COLORADO

Department of Health Care Policy & Financing

FY 2015–2016 Accountable Care Collaborative Site Review Aggregate Report

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

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1. Overview

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 2016, Health Services Advisory Group, Inc. (HSAG), performed a site review of each RCCO to assess progress toward implementing the ACC Program during its fifth year of operations. The site review process consisted of a focused evaluation of these domains: Integration With Specialist Providers, Follow-Up of Region-Specific Special Projects, Integration With Behavioral Health Services/Behavioral Health Organizations (BHOs), and Medicare Medicaid Program (MMP) 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 integrating behavioral and physical health for members. The site review process included a desk review of key RCCO documents prior to the site visit, on-site review of MMP 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 for ten MMP members for each RCCO to evaluate implementation of the service coordination plan (SCP) and the high-priority elements of overall care coordination. The Department selected 10 sample and 10 oversample cases of MMP members reported as having a SCP completed and who were newly enrolled into the program January 2015 through March 2015 and continuously enrolled through December 2015. The Department applied a targeted sampling methodology to select members from categories with specific characteristics—age group, high-risk diagnoses, behavioral health utilization, or members receiving

services from a Single Entry Point (SEP) or Community Centered Board (CCB). The Department then performed random sampling within those targeted subgroups.

Compliance with the SCP requirements for the care coordination record review was documented using a score of *Met*, *Partially Met*, *Not Met*, *Unable to Determine*, or *Not Applicable* for each requirement. For each requirement, HSAG provided observations and comments—as necessary--related to scores and to document the context of the care coordination findings. Care coordination record review scores are summarized by RCCO in Table 2-1. Year–to-year comparisons of all RCCOs' record review scores are summarized in Table 2-2, and statewide trending of record review scores are summarized in Table 2-3.

HSAG conducted the focused review of Integration With Specialist Providers, Follow-Up of Region-Specific Special Projects, and Integration With Behavioral Health Services/BHOs using a qualitative interviewing methodology to elicit information concerning activities and progress related to requirements outlined in the ACC contract and/or specific projects of interest to the Department. Region-specific special projects were selected by the Department from RCCO report deliverables previously submitted to the State or previous years' ACC site review reports. Results of the qualitative interview 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 focus area.

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 Integration With Specialist Providers, Follow-Up of Region-Specific Special Projects, Integration With Behavioral Health Services/BHOs, 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."

Summary of Compliance Findings

Table 2-1—Summary of 2015–2016 Care Coordination Record Review Scores							
RCCO	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Region 1	210	151	147	4	0	59	97%
Region 2	210	142	142	0	0	68	100%
Region 3	210	125	120	4	1	85	96%
Region 4	210	133	129	1	3	77	97%
Region 5	210	139	129	7	3	71	93%
Region 6	210	174	168	2	4	36	97%
Region 7	210	149	147	2	0	61	99%
Total	**1,470**	**1,013**	**982**	**20**	**11**	**457**	**97%**

Year-to-Year Comparison of Care Coordination Record Reviews

Table 2-2 and Table 2-3 provide a comparison of the overall 2015–2016 record review scores to the 2014–2015 and 2013–2014 record review scores. Although most contract requirements remained the same for the 2013–2014 and 2014–2015 review periods, scores may have changed due to reformatting and clarifications in the record review tool. Additionally, because the 2015–2016 record reviews focused on the SCP requirements for MMP members, these results are not directly comparable to prior years' scores.

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)	2015–2016 Score (% of *Met* Elements)
Region 1	99%	94%	97%
Region 2	64%	79%	100%
Region 3	43%	91%	96%
Region 4	100%	100%	97%
Region 5	59%	61%	93%
Region 6	69%	72%	97%
Region 7	98%	77%	99%
Total	**79%**	**83%**	**97%**

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)
Medicaid Care Coordination 2013–2014	1,044	858	679	97	82	186	79%
Medicaid Care Coordination 2014–2015	553	418	345	60	13	135	83%
MMP Care Coordination 2015–2016	1,470	1,013	982	20	11	457	97%

Summary of Activities and Progress by Focus Area

Integration With Specialist Providers

Region 1—Rocky Mountain Health Plans (RMHP)

- Specialists in RCCO Region 1 are primarily concentrated in the population centers of Grand Junction, Durango, and Fort Collins.
- Primary care medical providers (PCMPs) had established relationships and patterns of referral with preferred specialist practices. RMHP did not mandate implementation of referral protocols and practice compacts among physician groups. RMHP believed that referral processes must be locally agreed to and adopted between individual primary care and specialist practices to be effective and sustainable.
- RMHP was implementing its strategy for strengthening referral relationships between PCMPs and specialists through its practice transformation program, which included implementing team-based care in primary care practices and developing referral relationships and practice work flows with selected specialist practices. RMHP conducted a pilot project with one large pediatric practice and asthma specialist group; depending on the final results of the project, RMHP anticipated expansion of the practice transformation and referral initiative to engage additional high-volume specialist practices.
- RMHP had contracts with almost all specialists in the Mesa County area for its Prime line of business, and provider contracts specify that participating specialists must also be open to all RCCO members.
- Care coordinators make arrangements for members to access specialist care both inside and outside the network.
- RMHP was considering approaches for further disseminating specialist knowledge into PCMP practices, including specialist/PCMP co-management of members, e-consult programs, and Extension for Community Health Outcomes (ECHO) consultation and education programs.
- RMHP recognized the unique challenges associated with access to specialists in a predominantly rural/frontier geographic area.

