will pilot test a data and communications system product to assist in tracking admission and discharge of CJI members from the county jails. ICHP was also coordinating with the Department’s initiative with the Colorado Department of Justice to determine mechanisms for integrating prison

RCCO Coordination With Other Agencies/Provider Organizations

	<p>parolees into the RCCO. No short-term implementation plan had been defined.</p> <ul style="list-style-type: none"> ◆ Staff stated that Pueblo Community Health Center (PCHC) delivers the majority of services to pregnant Medicaid enrollees in the region and that primary care providers are incented to refer pregnant women to PCHC. Women also seek services through the public health departments and some community-based organizations. ICHP stated that implementing the Crimson care management system with community organizations and agencies may facilitate the timely identification of these members to the RCCO. ◆ ICHP conducted MMP demonstration program community forums with providers, local agencies, and community organizations at four locations across the region. ICHP will continue the dialogue through quarterly meetings in each of four communities with the intent of collaboratively developing a three-year community-based plan for coordinating care and services for MMP members. ICHP expects the development of community networks for MMP members and the establishment of the multiple associated relationships unique to this population to be a long-term, ongoing process. ◆ ICHP has been active and thoughtful in its approach to establishing relationships with community organizations and agencies since the inception of the RCCO, and has positioned the RCCO as a facilitator, coordinator, or provider of resources to enhance community health. Staff stated that statewide and local policy decisions may be required in order to overcome some of the barriers between agencies and the RCCO. ICHP is confident that it has established a positive foundation for engaging with a network of community organizations throughout the region.
<p>Region 6— Colorado Community Health Alliance</p>	<ul style="list-style-type: none"> ◆ CCHA has formal and informal arrangements with numerous agencies and organizations. CCHA participates in data sharing, care coordination referrals, grant applications and collaborative programs, and co-branding and sponsorship activities with various organizations. Fundamental to all relationships are mutual referral of clients and shared care coordination, and CCHA implemented BAAs, as necessary. ◆ The care coordinators are a primary source for identifying the high-priority organization and agency relationships in the region. The Department has also identified key agencies related to special populations. The CCHA community liaison maintains ongoing contact with many community organizations. CCHA assigns a member of its leadership team as the primary contact with each agency. ◆ CCHA identified that major success factors in developing relationships with both community organizations and agencies include the ability to identify a mutual goal, establish a noncompetitive and mutually supportive environment (i.e., reduce perceptions that the RCCO is a threat to another organization’s services), and provide a conduit for the flow of information to and from the Department. CCHA has engaged personnel at both the operational and leadership levels to ensure that it simultaneously maintains successful functional level (i.e., care coordination) and management/policy/program level activities with organizations. ◆ CCHA reported that the lead time required to establish relationships with agencies is longer than with community organizations. Challenges to developing a successful relationship include frequent staff turnover at agencies; inconsistency in the populations served by the RCCO and the organization; or when an organization is large and diverse, lacks a single point of contact, or continues to perceive the RCCO as a threat. ◆ Staff stated that increased visibility and understanding of the RCCO in the community has enhanced the development of collaborative processes with various organizations and agencies. CCHA has established a strong foundation for continued development

RCCO Coordination With Other Agencies/Provider Organizations

	<p>and expansion of a network of functional affiliations to serve RCCO members.</p> <ul style="list-style-type: none"> ◆ CCHA has established a formal relationship with the Boulder AIDS Project and a care coordination relationship with the Denver County AIDS Project. AIDS project programs provide all care coordination for members with HIV. CCHA provides support to the program through referrals, the infectious disease specialists, and the Advisory Committee. CCHA has not established data-sharing agreements with either agency. ◆ CCHA has met with the transitions and parole personnel in the State prison system to conduct cross-education and to discuss mechanisms for referring CJI individuals to the RCCO. CCHA has also been meeting with staff from the Jefferson County and Boulder County jails to discuss methods of coordinating services for CJI members. At the time of the review, neither process had resulted in implementation of solutions. CCHA is tracking the progress of two specific CJI projects being conducted by Foothills Behavioral Health Partners (CCHA’s partner BHO) and Jefferson County Mental Health, and will collaborate with both agencies in coordinating care for CJI members. ◆ CCHA described several initiatives for identification and management of Medicaid members who are pregnant, including a BAA relationship with Healthy Communities programs and Jefferson County DHS to identify and refer members who are pregnant, review of emergency room ADT information to identify and follow up with Medicaid members who are pregnant, and a special project with Westside Women’s Care to notify the RCCO of pregnant Medicaid members. ◆ CCHA’s MMP population has a lower percentage of elderly and a higher percentage of members with disabilities. CCHA has signed BAAs with the BHO, CCBs, and SEPs in its region to enable care coordination for MMP members. CCHA is pursuing a formal relationship with an additional 26 organizations, most of which are home health or long-term care (LTC) providers. CCHA had established informal care coordination relationships with hospice programs, and has developed a formal relationship with Vivage Quality Health Partners, owner of nine SNFs in the region, to partner on transitioning members back to the community. Staff characterized the completion of the SCPs as the most challenging aspect of the MMP demonstration program to date.
<p>Region 7— Community Health Partnership</p>	<ul style="list-style-type: none"> ◆ CHP has benefited in the development of numerous relationships with community organizations and agencies due to its community-based roots and the geographic concentration of the region. CHP’s Board of Directors includes leadership from community organizations. Executive management identifies the specific types of partnerships needed to address CHP’s strategic community health goals. CHP also identifies potential organizational and agency relationships in response to member needs, to fill gaps in contractual requirements, and through community networking. ◆ CHP’s approach to building relationships with organizations is to use one-on-one communications to identify areas of mutual need, work collaboratively to develop mechanisms to address those needs, and provide funding for implementation when appropriate. CHP has provided funding for numerous pilot programs in the community. ◆ CHP has established BAAs or MOUs with the CCB, BHOs, El Paso DHS, county public health departments, the SEP agency, and the Independence Center. Agency relationships generally culminate in formal agreements due to data-exchange requirements and the need to delineate responsibilities of both parties and any related

RCCO Coordination With Other Agencies/Provider Organizations

funding requirements.