Integration With Specialist Providers	
Regions 2, 3, 5—Colorado Access	◆ The concentration of specialists in the Denver metropolitan area, and where most RCCO 3 and RCCO 5 members receive specialist care, is centered near the tertiary care hospitals. University of Colorado Health (UCHealth) and Children's Hospital Colorado (Children's) specialists are the primary source of "super sub-specialists." The majority of members in Region 2 access diverse specialists associated with Banner Health in Weld County and Children's in Denver. ◆ Within Region 2, both Banner Health and UCHealth have extended specialist care to the rural areas by transporting rotating specialists to various communities. ◆ Transportation issues are the greatest barrier for members accessing specialist services in Region 2. ◆ Within Regions 3 and 5, Denver Health (DH) specialists are primarily available to impaneled staff providers, with members outside the DH system experiencing extensive wait times; Kaiser clinics and specialists are open only to Kaiser enrolled members. ◆ Due to the all-payor competition for access to specialists, providers do not have to accept Medicaid members; and the Medicaid fee structure presents a barrier to access to specialist providers. ◆ Existing personal and professional relationships among providers are the primary drivers of access to specialist care. Colorado Access has not formally adopted or implemented referral protocols with providers, but has used protocols developed in 2014 as available education and guidance for PCMPs. ◆ Within Region 2, several large PCMPs have adopted referral compacts for bi-directional communication of information with their various specialist providers. Within Regions 3 and 5, Colorado Access has instituted practice transformation programs with PCMPs that enhance practice operations for patients of all pay sources, which may encourage more widespread adoption of specialist referral protocols. ◆ Colorado Access' tele-behavioral health program provides psychiatric specialist expertise to primary care practices through patient-focused e-consults and education of primary care providers regarding primary care behavioral health interventions. Colorado Access was exploring extension of tele-health into other specialty areas. ◆ Colorado Access has engaged in several additional strategies to improve access to specialists: within Regions 3 and 5, Colorado Access is an active participant in community alliances focused on specialty care—Mile High Health Alliance (MHHA) and Aurora Health Access; within Region 2, RCCO leadership is continuously working with Banner Health to identify partnership initiatives that address Banner Health's needs related to specialist services. ◆ The Region 2 RCCO participated in numerous other partnership initiatives intended to extend specialty services into local communities throughout the region, including implementing co-located behavioral health providers and tele-behavioral health in several PCMP clinics, implementing a clinic-based clinical pharmacy program whereby pharmacists and residency students work with primary care providers (PCPs) to assist with medication therapy for members with chronic conditions, and facilitating a specialized care program to provide telehealth and care coordination for foster care children and families in two rural communities.

Integration With Specialist Providers	
Region 4—Integrated Community Health Partners (ICHP)	◆ ICHP's geographic region does not have an abundance of specialist providers; the majority of specialists are located in Pueblo. ◆ Members living in the outlying portions of the region often have transportation issues related to specialist appointments; care coordinators throughout the region assist members with transportation arrangements. ◆ Specialty providers have identified lower reimbursement and concerns about Medicaid member behaviors—i.e., no shows or lack of preparation for appointments—as Medicaid member issues. ◆ Access to specialists has been primarily based on personal referral relationships among providers. ICHP has developed and adopted specialist referral protocols and supporting tools for providers and members and has designed a toolkit to facilitate the bi-directional communication process between PCMPs and specialists. Provider implementation of the protocols is voluntary. ◆ ICHP had also engaged providers in several tele-health initiatives to enhance the capabilities of PCMPs to address some specialty needs of members. These included the University of Colorado ECHO program, New Mexico ECHO pain management program, and the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. ◆ ICHP staff have been very active in community-based work groups—Health of Pueblo and Access to Specialty Care—that have been established to evaluate and improve all-payor access to specialists in the region. ICHP's hospital partners were also evaluating mechanisms to impact specialist services.
Region 6—Colorado Community Health Alliance (CCHA)	◆ Centura Health, CCHA's ownership partner, provided CCHA members higher priority access to associated specialty providers. ◆ CCHA noted that general availability of specialists for Medicaid members is limited. CCHA determined that the subspecialist environment is overburdened, physician-centric, profit-oriented, and plagued by myths regarding treatment of Medicaid members. ◆ CCHA staff members were attending forums and provider alliances throughout the region and attempting to dispel myths regarding the complexity, general health, and unreliability of Medicaid members. ◆ CCHA has not adopted formal specialist referral protocols. CCHA considered implementing a "compact" with specialists, but determined that subspecialists are not interested in signed agreements. CCHA implemented practical measures to assist PCMPs and members by supplying the member with all necessary tools for an effective and efficient specialist referral. ◆ CCHA provided care coordination and some funding to support several pilot programs intended to increase access to specialists for the underserved. ◆ CCHA believed that one of the most promising initiatives for increasing access to specialists is the e-consult program—facilitated through the Colorado Regional Health Information Organization (CORHIO)—to offer PCPs direct consultation with subspecialists and eliminate the need for face-to-face consultation between the subspecialist and the patient.

Integration With Specialist Providers	
Region 7—Community Health Partnership (CHP)	◆ Colorado Springs Health Partners (CSHP) is the primary source of specialist care for CHP members. ◆ A general referral protocol for primary care medical providers addressed bi-directional communications between specialists and PCMPs. In addition, CSHP worked with CHP, the BHO, and PCMPs to develop numerous condition-specific protocols for high-volume or highly stressed specialty areas. CSHP was motivated by the desire to improve the appropriateness and time required for referrals to already overburdened specialists. ◆ CHP instituted a pay-for-performance program with 22 of 34 PCMPs to stimulate PCMPs to implement these referral protocols in their practices. CHP engaged CSHP in a pay-for-performance project to stimulate improved communications between CSHP specialist providers and PCMPs. ◆ Both specialists and PCMPs have been very receptive to using the protocols, and further protocol development was planned. ◆ CHP recognized that not all special needs can be addressed through specialists and that gaps in care within the community need to be more comprehensively addressed. CHP engaged in multiple pilot projects and community-based programs to expand specialized care services for members, including direct funding support for: ▪ Colorado Springs Fire Department Community Assistance Referral Education Services (CARES) program. ▪ Ascending to Health Respite Care program. ▪ Developmental Disability Health Center. ▪ Independence Center. ▪ Pikes Peak Hospice & Palliative Care Advanced Illness Counseling program. ▪ Non-Emergent Medical Transportation (NEMT) services. ◆ CHP was participating with community partners to complete a feasibility study for a specialty clinic expansion project at Peak Vista Community Health Centers.

Follow-Up of Region-Specific Special Projects

Region 1—Rocky Mountain Health Plans

- Relationship with the Health Information Exchange (HIE)
  - As a founding member of Quality Health Network (QHN), RMHP has been directly participating with QHN on developing HIE applications for RMHP and its providers since 2006.
  - RMHP received all HIE data through QHN and did not use the direct data feeds from CORHIO facilitated through the Department.
  - QHN established a technology connection with CORHIO to share information between the two major state HIE networks.
  - RMHP received real-time admit, discharge, and transfer (ADT) data and hospital notes from nearly all hospitals in the region and ambulatory data summaries for RMHP members from all active QHN users. Staff members noted that lack of standardization of laboratory data presented a challenge.
  - QHN's technology platform enabled open access to users and ease of interfacing with multiple systems, although connecting with multiple practice electronic health records (EHRs) remains a primary challenge.
  - RMHP and QHN collaborated on the IndiGO project—being tested in three PCMPs—to combine Medicaid data from the RCCO with practice EHR data, and which included a predictive risk modeling capability. RMHP was also pursuing through QHN the development of a virtual clinic process which will enable providers contracting with RMHP to provide e-consults to members, clinic staff, or care coordination teams (CCTs).
  - RMHP was enthusiastic about its working relationship with QHN and the many future applications that may be afforded through QHN technology.
- Expanding the Healthy Harbors (HH) program to other communities
  - Healthy Harbors—a program to meet the health care needs of children involved in child protective services—is a program of UCHealth in Larimer County.
  - HH care coordinators were fully integrated into the RCCO/UCHealth care CCT and four large PCMPs in northern Larimer County. HH coordinators have developed particular expertise in managing the complex needs and characteristics of the foster care population. HH staff worked closely with the county Department of Human Services (DHS).
  - HH developed a toolkit of information to engage communities to develop similar programs, including evaluation data of the positive impact of the program on foster children and their families. HH staff expressed the desire to identify opportunities and mechanisms for expanding the program into other communities across the state.
  - RMHP had not yet expanded the program into other Region 1 communities or CCTs. RMHP strategically targeted expansion of projects according to appropriate "fit," resource availability, and readiness within individual communities.
- Transferability of the B4 Babies and Beyond (B4 Babies) program to other communities
  - The B4 Babies program has been operating in Mesa County since 1990 as a mechanism to link uninsured and underinsured expectant mothers with Medicaid or CHP+ insurance, prenatal care, education, and community resources.
  - RMHP facilitated expansion of the program to La Plata and Archuleta counties through the San Juan Basin Health Department (SJBHD).

Follow-Up of Region-Specific Special Projects	
	▪ RMHP will explore further opportunities for expanding the program through its partnership with local public health (PH) agencies and other care coordination entities.
Regions 2, 3, 5—Colorado Access	◆ Relationship with the HIE ▪ Colorado Access established an agreement with CORHIO to receive daily ADT data and laboratory data from hospitals participating in the health information exchange. Colorado Access does not use the data feed provided through the Department's agreement with CORHIO. Approximately half of the 16 delegated entities have a direct relationship with CORHIO to receive data feeds pertaining to the entire patient base of each provider. ▪ Gaps or inadequacies in the data received through CORHIO included missing diagnosis codes in the ADT data (a hospital input issue) and lack of standardization of the laboratory data. ▪ ADT data were being used to provide reports to Colorado Access care managers, the transition of care (TOC) team, and delegates. Colorado Access was not using the laboratory data. ▪ Staff members described several challenges associated with integration and use of the CORHIO data. In general, however, staff members considered access to real-time ADT data successful for supporting care management activities. ▪ Colorado Access intended to capitalize on its relationship with CORHIO to further expand the innovative uses of both ADT and laboratory data to support population-based programming and evaluation as well as other clinical applications. ◆ Transition of care—transfer to delegates ▪ Colorado Access has defined and successfully implemented a robust TOC program. ▪ Colorado Access staff presented the TOC program to the delegate work group, which responded with interest in implementing the program within their PCMP practices. ▪ Colorado Access' practice transformation team was responding to requests from several practices to assist in implementing TOC processes within their practices. ◆ Integrating RCCO members into DH ▪ The State Medicaid Management Information System (MMIS) discontinued passive enrollment into Denver Health Managed Care (DHMC) for some categories of newly eligible Medicaid members including members already attributed to RCCO providers. Staff noted that some unconfirmed problems may still exist with the passive enrollment process. ▪ RCCO member access to DH primary care clinics did not appear to be a concern as RCCO members have equal access to the DH clinics; 38,000 RCCO members have chosen DH as their PCMP. ▪ Continuing challenges with RCCO member access to DH services included: access to DH specialists is prioritized for patients of DH staff physicians, and members of other RCCO providers experience delayed access; RCCO providers complain about difficulties with the DH authorization systems; many RCCO members have a misconception that they must live in the city of Denver to have access to DH medical and non-medical special services located on the DH campus.

Follow-Up of Region-Specific Special Projects	
	▪ RCCO managers continue to build relationships within the DH system to pursue solutions to member and provider issues and have initiated regular meetings with DH to help identify the appropriate staff to champion initiatives and make decisions within the DH system. ◆ ER-based care coordinators in University of Colorado Hospital ▪ In February 2016, Colorado Access initiated a two-year pilot project with University of Colorado (UC) Health to place two registered nurse care coordinators—funded by Colorado Access but employed by UCHealth—in the UC hospital *Fast Track* emergency room (ER) to divert Medicaid members to more appropriate services when indicated. Care coordinators intervened with those Medicaid members entering the *Fast Track* ER who did not need diagnostic interventions or inpatient services. ▪ Colorado Access outlined detailed work flow and training tools for the project. ▪ At the time of HSAG review, only one of two care coordinators had been hired and data indicated an average of 67 encounters monthly with Colorado Access members. UCHealth was in the process of hiring a second coordinator. Colorado Access will evaluate the effectiveness of the program prior to expansion. ◆ Improving delegate compliance with comprehensive care coordination requirements ▪ Colorado Access had developed an extensive delegate training plan and a comprehensive Pre-Delegation Care Management Audit Tool for application with new delegates. In addition, Colorado Access had performed audits of care management records in 13 existing delegate practices, with corrective action plans implemented as needed. ▪ Colorado Access staff conducted regular mandatory group meetings with delegate care managers to discuss issues and solutions for improving care management performance and encouraged peer-to-peer consultation among delegates to promote care management best practices. ▪ Staff members stated that most delegates responded very favorably to Colorado Access' expanded emphasis on meeting RCCO comprehensive care management requirements, and staff members were confident about the potential for all delegate PCMPs to ultimately perform according to RCCO care management standards.
Region 4—Integrated Community Health Partners	◆ Relationship with the HIE ▪ At the time of on-site review, ICHP was using the CORHIO ADT data feed provided through the Department and reported that the transmission was working smoothly. ADT data were integrated directly into the Crimson Care Management system. ▪ ICHP also had a direct contract with CORHIO to receive extensive RCCO member data from CORHIO and to develop mechanisms to integrate the data into the ICHP database; ICHP was to begin receiving laboratory data through CORHIO as the first component of building a clinical data repository. ▪ ICHP was examining the cost and value of encouraging additional practices to participate in CORHIO. ▪ ICHP considered its partnership with CORHIO to be a significant asset, and staff members were enthusiastic about the ultimate potential of the information technology (IT) system strategy to support improved outcomes for RCCO members.