- ◆ Staff described the major challenges in developing relationships with community organizations or agencies as managing the staff time required to develop and maintain relationships, overcoming organizations’ fears that the RCCO wants to assume the roles of those organizations (e.g., care coordination), and addressing the perception that the Medicaid component of an organization’s business is not large enough to demand attention.
- ◆ CHP envisions that its relationships with community organizations will continue to broaden (with more organizations serving common populations) and deepen (through more formalized processes) as the RCCO continues to gain recognition as an established entity.
- ◆ The Southern Colorado AIDS Project (S-CAP) serves as the primary care coordination resource for RCCO members with HIV in the region. CHP signed a BAA with S-CAP to allow the exchange of information regarding hospitalizations of shared clients, but there is minimal need for an ongoing functional arrangement between the organizations.
- ◆ CHP has relationships with several community organizations and providers of services to CJI members, including AspenPointe, Peak Vista, Community Access to Coordinated Health (CATCH) faith-based clinics, and Dorcas. Staff stated that there is still a considerable amount of work required to determine effective mechanisms for consistently identifying CJI individuals for enrollment in Medicaid or for providing early intervention services upon release of CJI members from jails.
- ◆ CHP identified several points of service, including the major women’s health providers, Healthy Communities Program, and several community organizations that may offer an opportunity for identifying Medicaid members not connected to the provider network early in their pregnancy. RCCO staff members monitor ADT reports to identify when Medicaid members seek emergency services related to pregnancy and follow up to assist the member with attribution to a PCMP. However, CHP had not yet identified effective mechanisms for consistently integrating Medicaid-eligible pregnant women into the RCCO provider network.
- ◆ CHP had dedicated staff to implement the MMP program and State-defined protocols with all applicable providers and entities and had developed many of its pertinent MMP relationships prior to implementation of the MMP program. CHP expanded relationships with many agencies and organizations due to the MMP program; established data-sharing arrangements with hospitals, the BHO, CCB, the SEP, and Pikes Peak Hospice & Palliative Care; and had referral protocols with the medical specialty network and some home health agencies. At the time of review, CHP had initiated relationships with a limited number of SNFs.

Care Coordination Record Reviews

**Region 1—
Rocky
Mountain
Health Plans**

- ◆ Care coordination record reviews demonstrated that RMHP and its delegates consistently provided comprehensive care coordination activities throughout the region, including engagement with appropriate partners who were providing services or care coordination for members with complex needs. Nine of 10 records reviewed scored 100 percent.
- ◆ RMHP customized its Essette care management documentation system to integrate the information related to the comprehensive care management characteristics of the ACC and the information requirements of the SCP. Therefore, the software provides a structure for assisting care coordinators with meeting RCCO objectives. RMHP offered the Essette system to partner organizations and CCTs.
- ◆ HSAG observed that RMHP might benefit from pursuing a master agreement with each major CMHC rather than using an individual member release of information (ROI) to facilitate sharing essential elements of the care coordination plan among care coordinators.

**Regions 2, 3,
5—Colorado
Access**

- ◆ Colorado Access had a score of 78 percent compliance with comprehensive care coordination requirements across the three regions. Region 2 had a compliance score of 79 percent, Region 3 had a compliance score of 91 percent, and Region 5 had a compliance score of 61 percent. Region 3 scores improved significantly (48 percentage points), Region 2 scores improved moderately (15 percentage points), and Region 5 scores improved modestly (2 percentage points) compared to the previous year’s record reviews.
- ◆ Many PCMP delegates tracked care coordination activities within the member’s electronic health record (EHR). Because primary care EHR systems are not designed to document complex care coordination activities, pertinent information appeared disjointed and was difficult to locate. In addition, reviewers noted that a detailed comprehensive assessment of a member’s medical, behavioral, social, and cultural needs (similar to the recently implemented Colorado Access comprehensive needs assessment tool) was inconsistently documented. Care coordination records commonly lacked documentation of outreach to external care coordinators and agencies.
- ◆ Colorado Access allowed delegates to target members for care coordination based on internal systems and data available within the individual practice, and processes used varied across PCMPs. Delegates submitted lists of members engaged in complex care coordination for selection of the sample for on-site record reviews. Of the 30 members selected by the Department for on-site record review, 12 members in the original sample and 19 members in the oversample were omitted on-site because the member did not have complex needs, received no care management, or was not a patient in the designated PCMP practice.

**Region 4—
Integrated
Community
Health
Partners**

- ◆ ICHP care coordination record reviews scored 100 percent compliance with RCCO care coordination contract requirements. Overall, ICHP’s “team” approach to care coordination appears to be operating effectively across the region. Common primary barriers encountered by care coordinators were the lack of valid member contact information or the member’s unwillingness to participate in efforts and/or follow-through on referrals.
- ◆ On-site care coordination record reviews demonstrated that member populations, community health resources, and systems of documentation and communication remain diverse between care coordination teams and service areas. HSAG noted in several cases