Follow-Up of Region-Specific Special Projects	
	◆ Crimson Care Management system ▪ The Crimson Care Management system (Crimson) has three major components—a patient-level clinical data warehouse, claims analysis software, and a care coordination application. ▪ Crimson has the unique capability to provide integrated ambulatory care information from multiple sources to a broad base of service providers, agencies, or other designated users through HIE functions. ▪ ICHP staff members defined being in the technical development stage of this long-term project and characterized the data integration component as requiring the most attention. ▪ ICHP had implemented the clinical application with two federally qualified health centers (FQHCs). ICHP had programmed and was using the care coordination application to support completion of the MMP Service Coordination Plan (SCP). ▪ Overall system design and implementation plans were very ambitious and will require continuous commitment of staff and financial resources. ◆ Patient registries for Pain Management, Adults With Diabetes, Children With Diabetes ▪ The patient registries were databases of members who met the criteria for being included in designated special focus projects. Members that met the criteria for each program were identified pulled from State Data Analytics Contractor (SDAC) data, and registries were refreshed periodically to update members still eligible for the projects. ▪ Interventions for each program were defined in study protocols and tracked in the registry database. ▪ The Diabetes Monitoring in Members Taking Antipsychotic Medication project was retired prior to the HSAG site review. ▪ Regions 1 and 7 were also adopting the registry database and program for Children With Diabetes. ▪ At the time of on-site review, ICHP was focused on identifying enough medication-assisted treatment (MAT) providers and appropriate local social support resources to enable implementation of the protocols for the Opioid Dependence in Chronic Pain Management project.
Region 6—Colorado Community Health Alliance	◆ Relationship with the HIE ▪ CCHA has been receiving RCCO member ADT data feeds through the Department's contract with CORHIO. For other lines of business, Physician Health Partners' (PHP) was receiving information directly from CORHIO for tracking PHP member hospital data. ▪ The member identification (ID) match in the feed from the Department is only 60 percent accurate and includes incomplete or inaccurate information for individual members. CCHA was not able to use the Department-facilitated CORHIO data feed as a reliable source for timely ADT data from hospitals. ◆ Practice performance scorecard ▪ The practice performance scorecard was used to evaluate provider performance related to all PHP members (not just RCCO members) and was intended to provide a snapshot of practice performance in several categories: practice operations,

Follow-Up of Region-Specific Special Projects

	medical home functions, Medicaid-specific functions, health information management functions (e.g., EHRs, patient registries), and quality parameters. ▪ The scorecard was intended to stimulate follow-up discussion with the practices and was distributed quarterly with an annual on-site face-to-face discussion between practice physicians and CCHA's medical director. ▪ The scorecard program has been evolving and has undergone several revisions for improving the value of the type and presentation of data. ▪ The scorecard was soon to be expanded to include 20 to 25 practices. ▪ CCHA was examining the potential of an incentive-based practice engagement program in which each practice would identify its own goals to be tracked through the scorecard, with progress toward meeting those goals translated into value-based payments. ◆ Partnership with Vivage Quality Health Partners ▪ Vivage Quality Health Partners (Vivage) owns and operates numerous skilled nursing facilities (SNFs) in or near the CCHA service area. Vivage facilities serve the largest proportion of CCHA SNF residents. ▪ CCHA and Vivage implemented a collaborative pilot project to improve shared clients' transition of care from SNFs back to the community by capitalizing on the care coordination resources and unique areas of expertise in each organization. ▪ Challenges in the development process included identifying and developing contacts with the maze of long-term services and supports (LTSS) providers in the service area. ▪ At the time of the on-site review, CCHA and Vivage had identified over 30 members for collaborative care coordination. ▪ The mutual objective of Vivage and CCHA is to revise the program based on pilot project results and to expand it to additional SNFs, LTSS providers, and other RCCOs.
Region 7—Community Health Partnership	◆ Relationship with the HIE ▪ CHP entered into a direct contract with CORHIO on behalf of its ambulatory providers to collaboratively develop a "technology solution" to interface between ambulatory provider electronic health record (EHR) systems and a community data repository within the CORHIO framework to facilitate communitywide exchange of patient ambulatory clinical data. ▪ CHP was also building a CHP proprietary data warehouse capable of receiving real-time ADT data from CORHIO and integrating RCCO member clinical information with historical claims data. ▪ Separate from these initiatives, CHP will be implementing a community care coordination tool that can be accessed and updated by all members of the healthcare team. ▪ Five of the larger provider network practices were prioritized for initial implementation of the new technology; CHP anticipated that by 2018 the technology would be completely deployed with all RCCO PCMPs. ▪ Staff members were quite enthusiastic about CHP's relationship with CORHIO.