Care Coordination Record Reviews

	<p>that components of care coordination continue to be embedded throughout the EHR, such that there is not a consolidated view of the care coordination processes. Staff stated that ICHP hopes to achieve an integrated care coordination record through the design and implementation of the Crimson care management system.</p> <ul style="list-style-type: none"> ◆ Lack of consistent access to ADT information was preventing care coordinators from assisting some members with TOCs. ICHP has been working with CORHIO to accomplish a direct link that will enable timely access to hospital ADT and other member information.
<p>Region 6— Colorado Community Health Alliance</p>	<ul style="list-style-type: none"> ◆ CCHA implemented a new care coordination software system in December 2014 and added a supervisory position to provide more consistent oversight of CCHA care coordination processes. The Essette care coordination system included enhanced features for documenting comprehensive care coordination processes and reporting capabilities that will enable monitoring of care manager performance. However, these improvements were implemented late in the review period and had limited impact on the scores of the record reviews. ◆ CCHA care coordination record reviews scored 72 percent compliance with comprehensive care coordination requirements, a modest overall improvement of 3 percentage points over the previous year’s review. However, record reviews demonstrated improvements in several specific areas: comprehensive assessments of member needs, regular follow-up with the member, and many referrals to needed services—particularly financial and housing resources. ◆ Care coordination record reviews indicated the following opportunities for improvement: (1) care coordinators tended to close cases prematurely prior to all needs of the member being met, when the member stated that he/she had no other immediate needs, or after limited phone outreach attempts with no response from the member; (2) care coordinators appeared to be focused on maintaining direct communications with members and providing referral information for member follow-up rather than actively linking members to needed services; and (3) care coordinators were not consistently outreaching external case managers or the member’s PCMP to directly discuss care coordination activities. ◆ Several cases in the record sample were omitted due to lack of complexity of member needs. Staff stated that the CCHA care coordination system did not have the capability to differentiate cases based on stratification of high-risk. However, in 2015, each care coordination record will include an acuity indicator that will enable CCHA to better delineate the complexity of a care coordination case.
<p>Region 7— Community Health Partnership</p>	<ul style="list-style-type: none"> ◆ CHP care coordination record reviews scored 77 percent compliance with comprehensive care coordination criteria. Care coordination of children scored higher than care coordination for adults with complex needs. PCMP-based record reviews demonstrated a tendency to be focused on coordinating the member’s physical health needs rather than comprehensive needs of members with complex situations. When care coordination was performed by multiple staff, no single individual was responsible for oversight, and care coordination documentation was frequently scattered throughout the medical record. When the RCCO care coordinator was actively engaged in supporting the PCMP coordinator, the care coordination record did not integrate specific RCCO coordinator activities. ◆ CHP anticipates that the Crimson care management system will resolve barriers to documenting an integrated care coordination plan. However, the Crimson system is

Care Coordination Record Reviews

intended to be pilot tested for a period of time prior to expansion to all PCMPs.

- ◆ Staff stated that the most challenging patient category for care coordinators is members with complex needs who do not cooperate or follow through with care coordination efforts. CHP is considering developing guidelines for determining when to appropriately close a care coordination case.

3. Trends Related to Discussion Themes

In FY 2011–2012, the Department and HSAG identified five key characteristics or attributes essential to the success of the ACC Program: Medical Home/Integration of Care (Care Coordination), Network Adequacy, Outcomes Measurement, Member Involvement, and Collaboration. In the FY 2011–2012 RCCO Aggregate Report, HSAG organized information obtained during the FY 2011–2012 RCCO site reviews to identify trends and made recommendations appropriate for an evolving statewide ACC effort.

In FY 2012–2013, the Department and HSAG determined that the annual RCCO site reviews would focus on Medical Home/Integration of Care (Care Coordination) and Network Adequacy. In the FY 2012–2013 RCCO Aggregate Report, HSAG organized information obtained during the FY 2012–2013 RCCO site reviews to identify progress and trends, made recommendations related to these two domains, and provided information related to collaborative processes identified during on-site interviews.

For FY 2013–2014, the Department determined that priorities for review were to evaluate the evolution of the RCCOs’ Provider Network Development and Provider Support activities and progress made in the RCCOs’ Care Coordination programs. In the FY 2013–2014 RCCO Aggregate Report, HSAG organized information obtained during the FY 2013–2014 RCCO site reviews to identify progress and trends, and made recommendations related to these three domains.

For FY 2014–2015, the Department determined that priorities for review were to evaluate the RCCO’s activities and progress related to these domains: Delegation of Care Coordination, RCCO Coordination With Other Agencies and Provider Organizations (including a focus on select Medicaid expansion populations), and Care Coordination programs. The remainder of this section contains analysis of the aggregated information obtained during the site review process to identify the common themes related to each of these three domains.

Delegation of Care Coordination

Based on estimates provided by each RCCO, slightly more than 50 percent of ACC members statewide are receiving care coordination through delegated entities, with a higher proportion in rural than urban areas, as follows:

Rural area RCCOs:

- ◆ Region 1—60 percent delegate care coordination; 40 percent RCCO care coordination
- ◆ Region 2—60 percent delegate care coordination; 40 percent RCCO care coordination
- ◆ Region 4—100 percent delegate care coordination

Urban area RCCOs:

- ◆ Region 3—45 percent delegate care coordination; 55 percent RCCO care coordination
- ◆ Region 5—45 percent delegate care coordination; 55 percent RCCO care coordination
- ◆ Region 6—35 percent delegate care coordination; 65 percent RCCO care coordination
- ◆ Region 7—50 percent delegate care coordination; 50 percent RCCO care coordination

Each RCCO has implemented one of two basic models of delegation: (a) PCMP-based delegation, primarily associated with RCCOs that are geographically aligned with the urban areas (Regions 3, 5, 6, and 7); or (b) community-based delegation, primarily associated with RCCOs that are geographically aligned with the rural areas (Regions 1, 2, and 4).

Common characteristics of PCMP-based delegation include:

- ◆ RCCOs tend to be “hands-off” regarding detailed operational processes for care coordination to allow for variations in each PCMP’s existing internal systems and processes. Cross-RCCO affiliation of some major PCMPs further inhibits the integration of individual RCCO and PCMP processes.
- ◆ Delegated PCMPs tend to be more independent and collectively less responsive to the evolving needs and requirements of the ACC.
- ◆ RCCOs have conflicting “political” challenges with PCMP delegates due to the necessity of having these major PCMPs as part of the RCCO provider network while simultaneously needing to implement expectations that delegates be responsive to the ACC contract requirements and programs of the RCCO.

Common characteristics of community-based delegation include:

- ◆ RCCOs configure community care coordination teams using staff from existing major entities within the local communities. During 2014, RCCOs supplemented the community teams with additional RCCO-employed staff to accommodate the expansion of Medicaid.
- ◆ The community teams generally provide support for complex care coordination to multiple PCMPs in their areas.
- ◆ Whether employed by the RCCO or the community entities, care coordination staff is directly accountable to RCCO for care coordination of RCCO members.
- ◆ RCCO management staff is highly involved with community teams and community teams are highly integrated with the community and provider organizations in local areas.
- ◆ The community teams readily integrate new RCCO requirements and pilot programs and provide a base for integration with community organizations where BAAs/MOUs have been established by the RCCOs.