Follow-Up of Region-Specific Special Projects	
	◆ Dorcas Program and faith-based clinics for criminal justice-involved (CJI) members ▪ CHP had not actively pursued relationships with Dorcas—a project to assist women being released from incarceration to transition successfully back into the community—or the faith-based safety-net clinics for the uninsured. ▪ As an alternative to these projects, CHP redirected efforts into alternative strategies to engage CJI members. ▪ CHP facilitated agreements among agencies to enable a DHS case manager and a PH care coordinator to be assigned to the Criminal Justice Center to enroll eligible persons in Medicaid and connect CJI members to necessary healthcare and social services before release from El Paso County Jail. ▪ In multiple Department of Corrections (DOC) facilities, CHP and the BHO criminal justice systems coordinator engaged in extensive education of staff regarding Medicaid eligibility and services available to CJI Medicaid members. ▪ CHP and the BHO provided monthly education forums directly to inmates in two corrections facilities and met face to face with prisoners prior to planned release. This activity was to be expanded to three additional facilities in April 2016. ▪ One of the major challenges in CJI initiatives, due to inaccuracy of DOC data concerning the residence of parolees upon release, has been linking the member to appropriate follow-up services. ◆ Co-location of care coordination resources in local emergency departments ▪ The Emergency Department Diversion (EDD) program was an established program between Peak Vista and Memorial Hospital to embed Peak Vista care managers in the hospital ED and engage Peak Vista clients regarding alternatives to using the ED for services. In 2013, CHP partnered with Peak Vista to expand the program to all local hospitals and to engage all RCCO members. ▪ EDD staff members were negotiating on-site operational processes to accommodate the emerging development of fast-track emergency department programs by hospitals. Staff recognized that the objectives of fast-track programs may be in direct conflict with the objectives of the EDD program. ▪ A multi-organization task force was formed to examine other initiatives to divert members prior to them arriving in the ED. ▪ CHP also financially supports the CARES program and the Ascending to Health Respite Care program as two community initiatives that contribute to reducing unnecessary ED utilization.

Integration With Behavioral Health Services/BHOs	
Region 1—Rocky Mountain Health Plans	◆ The Larimer County subsection of Region 1 overlaps with the Access Behavioral Care-Northeast (ABC-NE) BHO. The majority of the Region 1 geographic area overlaps with Colorado Health Partnerships (CHP)—which is owned by the participating community mental health center (CMHC) partners. Therefore, all collaborative operations between the CMHCs in the region and RMHP also represent an inherent alignment with the BHO. ◆ Representatives from Mind Springs Health (one of CHP's partner CMHCs) participate on RMHP's Medicaid and Safety Net Executive Committee. ◆ RMHP and the BHO/CMHCs were sharing a large amount of data and information for program analysis and member care coordination. ◆ CMHCs are actively engaged in the CCTs throughout the region. The specific models of integrating behavioral and physical health care coordination vary among CCTs. RMHP views CCTs as the care team model for the ACC. ◆ Staff estimated that 20 to 25 percent of all RCCO members had access to integrated behavioral health/physical health (BH/PH) services in practices; 12 to 15 practices were receiving RMHP payments to support the integration of behavioral health care into primary care practices. ◆ The Mind Springs Health Whole Health initiative trains and oversees community health workers (CHWs), who work within select PCMPs as part of the care teams. CHWs are assigned to provide community-based care coordination to members with extensive psychosocial needs. Axis Health System employed two CHWs embedded in each of its integrated FQHC/CMHC clinic sites. ◆ RMHP used a multi-faceted approach to support the integration of behavioral health into PCMPs—education, CHWs, and financial incentives. RMHP's goal in 2015–2016 was to move primary care practices beyond behavioral health co-location to "ownership" of behavioral health practitioners in comprehensive primary care practices. ◆ RMHP intended all of its initiatives to apply to members of all payor sources aligned with the practice, not RMHP members only. ◆ "Lessons learned" regarding integration of behavioral health practitioners into primary care practices included: behavioral health in primary care is a completely different practice model and environment for behavioral health therapists, recruiting behavioral health personnel to work in primary care practices is a challenge, and on-site behavioral health therapists may positively impact primary care shortages by increasing scheduling availability for PCPs. ◆ RMHP's partnership with the family practice residency program in the region anticipates the long-term return of having introduced residents to the integrated BH/PH practice model. ◆ RMHP cited challenges associated with developing integrated care options in a primarily rural region. ◆ Global reimbursement mechanisms will be required to sustain integrated care practices. ◆ Crisis Support Services: The state-designated crisis support centers in Region 1 include three CMHCs on the western slope and one in Fort Collins. Centers provided crisis hotline and walk-in support services and were collectively able to cover a broad

Integration With Behavioral Health Services/BHOs	
	geographic region with mobile response units. RMHP—in partnership with several CMHCs and CCBs—had received a grant for a pilot program to enhance existing crisis support services to better serve individuals with intellectual or developmental disabilities. RMHP educated all CCTs regarding the crisis support system. The RMHP CCTs have ongoing relationships with the CMHCs in their service areas.
Regions 2, 3, 5—Colorado Access	◆ Region 5 in its entirety is geographically aligned with Access Behavioral Care-Denver (ABC-D). Region 3 in its entirety is geographically aligned with Behavioral Healthcare Inc. (BHI). Region 2 in its entirety is aligned with Access Behavioral Care-Northeast (ABC-NE). ◆ Due to the extensive geographic and functional overlap of the RCCO and BHO regions, Colorado Access has integrated management committees and program activities for its Medicaid lines of business in Regions 2 and 5 and works with BHI to execute integrated programming in Region 3. Care management activities of the RCCO and BHO are highly integrated in all regions. ◆ Colorado Access' goal in all three RCCO regions is to ensure that 80 percent of members have access to integrated BH providers within the next five years. Colorado Access has employed a variety of integration models and reimbursement methods to encourage and support this transition, including CMHC-employed practitioners co-located in primary care practices, PCMP-employed behavioral health providers contracted and reimbursed through the BHO, and tele-behavioral health implemented in PCMPs. ◆ Staff members estimated that more than 50 percent of members in Regions 3 and 5 and 60 to 65 percent of members in Region 2 currently had access to co-located behavioral and physical health services. ▪ In Region 5, Mental Health Center of Denver (MHCD) has collaborated with six primary care practices—with planned expansion to an additional five to six sites—to implement a pre-defined model for placing co-located BH therapists in PCMP practices. Four major PCMPs, including Kaiser and DH, also employed BH providers. ▪ In Region 3, three PCMPs partnered with various local CMHCs to co-locate BH therapists in the PCMPs. Four PCMPs also employed on-site BH providers. ▪ In Region 2, two CMHCs partnered with the FQHC in Weld and Larimer counties to co-locate BH therapists in two clinic locations and integrate primary care practitioners into each CMHC. Banner Health and Salud Family Health Centers also employed behavioral health therapists co-located in numerous primary care clinic locations. A private BH counseling company has co-located 25 BH therapists in various primary care settings in Larimer and Weld counties. ◆ Colorado Access' tele-behavioral health provides psychiatrist e-consults to PCMPs and members to enable PCMPs to manage individual members' behavioral health needs within the primary care environment. Tele-behavioral health had been implemented in six PCMPs and was pending implementation in three additional sites. ◆ Colorado Access was also actively engaged in many and varied pilot programs or special projects in each region to test innovative models of BH/PH integrated care. Some projects were successful and sustained, and others were suspended due to funding complexities or other circumstances. ◆ Colorado Access staff members stated that revision in payment mechanisms to