All RCCOs significantly expanded care coordination staff resources over the past year in response to rapid expansion of the Medicaid populations. RCCO staff members support delegated PCMP and community care coordination teams, as well as provide care coordination for nondelegated PCMP members.

All RCCOs had a formal agreement with each delegate outlining the responsibilities for care coordination. All RCCOs updated the delegation agreement template to reflect the current amended ACC contract requirements; however, in most RCCOs, requirements within individual delegation agreements may vary and/or may not all include the current ACC contract requirements. Most entities that were delegated care coordination prior to the most recent RCCO contract amendment have pre-existing agreements that have been amended.

Some RCCOs (Regions 2, 3, 5, and 7) adopted a philosophy/strategy at the inception of the ACC Program that care coordination should be performed at the primary care medical home level

whenever possible. These regions have continuously pursued delegation agreements with additional PCMP practices, and they invest resources to train, fill care coordination gaps, and assist delegates with performing care coordination according to RCCO expectations. Conversely, Regions 1, 4, and 6 have not aggressively pursued additional delegation agreements.

All RCCOs determined the major delegated entities in their regions prior to developing predelegation assessment tools and processes that incorporate the current “evolved” characteristics of comprehensive care coordination. RCCOs previously evaluated systems and capabilities of delegation candidates at a high level, and many original delegates were presumed to have care coordination capabilities due to their primary care medical home status. Most RCCOs updated their predelegation assessment tools in 2014 to be more closely aligned with the current ACC contract requirements related to comprehensive care coordination. (Exceptions are Region 6, which is not intending to delegate additional entities, and Region 1, which has a predelegation assessment process that does not include a pre-assessment tool.) However, RCCOs intend to apply these updated tools only to new delegation applicants.

All RCCOs, except Region 1, had developed care coordination chart audit tools to evaluate delegate performance annually or as needed. However, with the exception of Region 4, RCCOs had not used these tools to conduct chart audits on existing delegates. Region 7 had several versions of chart audit tools and was still developing its processes; Region 6 was changing its tool and intended to audit delegates in 2015; and Regions 2, 3, and 5 had conducted an internal audit and expected to audit their delegates in 2015. Region 1 has ongoing, automated access to the care management systems of each delegate, and it has not identified the need to perform delegate chart audits to date.

All RCCOs conducted high-level, ongoing oversight of delegates through monitoring of care coordination metrics and KPI data. All RCCOs met regularly with delegate care coordinator committees or work groups to review ACC Program changes, encourage sharing of best practices among delegates, and review performance data. Regions 1 and 4 also engaged care coordinator work groups to develop procedures and tools, and implement pilot projects in local communities.

All RCCOs invested in or made improvements in care management information systems to facilitate the comprehensive care coordination requirements. Region 1 uses the Essette care management software that it continuously modifies to accommodate the evolving requirements of the RCCO; Regions 2, 3, and 5 developed a comprehensive needs assessment tool and improved documentation in its Altruista care management system; Region 4 invested in the Crimson care management system that will be implemented in 2015; Region 6 implemented the Essette care management system in December 2014 but had not yet customized it; and Region 7 invested in the Crimson care management system for pilot testing in 2015. These systems have been (or will be) implemented by RCCO-based care coordinators and offered, but not required, for implementation by delegates.

The responsibility for completing SCPs for MMP members varied across the RCCOs. Region 1 required its CCTs and RCCO staff to complete the SCPs; Regions 2, 3, and 5 required seven of its 13 delegates and dedicated RCCO staff to complete the SCPs; Region 4 required its delegates to complete the SCPs for all MMP members; Region 6 required four of its five delegates and RCCO staff to complete the SCPs; and Region 7 RCCO staff completed the SCPs for all MMP members. All RCCOs noted the significant time and resources required for completing SCPs. All RCCOs stated that the core care coordination processes for MMP members are the same as those used with

other member populations, but require coordination with expanded numbers and types of community organizations and entities.

All RCCOs are coordinating with CORHIO to gain timely access to ADT information and anticipated that consistent access to this information will facilitate their involvement in members' transitions of care.

RCCO Coordination With Other Agencies/Provider Organizations

All RCCOs have both formal and informal relationships with numerous community organizations and agencies in their regions, including those organizations outlined in the ACC contract to support specific populations. The number and diversity of RCCO relationships with community organizations and agencies continues to expand in all regions.

All RCCOs have committed significant staff resources to developing and nurturing multiple partnerships. Most RCCOs did not differentiate the approach used in pursuing or developing relationships with community organizations versus agencies; however, agency relationships are more likely to culminate in a formal agreement, such as a BAA or MOU.

The majority of RCCO relationships with external organizations involve data-sharing and collaborative care coordination functions. All regions described community partnership initiatives related to a variety of collaborative projects or pilot programs. Region 1, Region 4, and Region 7 were particularly active in funding community-driven pilot programs. All RCCOs stated that they provide resources such as funding, data, and convening of participants to support the initiatives of community organizations and community-driven priorities.

All RCCOs use care coordinators as a major source for identifying targeted relationships with community organizations. All RCCOs also targeted relationships according to Department or contract-driven priorities. Several RCCOs described that community networking, participation in community alliances, data analysis of frequently used provider organizations, the RCCOs' strategic programs (e.g., homeless shelters or services for the disabled), and community representatives involved in RCCO leadership were additional sources for identifying potential community partnerships.

All RCCOs acknowledged the Department's role in introducing them to specific agency groups (e.g., CCBs, SEPs, DOC) as very advantageous and appreciated.

All RCCOs stated that communities and agencies recognizing them as established entities and key components in the Medicaid system has enhanced their position in developing relationships with multiple organizations. In addition, several RCCOs noted that organizations recognize their value in coordinating resources related to mutual objectives.

Specific factors that contribute to developing *successful* relationships with organizations and agencies were noted by the RCCOs as follows:

- ◆ All RCCOs identified having mutually aligned missions and goals with a partnering organization.