Integration With Behavioral Health Services/BHOs	
	enhance the payment rate for costs of the more comprehensive service models is needed to sustain integrated BH/PH services and in anticipation of the Regional Accountable Entities (RAEs) of the ACC Phase II contract. ◆ Crisis Support Services: The major CMHCs in each of Colorado Access' RCCO regions served as the designated crisis support centers in those regions. Colorado Access had educated its staff and providers on the availability and use of crisis support services for members, although the direct relationship between the crisis support centers and the RCCOs/BHOs is somewhat remote. Staff members stated that anecdotal feedback indicated that the crisis support centers and services were well utilized in all locations.
Region 4—Integrated Community Health Partners	◆ The entirety of Region 4 geographically overlaps with Colorado Health Partnerships (CHP) BHO, and Beacon Health Options provides administrative services to both ICHP and CHP. The major overlap in structure, geography, and functional responsibilities of CHP and ICHP has been a major strength in achieving behavioral and physical health integration. ◆ From ICHP's inception as a RCCO, FQHCs and CMHCs in any given geographic area have operated as integrated care coordination teams and regularly collaborate, both formally and informally, on ICHP projects. ◆ ICHP estimated that 39 PCMPs have on-site behavioral health services for members and 80 to 85 percent of members have access to co-located behavioral and physical healthcare services. Some CMHCs have integrated or co-located physical health practitioners. ◆ More than 17 PCMPs regularly conduct behavioral health screening and/or developmental screening for children. ◆ The majority of the integrated practices were co-location models. Both ICHP and CHP encouraged the advancement of practices to a fully integrated model by providing practice transformation, technical support, and financial incentives. ◆ Staff stated that some challenges in integrating behavioral and physical health systems are related to differences in reimbursement systems, provider perspectives, and methods of health record documentation (i.e., EHRs). ◆ The shared ICHP and BHO vision for the RAE is to build health teams throughout the region, supported by an integrated infrastructure. ◆ Crisis Support Services: The Health Solutions CMHC in Pueblo is the only State-designated crisis center in the region. The center has a mobile unit through which licensed clinicians may be deployed to a broad geographic area. Care coordinator teams may refer members to the crisis center; all care coordinators had been educated and had disseminated the crisis support center information throughout the provider network. ICHP staff members were not aware of how extensively crisis center services were used or how well they were received within the community.

Integration With Behavioral Health Services/BHOs	
Region 6—Colorado Community Health Alliance	◆ CCHA in its entirety is geographically aligned with Foothills Behavioral Health Partners (FBHP) BHO. CCHA and FBHP have been actively and continually engaged in activities related to shared members. This long-term relationship has provided a strong foundation for BHO/RCCO integration that has naturally evolved over time. In addition, FBHP's CMHC partners—Jefferson Center for Mental Health (JCMH) and Mental Health Partners (MHP)—are the hub of strategic and functional relationships with CCHA. ◆ Through the resources of the CMHCs, CCHA and FBHP co-located CMHC providers in 27 PCMP locations, including the FQHCs. ◆ Clinica Colorado, one of the region's FQHCs, embedded physical health providers at MHP's wellness center. A fully integrated adult health home for members with severe mental illness was instituted with the participation of Metro Community Health Partners (MCHP) providing physical health services, JCMH providing behavioral health services, and Arapahoe House providing substance abuse services. ◆ CCHA and FBHP collaborated to improve depression screenings throughout the network, and staff members reported that screenings significantly improved in practices with co-located behavioral health professionals. JCMH trained its providers co-located in pediatric practices to conduct postpartum depression screenings for mothers attending newborn appointments. ◆ Staff members cited the Bridges to Care mobile health team project, co-location of care coordinators in hospital emergency rooms, and mental health first aid training of CCHA call center staff as examples of population health initiatives for members with behavioral health needs. ◆ The ultimate goal of both the BHO and the RCCO was to achieve a fully integrated behavioral and physical health organization for the RAE envisioned in ACC Phase II. One of the challenges of transforming healthcare delivery is sustaining the financial resources required to maintain the new integrated delivery models, which may require a payment reform initiative. ◆ Crisis Support Services: CCHA has an inherent relationship with the community crisis centers through JCMH and MHP, the designated crisis centers in the region.
Region 7—Community Health Partnership	◆ Colorado Health Partnerships is the primary BHO for Region 7, including the AspenPointe CMHC in Colorado Springs. While the BHO overlaps with several RCCO regions, AspenPointe is tightly aligned organizationally and operationally with Community Health Partnership (CHP). Since the inception of the RCCO, AspenPointe has been a partner organization on CHP's Board, has participated on nearly every RCCO committee, has provided the customer service call center functions to the RCCO, and has actively participated in numerous collaborative initiatives with the RCCO. ◆ At the time of HSAG review, CHP reported that 15 PCMPs, including the largest PCMPs, had co-located or integrated behavioral health services. AspenPointe provided behavioral health resources to PCMP offices as needed to support a co-location practice model and also participated in practice transformation efforts related to advancing integrated care delivery within PCMP locations. CHP also described results of co-location pilot projects with CSHP and Peak Vista. AspenPointe hired a nurse to participate in evaluation of individuals with primary medical needs.