- ◆ Five of seven RCCOs cited their ability to bring resources, including financial resources, to organizations and communities.
- ◆ Four of seven RCCOs noted that Department-driven financial or contract incentives contributed to successful alliances with agencies.
- ◆ Four of seven RCCOs cited their provision of needed data or structure for collaborative initiatives.
- ◆ Four of seven RCCOs noted their positioning to address the needs of other organizations and local communities.
- ◆ Four of seven cited persistent staff attention to building trust and/or simultaneously maintaining successful functional level (i.e., care coordination) and management/policy/ program level activities with organizations.
- ◆ Three of seven stated that other organizations value their ability to serve as a conduit for information flow with the Department.

Specific factors that present significant *challenges* to developing relationships with organizations and agencies were noted by the RCCOs as follows:

- ◆ All RCCOs stated that managing staff time and resources needed to create and maintain relationships with multiple community organizations across the region presented an ongoing challenge.
- ◆ All RCCOs noted the political environments within various health agency groups (e.g., CCBs, SEPs, and home health providers) and/or operational environments (e.g., frequent staff turnover) within agencies may delay the development of functional relationships.
- ◆ All RCCOs cited agencies' perceived competitiveness with the RCCO and fears among agencies that they may be replaced by the RCCO or experience other negative implications (e.g., State-imposed rate adjustments).
- ◆ Five of seven RCCOs cited the "silo" effect of agencies—funding sources, contracted mandates and purposes, or populations served that may not always align between the RCCO and agencies.
- ◆ Four of seven noted the shifting priorities and/or federal or State-mandated program changes of both the RCCO and a partnering organization.
- ◆ Three of seven noted other organizations' limited understanding of RCCO roles and responsibilities.
- ◆ Three of seven noted continuous legal review and HIPAA concerns that impede execution of formal agreements.
- ◆ Two of seven noted the shortage of or financially strained healthcare resources in rural communities.

All RCCOs have developed a strong foundation of community partnerships to engage future relationships and facilitate ACC Program objectives.

Special Populations:

All RCCOs have developed relationships with the Colorado AIDS Project within their region. Colorado AIDS Project organizations provide services and programs that address the comprehensive needs of members with HIV in the regions. Although all RCCOs have a referral and

communication relationship with AIDS Project staff, no RCCO determined the need for ongoing involvement with the care coordination of members with HIV. Colorado Access is pursuing relationships with providers in Regions 2 and 5 that will enable members with HIV to be attributed to an appropriate PCMP.

Despite efforts during 2014, all RCCOs have made only minimal progress in defining effective mechanisms for engaging CJJ members in the RCCO to ensure access to needed services early after release from jail or prison. All RCCOs were anticipating that the Department's initiative with the DOC would determine solutions related to the prison population. While Regions 3, 5, and 6 initiated limited relationships with the larger county justice systems, the rural regions (Regions 1, 4, and 2) found contacting individual counties too cumbersome to implement. Region 7 identified community service providers for CJJ members but had not actively pursued a relationship with those organizations. Regions 1, 4, and 6 initiated performance improvement projects (PIPs) and/or other pilot projects related to the CJJ population. Colorado Access was working collaboratively with the Access Behavioral Care BHOs to identify mechanisms for early engagement of CJJ members. No RCCO had defined implementable solutions for integrating the CJJ population into the RCCO.

All RCCOs implemented initiatives to address the needs of pregnant Medicaid women and to improve the early identification and linking of pregnant women to the RCCO and needed services. All RCCOs were using the Department's report of women enrolling in Medicaid with self-identified pregnancy. Regions 6 and 7 were monitoring ADT emergency visit reports to identify Medicaid enrollees who were pregnant. Regions 1, 2, 3, 5, and 6 had or were pursuing agreements with major women's service providers and/or community organizations/agencies that may be a point of contact with Medicaid pregnant women. RCCOs 1, 2, 3, and 5 had an active mutual referral relationship with community agencies or programs serving mothers and babies. Overall, Regions 1, 2, 3, and 5 appeared the most actively engaged with initiatives for pregnant women. While all RCCOs described activities to address this population, no RCCO has yet determined consistently effective mechanisms for identifying and integrating Medicaid-eligible pregnant women into the RCCO provider network.

All RCCOs made significant progress in establishing relationships with community organizations, agencies, and providers for the MMP population. All RCCOs had signed agreements with hospitals, CCBs, SEPs, BHOs, CMHCs, and some DHSs in their regions. Some RCCOs also established relationships with organizations, such as Area Agencies on Aging and hospice programs. All RCCOs described their relationships with home health agencies and SNFs as limited or introductory, but all RCCOs intended to define strategies for more formal alignment with these organizations in 2015–2016. Region 4 initiated a region-wide, multi-year project to engage multiple community providers and organizations in implementing the MMP protocols. Regions 2, 3, and 5 implemented an all-inclusive approach to maintain relationships with an expanding number of community organizations through their Health Neighborhood meetings. Region 6 established a formal partnership with a multi-facility SNF owner in the region. All RCCOs anticipated that community partnerships for MMP members would continue to expand over time and would require a long-term commitment of resources.

Care Coordination

Statewide, care coordination record reviews scored 83 percent compliance with comprehensive care coordination criteria. Individual RCCO scores varied from a low of 61 percent compliance in Region 5 to 100 percent compliance in Region 4. Region 1 and Region 4 combined had a score of 100 percent on 19 of the 20 records reviewed. Statewide compliance scores improved 4 percentage points between 2013–2014 and 2014–2015 reviews. Year-to-year change in scores varied from a 21 percentage point decrease in Region 7 to a 48 percentage point increase in Region 3. The performance by individual delegates and the proportion of records from either high-performing or low-performing delegates in the sample selection impacted individual RCCO scores. (HSAG also noted that any improvements in individual RCCO systems and processes resulting from the 2013–2014 review may have been implemented late in the review period, and had limited impact on the scores of the 2014–2015 record reviews.)

Of the records reviewed statewide that included one or more deficiencies, HSAG observed the following as the most common areas for improvement:

- ◆ Care coordinators, particularly those associated with a delegate PCMP, were not consistently documenting outreach to external case managers or providers to directly discuss care coordination activities.
- ◆ Care coordinators were not consistently documenting an adequate assessment of cultural beliefs and values.