Integration With Behavioral Health Services/BHOs	
	◆ Region 7 developed strategies specific to each individual practice to advance the integration of services and emphasized the importance of designing appropriate strategies for various levels of integration. ◆ CHP and AspenPointe also cooperated in numerous program development and operational activities—developing a communitywide crisis response system, HIE solutions for communications between behavioral and physical health providers, and bi-directional data sharing agreements; and initiating collaborative care coordination teams. ◆ Major challenges encountered in BHO/RCCO integration activities included: ▪ Shortage of psychiatrists to provide medical management of behavioral health disorders. ▪ Physical health and behavioral health being two different systems of service with different coverage and benefit responsibilities and different perspectives and approaches to care. ▪ RCCO and BHO having two different payment systems, which require creative approaches for integrating behavioral and physical health services for individual members. ▪ Inability of small and rural practices to co-locate counselors into their practices. ▪ Inability of PCMPs to be reimbursed for primary behavioral health interventions. ◆ Staff members stated that reimbursement issues related to all integrated practice models needed further exploration and resolution. ◆ Crisis Support Services: AspenPointe is the designated crisis support center within Region 7. Staff stated that the crisis center was frequently accessed and was supported by the community as an important component of the communitywide crisis support system. AspenPointe crisis services were only one component of a more global community response initiative that preceded the State-sponsored crisis support system and included a mobile response unit, the CARES program response team, local safety providers such as law enforcement, and the community Ascending to Health Respite Care program.

Care Coordination Record Reviews	
Region 1—Rocky Mountain Health Plans	◆ RMHP scored 97 percent overall compliance with SCP care coordination requirements. ◆ The majority of SCPs were documented in the RMHP Essette care management system, which had been programmed to include all elements of the SCP. ◆ Fifty percent of the records reviewed were for members who demonstrated no or limited needs or whose needs were addressed entirely by other entities. ◆ When the member was already linked with an external care coordinator, well-established with services, and unable to identify any unmet needs, the RCCO care coordinator generally deferred to the external case manager—single entry point (SEP), CCB, SNF, or PCMP—as the lead coordinator. ◆ In cases where the member demonstrated complex needs or any unmet needs, the RCCO care coordinator remained involved and worked closely with the SEP or CCB, as applicable. ◆ In several cases, RMHP used information from the SEP's uniform long-term care (ULTC) form to complete the SCP. Two members were either uncooperative in completing the SCP or uncooperative with care coordinator efforts.
Regions 2, 3, 5—Colorado Access	◆ Colorado Access scored 96 percent overall compliance with the SCP care coordination requirements—100 percent in Region 2, 96 percent in Region 3, and 93 percent in Region 5. ◆ Eight of the 30 SCPs were completed by delegates—one delegate per each region—with the remainder completed by Colorado Access care coordination staff. ◆ All records completed by Colorado Access coordinators were documented in the Colorado Access web-based SCP tool. Delegates documented the SCP elements in their internal EHR systems or in the Altruista Health care management system. ◆ Eighty percent of records demonstrated that the member had no or limited unmet needs and/or the member's needs were being met entirely through other entities—SEP, CCB, long-term care facility, or PCMP. ◆ When the member was already linked with an external care coordinator, well-established with services, and unable to identify any unmet needs or goals, the RCCO care coordinator deferred to the external case manager as the lead coordinator. ◆ In several cases information from the SEP care manager was obtained through review of information in the Colorado Access SEP database rather than through interpersonal communication with the SEP care manager. ◆ Record reviews indicated that mechanisms currently in use for integrating member ADT data were not consistently successful in timely identification of MMP members needing transition of care follow-up. ◆ Colorado Access was applying the six-month SCP update time frame requirement as the target date for beginning to schedule follow-up care coordinator appointments. In several cases, inability to reach the member, lack of response from the member, or RCCO care coordinator unavailability delayed completion of the six-month SCP update by several months. ◆ One of Colorado Access' challenges included aligning the DH clinic-based health team care management model with RCCO contract expectations.

Care Coordination Record Reviews	
	◆ Colorado Access' internal care management transformation project was designed to integrate care management teams across product lines using functionally defined roles within the care teams; staff estimated that the transformation project was 25 percent completed and that Phase 1would be complete by the end of August 2016.
Region 4—Integrated Community Health Partners	◆ ICHP scored 97 percent overall compliance with SCP care coordination requirements. ◆ ICHP integrated the MMP SCP tool into the Crimson Care Management system for all care coordinator teams to document the elements of the SCP. ◆ Many members were connected with external CCB or SEP case managers prior to the RCCO becoming involved. CCBs in the region were particularly adept at meeting members' comprehensive needs for services. ◆ In most cases, RCCO care coordinators contacted case managers from other agencies to ensure that members were receiving needed services. ◆ When members' needs were limited or already being adequately addressed, member goals were often vague or not actionable. ◆ Staff members offered additional observations and noted experiences with the SCP process, including: some care coordination teams hired separate staff members to complete the SCPs, some of whom were inexperienced and required additional training to understand that the SCP served as an active care coordination plan and not merely a documentation tool; the SCP was a good tool for identifying social determinants and for stimulating outreach to other case managers involved with the member—i.e., "coordinating the coordinators;" and staff questioned whether completion of the entire SCP document was necessary once it had been established that the member had limited unmet needs.
Region 6—Colorado Community Health Alliance	◆ CCHA scored 97 percent overall compliance with SCP care coordination requirements. ◆ CCHA integrated the elements of the SCP into its Essette care management system; delegated entities incorporated the SCP into their electronic medical record (EMR). ◆ Several cases involved coordination with agencies—especially SEPs and CCBs—that were already working with the member and meeting the majority of the member's needs and goals. ◆ The RCCO care coordinators documented outreach to agencies to confirm and obtain the member's service plan. RCCO coordinators addressed any identified gaps and/or assisted with addressing newly identified member goals. ◆ In several cases, the member had minimal additional needs or declined assistance from the RCCO care coordinator. ◆ Lack of real-time ADT information resulted in some ER visits and hospitalizations being identified three months after occurrence, negating the opportunity for proper assistance with transition of care and follow-up. ◆ Compared to previous years' on-site reviews, CCHA made significant improvements in comprehensive care coordination processes and documentation. ◆ CCHA and delegates agreed that the SCP tool was useful for informing modifications to the documentation systems and served as a guide for understanding the essential elements of comprehensive care coordination.

Care Coordination Record Reviews	
Region 7—Community Health Partnership	◆ CHP scored 99 percent overall compliance with SCP care coordination requirements. ◆ CHP had programmed the elements of the SCP into an electronic database. Staff stated that CHP used this tool to document care coordination for all members. Peak Vista documented its care coordination assessment and interventions in the EMR, which was auto-populated or linked to some data already documented in other portions of the EMR. ◆ Very few members demonstrated complex needs or identified unmet needs and goals. Many members were connected with the SEP or CCB case managers prior to the RCCO becoming involved. ◆ In most cases, RCCO care coordinators contacted care coordinators and case managers from other agencies to ensure that members were receiving needed services though no written care plan information had been exchanged. ◆ When the member was already linked with an external care coordinator, well-established with services, and unable to identify any unmet needs, the RCCO care coordinator generally deferred to the CCB or SEP as the lead coordinator. ◆ Staff explained that for a significant period of time the SEP was not cooperative with sharing information and would not accept direct referrals from the RCCO; however, staff reported that communications were improving between RCCO and SEP care managers.