The Department identified each RCCO's record review sample from a list of members with complex needs submitted by each RCCO. In order to configure a list for the Department, RCCOs solicited input from their delegates regarding members with complex needs who received care coordination services. On-site record reviews indicated that identification/risk stratification of members with complex care coordination needs was inconsistent among delegates and RCCOs. Sample lists from Region 2, Region 5, Region 6, and Region 7 included a number of records that were omitted because the member did not have comprehensive care coordination needs.

As in previous years, reviewers found it especially difficult to review comprehensive care coordination cases that were documented in PCMP EHR systems. PCMP EHRs are designed to allow effective documentation of the “medical model” of care coordination and follow-up (i.e., clinical referrals and reports), but are less effective in allowing clear documentation of comprehensive assessment of social, behavioral, and cultural needs and related services. In addition, the EHR structure does not allow for consolidated documentation of complex care coordination needs, interventions, and follow-up.

While all RCCOs and delegates assigned one or more coordinators to a member's case, Region 5 and Region 7 record reviews demonstrated that it was often not apparent that a lead coordinator was assigned to oversee multiple care coordinator activities and to be accountable for the member's overall care coordination.

Some Region 5, Region 6, and Region 7 record reviews demonstrated that care coordination activities were episodic and/or care coordination activities were prematurely discontinued due to members being unresponsive to care coordination efforts. Both Region 6 and Region 7 were

considering developing guidelines for determining when to appropriately close a care coordination case. Staff in several regions stated that members with complex needs who do not cooperate or follow through with care coordination efforts are a major frustration for care coordinators.

4. Conclusions and Overall Recommendations

Conclusions

Based on HSAG’s review of four years of RCCO operations, it is apparent that each RCCO has committed to one of two basic but distinctly different models of delegating care coordination—a community-based team model or a PCMP model. RCCOs that implemented the community-based team model have had this model in place over several years, have limited expansion of delegation to additional entities, and have generally experienced stable staffing in the care coordination teams. In general, HSAG finds that the community-based teams demonstrate better performance in meeting comprehensive care coordination requirements and respond more quickly to the evolving expectations of the ACC and amended ACC contract requirements. In addition, the care coordination teams are well-positioned to integrate with community organizations and agencies, and to implement community-based RCCO pilot programs. PCMP-based care coordination is associated with the larger PCMPs in the network, many of which are the RCCO’s initial or early delegates. PCMP care coordination processes have not been as readily flexible to program changes and evolving expectations of the ACC due, in part, to the following: (1) PCMP’s existing systems and processes of care coordination are applied to a broad payor mix of patients, (2) cross-RCCO affiliations of some of the larger delegate PCMPs, and (3) the predominantly “medical model” of PCMP care coordination versus the comprehensive care coordination requirements of the ACC. Staff members in the community-based teams are directly accountable to the RCCO for coordinating care for RCCO members, while care coordination staff of PCMP delegates remain accountable to the PCMP. Further complicating the PCMP-based delegation model is the potential political conflict of needing to have the PCMP in the RCCO provider network while simultaneously needing to enforce delegate care coordination performance that complies with RCCO standards. Therefore, RCCOs that have implemented a PCMP-based model of care coordination are experiencing legitimate challenges that will require strong RCCO leadership to engage PCMP delegates to modify operational approaches as necessary to comply with the standard of care coordination for Medicaid members.

Although the sample size was small for any individual delegate, on-site care coordination record reviews indicated that delegate performance of comprehensive care coordination varied across RCCOs, as well as within individual RCCOs. The most common opportunities for improvement in care coordination record reviews were documentation of care coordinator outreach to external organizations and documentation of the member’s cultural beliefs and values, indicating a need for continued training and/or tools to support these requirements. In addition, as in previous years’ reviews, HSAG continued to observe that PCMP EHR systems, designed primarily to document and track medical management, may contribute to inadequate documentation of RCCO comprehensive care coordination requirements. While PCMP-based care coordinators may understand how to navigate the practice’s EHR system for pertinent care coordination documentation, on-site record reviews demonstrated that care coordinator notes regarding assessments, interventions, and follow-up were spread throughout the medical record, were disjointed, and often appeared out of context. EHR systems, in general, are not effective tools for documenting comprehensive care coordination for members with complex needs.

All RCCOs have invested in or improved their care management information systems to facilitate the comprehensive care coordination requirements. However, RCCOs indicated that a delegate's implementation of the RCCO's system is optional, and some systems, such as the Crimson system in Regions 4 and 7, had not yet been implemented by the RCCOs. HSAG cautions that software systems themselves may not provide a solution for comprehensive care coordination unless they (a) have been modified to support current ACC care coordination requirements, (b) are successfully implemented in the RCCOs, and (c) are adopted by delegates within the RCCOs.

While RCCOs have established many data-sharing and care coordination agreements with external organizations, it is premature to evaluate if those agreements are executed effectively and consistently. In addition, RCCOs must be cognizant of the need to effectively communicate the terms of all BAA/MOU arrangements with external organizations to the delegates. These agreements are vulnerable to being "in paper only" agreements that are not fully executed to achieve the desired outcomes. RCCOs should determine how to evaluate meaningful implementation of the agreements going forward.

Risk identification methodologies varied among delegates and the RCCOs to allow for variations in individual delegate stratification and referral methods. During on-site care coordination record reviews at some of the RCCOs, HSAG omitted multiple cases because the member did not have complex care coordination needs. The inability of some RCCOs to appropriately identify members with complex needs for the on-site record review sample might indicate that these RCCOs should be concerned with delegate processes for risk tiering or other methods of identifying members with comprehensive care coordination needs. In those RCCOs where members with routine needs were misidentified as members with complex needs, there could, conversely, be a question of whether all members who do have complex needs are effectively being identified and referred to care coordination.

Most RCCOs updated their delegation agreements and pre-delegation assessments to more closely align with the requirements of the amended ACC contract, including comprehensive care coordination characteristics. RCCOs also defined or were in the process of defining chart audit monitoring tools that incorporated comprehensive care coordination requirements. These documents collectively would convey to delegates the "evolved" standards for care coordination of RCCO members. However, the RCCOs were implementing the updated delegation assessment tools and revised delegation agreements only with new delegation candidates—not established delegates. This process risks that two different standards and sets of expectations—one based on the evolved requirements of the ACC contract and one based on the previous ACC contract requirements—will exist with delegates. Therefore, the opportunity for the RCCOs to obligate each delegate to comply with the responsibilities for comprehensive care coordination as outlined in the amended ACC contract has not been fully realized in most RCCOs. Because on-site care coordination record reviews indicated opportunities for improvement in comprehensive care coordination performed by many established delegates (except Regions 1 and 4), RCCOs should reconsider whether updated delegation agreements and assessments might also be indicated with existing delegates.

All RCCOs engaged in ongoing assessment of delegates through monitoring of high-level care coordination metrics and KPIs rather than member-specific care coordination processes. In addition, with the exception of Region 4, no RCCO had effectively implemented chart audits with delegates. While delegate care coordinators participate in care coordination committees or work groups in

every RCCO, only Regions 1 and 4 appear to use these peer sessions to engage care coordinators in developing processes, procedures, pilot projects, or other mechanisms that can be voluntarily implemented by delegates. Additional RCCOs might benefit from engaging care coordinators to more actively participate in collaborative care coordination activities that encourage competition, more consistency in care coordination processes, and transfer of best practices among delegates.

All RCCOs are coordinating with CORHIO to gain timely access to ADT information from all participating hospitals. However, HSAG cautions that these relationships are in early implementation and should be carefully monitored to determine effectiveness. If necessary, the Department may need to facilitate further integration of data from the CORHIO health information exchange system.

Statewide, care coordination record reviews have minimally improved over the past year. Variations in RCCO scores were primarily based on the specific delegated entities that were represented in the selected sample and the individual performance of each of those delegates. However, RCCOs also noted that they had not implemented many of the operational improvements based on the previous year's on-site review until late in the record review period, thereby having little impact on improving scores year-to-year. The Department may want to consider suspending HSAG care coordination record reviews for one year to allow planned system changes and improvements to be more fully implemented.

All RCCOs have established extensive numbers and types of both formal and informal relationships with community organizations and agencies throughout their regions, and are committing significant staff time and resources to developing and nurturing these relationships. All RCCOs demonstrated that they are developing an in-depth understanding of the characteristics and needs of diverse organizations in the Medicaid healthcare environment. New agency relationships driven by the needs of the expansion populations, such as MMP, expanded the number and types of relationships pursued by the RCCOs. While most *formal* relationships have been defined to further the objectives of the ACC (i.e., data-sharing and care coordination agreements), all RCCOs have also consistently positioned themselves as facilitators/supporters of local community health concerns or as collaborators in supporting other organizations' agendas and goals. RCCO participation in local community-based healthcare agendas generates enthusiasm and positive response to partnering with the RCCOs. This is especially evident in the more rural regions, where there is a need to disassociate the RCCO with Denver-based or State-driven processes as much as possible. All RCCOs have plans to continue developing both formal and informal relationships with additional organizations and provider partners. It appears that linking with community partners may become a fundamental "feature" of the ACC over time, and executing grass-roots relationships and collaborative initiatives may ultimately be a key contributor to innovative, statewide healthcare reform. While all RCCOs have developed a broad-based foundation of community organization relationships to engage in future partnerships and facilitate ACC Program objectives, RCCOs may have to begin establishing strategic priorities for partnerships in order to target the staff time and resources required to successfully engage, conclude, and realize implementable functional relationships with multiple organizations.

With the exception of the CJI population, RCCOs have made significant progress in identifying and establishing relationships with agencies and organizations to address the needs of special populations. All RCCOs have a referral and communication relationship with the Colorado AIDs

Projects in their regions and have confidently deferred the care coordination of members with HIV to these Ryan White programs. All RCCOs have data-sharing or care coordination agreements with the major agencies associated with the MMP population, such as CCBs, SEPs, BHOs, hospitals, and a variety of additional organizations. To date, RCCOs achieved only limited or introductory relationships with home health agencies and SNFs, but were intending to target those organizations in 2015–2016. RCCOs expect to expand community partnerships for MMP members over the next several years. All RCCOs have established relationships with or have identified community organizations, providers, and programs that may be a point of contact or service for Medicaid-eligible pregnant women; however, consistently effective mechanisms for identifying these members to the RCCOs have not yet been perfected in any region. Despite efforts during 2014, all RCCOs have made only minimal progress in defining effective mechanisms for engaging CJJ members in the RCCO to ensure access to needed services early after release from jail or prison. However, a number of pilot projects have been initiated in various regions. Due to the complexity and structure of the State and county justice systems, individual RCCOs may not be well-positioned to systematically define and implement mechanisms for integrating this population into the ACC Program in the near future.

Department initiatives to strengthen relationships between major healthcare industry groups (such as CCBs and SEPs) or to negotiate statewide solutions for common challenges (such as access to CORHIO ADT data or obtaining reports of self-reported pregnancies of Medicaid-eligible women) have been well-received and useful to all RCCOs. A particular challenge with publicly funded agencies and major industry groups is the siloing effect that has resulted from many years of separate funding sources and associated/mandated requirements. Therefore, Department-facilitated initiatives should be continued whenever possible to clarify intended relationships between RCCOs and other State agencies and to reduce perceptions of threat or competition from the RCCOs. To further enhance this process, RCCOs and the Department might collaboratively consider whether developing master MOU agreements between major industry groups and the ACC might be advantageous as an intended outcome of these discussions. On-site interviews revealed that collaborative discussions with the SNF and home health industry groups, as well as the DOC and county justice systems, may accelerate the development of functional integration with these entities.

Since the inception of the ACC Program, HSAG has observed that RCCOs have difficulty accessing necessary care coordination information from behavioral health providers. Although data-sharing and collaborative care coordination MOUs have now been established between the RCCOs, BHOs, and many CMHCs, it appears that individual behavioral health providers remain hesitant to respond to inquiries from RCCO care coordinators unless the behavioral health provider is integrated into a PCMP practice or has a long-term partnership with the RCCO. Considering that the integration of behavioral and physical health providers is a major objective of the ACC, additional statewide efforts to clarify and overcome concerns regarding HIPAA and State laws governing the confidentiality of behavioral health information may be warranted.

Incidental to on-site interviews, several RCCOs referenced continued issues related to accurate attribution of members to the RCCO or a PCMP, indicating that there are continued opportunities for improvement in the attribution process. Examples of issues worthy of improved attribution mechanisms included: (1) the length of time between Medicaid enrollment and assignment of a member to a RCCO region (estimated up to three months) prevents early engagement with the member for needed care coordination services (e.g., pregnant women, newly-released CJJ

members); (2) attribution of members to the incorrect PCMP requires continuous attention of RCCO staff and reattribution processing by the Department, and is inefficient; and (3) attribution of a member to a particular RCCO based on the geographic location of the individual clinic where the member receives services would diminish the issue of an individual provider location needing to interact with the operational processes and communications of multiple RCCOs.

Overall Opportunities for Improvement and Recommendations

The requirements for comprehensive care coordination have evolved since inception of the ACC Program, and capabilities of the early established delegate entities were not typically evaluated using the “evolved” standards for comprehensive care coordination described in the amended ACC contract. HSAG recommends that RCCOs, as necessary, target staff resources toward implementing processes that ensure consistent expectations and performance among all delegates, as follows:

- ◆ Confirm that the revised delegation agreement, pre-delegation assessment, and monitoring tools have been updated to represent the care coordination requirements outlined in the current ACC contract and associated expectations of the RCCO.
- ◆ Apply assessments to all established delegates (as well as new applicants) as an opportunity to clearly communicate each RCCO’s “evolved” expectations with each delegate and identify any gaps in processes or performance pertaining to comprehensive care coordination of Medicaid members.
- ◆ Use RCCO staff resources to assist existing delegates with filling gaps and improving performance, as necessary, and ensure that, going forward, all delegated entities are performing comprehensive care coordination according to the same standards.
- ◆ Consider defining a cross-RCCO collaborative process to share tools and staff resources for assessing, training, and coaching delegated entities that are affiliated with multiple RCCOs, thereby economizing RCCO resources and simplifying the process for an individual delegate.
- ◆ Implement an updated delegation agreement with each entity delegated for care coordination, as necessary.
- ◆ Implement care coordination audit/monitoring tools to reinforce the comprehensive care coordination requirements on a regular basis.

To address opportunities for improvement identified in care coordination record reviews, all RCCOs should consider the following, as applicable:

- ◆ RCCOs should work with delegates individually and collectively to explore the need for more consistent member risk stratification/tiering definitions between the RCCO and delegates, and to ensure that all members with complex needs are consistently being identified for care coordination.
- ◆ RCCOs should conduct additional care coordinator training regarding the need to outreach external care managers and providers, and develop mechanisms to ensure that all RCCO BAA/MOU arrangements with external organizations are communicated to delegates for implementation.
- ◆ When multiple internal care coordinators are involved in coordinating services for a member, the delegate or RCCO should ensure that a lead coordinator is assigned to “coordinate the

coordinators,” act as a primary point of contact for the member, and ensure that all member needs are fully addressed and documented in the record.

- ◆ RCCOs should work with delegates who use EHR systems as the vehicle for documenting care coordination needs and activities to ensure that comprehensive member needs are being assessed and that care coordination activities are clearly documented and easily accessible. Delegates might consider, at a minimum, developing a designated section of the EHR to document and consolidate pertinent care coordination information, particularly for members with complex or ongoing care coordination needs and interventions.

Care coordination activities for members with complex needs require a significant amount of financial and staff resources for delegates, the RCCOs, and the healthcare system at large. Members who are poorly engaged or unresponsive to care coordination efforts are a major frustration for care coordinators. Several RCCOs have identified the need to develop guidelines for determining when it is appropriate to discontinue care coordination efforts with a member. Each RCCO might consider defining a work group to develop such guidelines and promote consistency among delegate and RCCO care coordination staff. RCCOs might also consider developing a collaborative cross-RCCO work group (including delegate representatives) to recommend appropriate guidelines and promote consistency in the application of the guidelines across the ACC.

The Department needs to continue initiatives to strengthen relationships between industry groups or negotiate statewide solutions for common challenges whenever possible. Department-assisted introduction of RCCOs to major statewide health industry groups clarifies the role of the RCCOs, diminishes fears of competition, and facilitates more rapid collaboration between RCCOs and particular sectors of the healthcare system. In 2015–2016, the Department should consider facilitating introductory discussions with SNF groups and home healthcare groups.

While the RCCOs have initiated a number of pilot projects and PIPs to address the challenge of integrating and providing services to CJI members, these projects will not provide short-term outcomes and may not be implementable system-wide. If the CJI population is an immediate high priority of the RCCOs or ACC, the Department should dedicate staff resources to consistently pursuing relationships with the DOC and the county justice/corrections systems, engaging those agencies and the RCCOs in collaborative planning and implementing statewide solutions, and resolving any State policy issues that challenge successful implementation.

The Department and/or a cross-RCCO collaborative work group should engage with community mental health industry groups to further evaluate laws concerning confidentiality of member behavioral health information, specifically define the level of detail needed for effective care coordination, and possibly engage legal resources to assist in defining a master or model agreement to expedite the implementation of effective data-sharing care coordination agreements with behavioral health providers statewide.

RCCOs should actively pursue and complete notification/referral agreements with community organizations that may encounter Medicaid-eligible women early in their pregnancy. However, RCCO efforts are dependent on pregnant women making a point of contact with the health delivery system. Effective communication mechanisms to initially engage pregnant women in some point of contact remains an outstanding concern, and may require collaborative community or statewide public relations or media initiatives.

Several RCCOs identified concerns about the quality of the data included in the RCCO Care Coordination Report to the Department, and the additional staff resource required to report the data by member eligibility category (e.g., foster children, MMP members). The Department may want to reevaluate the specific components of the report deliverable, considering the level of importance of the information collected, who is using the data, and whether the data are available through other sources.

While there are always opportunities for improvement, HSAG observed that the RCCOs individually and collectively continue to make significant progress and enthusiastically commit significant energies year to year to meet the needs of members and respond to the expanding, evolving objectives of the ACC. Over the few years since the inception of the ACC, it appears that the collaborative efforts of the Department, the RCCOs, providers, and communities, are establishing a solid foundation for meaningful healthcare reform in Colorado.