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. HSAG identified trends and made recommendations related to these five domains.

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. HSAG identified progress and trends and made recommendations related to these two domains.

In FY 2013–2014, the Department determined that priorities for review were to evaluate the evolution of the RCCOs' Provider Network Development, Provider Support Activities, and Care Coordination Programs. HSAG identified progress and trends and made recommendations related to these three domains.

In FY 2014–2015, the Department determined that priorities for review were to evaluate the RCCOs' activities and progress related to Delegation of Care Coordination, RCCO Coordination With Other Agencies and Provider Organizations (including a focus on select Medicaid expansion populations), and Care Coordination Programs. HSAG identified progress and trends and made recommendations related to these three domains.

For FY 2015-2016, the Department determined that the priorities for review were to explore the RCCOs' activities related to: Integration With Specialist Providers, Select Region-Specific Projects (including each region's relationship with the HIE), Integration With Behavioral Health Services/BHOs, and Implementation of SCPs for MMP members. 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 four domains.

Integration With Specialist Providers

In all RCCO regions, specialists are primarily located in the major population centers and/or are associated with tertiary hospitals. Within the vast geography of the rural regions—Regions 1, 2, and 4—population centers offering access to diverse specialists are limited to one or two locations. Some "super-subspecialists" are located only in the Denver metropolitan area. All rural region RCCOs reported that member transportation issues are a major barrier to accessing specialists.

All RCCOs offered members and PCMPs care coordinator assistance with referrals to specialists. All RCCOs reported that medical directors or other management may use personal contacts with specialists to intervene in select individual cases in which increased facilitation of a referral is needed.

All RCCOs acknowledged that there is a general shortage of specialists within the state to serve the entire population, specialists are highly stressed, and access to specialists is an all-payor concern. In five of seven RCCOs (Regions 2, 3, 4, 5, and 6), RCCO leadership were participating in community

all-payor forums, alliances, and work groups to evaluate and improve access to specialists within the regions. All RCCOs noted that, due to all-payor competition for access to specialists, reduced Medicaid reimbursement and specialist concerns about Medicaid member behaviors—i.e., no shows or lack of preparation for appointments—were a deterrent to access.

All RCCOs reported that established personal and professional relationships among providers are the primary drivers of access to specialist care. All RCCOs had developed basic referral protocols and tools to improve bi-directional communication between PCMPs and specialists and efficacy of Medicaid specialist referrals. All regions disseminated protocols to providers for educational purposes and for voluntary implementation. Region 7 was the most assertive in developing and implementing protocols—including several high-volume, diagnosis/condition-specific protocols.

No RCCO mandated provider implementation of referral protocols, determining that specialists are not generally interested in written agreements and that practices could not readily integrate single-payor operational processes. Region 7—a smaller geographic region in which Medicaid primary care and specialist providers have a close working relationship—was incenting providers to adopt specialist protocols through pay for performance initiatives. Regions 1, 3, and 5 were encouraging adoption of referral protocols—for all patient pay sources—through robust practice transformation initiatives with select PCMPs. Several RCCOs reported that, where protocols had been implemented, specialists experienced improved efficiencies, increased capacity, and elevated provider satisfaction.

All RCCOs except Region 7 described that e-consult programs offered the most promising potential for disseminating specialist expertise to members in primary care practices. All RCCOs had implemented or were planning to implement e-consult programs on a number of different levels, including ECHO programs, C-PAK, and/or direct member or provider specialist consultations.

Recognizing that not all specialty needs can be addressed through specialists, most RCCOs were facilitating or funding multiple pilot projects and community-based programs to expand specialty care services for Medicaid members. Regions 1, 2, 6, and 7 described numerous innovative pilot projects and partnership initiatives to implement services for special populations such as members in foster care, members needing behavioral health services, members with disabilities, and homeless members.

Follow-Up of Region-Specific Projects

RCCO Relationships With the HIE

Each RCCO except Region 6 had a direct contractual relationship with CORHIO or QHN to receive ADT and other information from HIE participating hospitals. Only Regions 4 and 6 had used the data feeds from CORHIO facilitated through the Department. All RCCOs were receiving daily ADT data from nearly all hospitals in the region. Three RCCOs—Regions 1, 4, and 7—were engaged in extensive working relationships with CORHIO/QHN to develop HIE technology applications beyond hospital ADT and laboratory data, and Regions 2, 3, 5—Colorado Access—stated similarly intending to expand relationship with CORHIO. Regions 2, 3, 5, and 6 reported technology challenges or operational workarounds required for integration and use of ADT data.

RCCOs commonly reported that the usefulness of clinical laboratory data was limited by its lack of standardization. Despite technology challenges, six of seven RCCOs—excluding Region 6—viewed their individual relationships with the HIE and/or access to ADT data as a positive factor in supporting the goals of the RCCO.

Regions 1, 4, and 7 were committed to expending significant financial and staff resources to achieve their goals related to use of HIE data. These included integrating HIE data into an internal data warehouse/clinical database for population health analytics (Regions 4 and 7); integrating data into the Crimson Care Management system to be shared with other community organizations and providers (Region 4); integrating ambulatory data into a community data repository accessible to providers and community organizations through the CORHIO framework (Region 7); integrating RCCO Medicaid data with EHR data for predictive modeling and other applications in PCMP practices (Region 1); and creating a virtual clinic process through the HIE to enable e-consults to members, providers, and care coordination teams (Region 1).

Region-Specific Projects

HSAG gathered information to update the Department regarding select focus projects previously initiated in each region. While the projects varied across the regions, RCCOs commonly were engaged in collaborative partnerships with other community organizations or providers in these initiatives. All RCCOs tended to use pilot program testing, data evaluation of outcomes, and informal rapid-cycle decision-making to determine the viability of the projects. Several projects targeted for HSAG review had been retired or were minimally implemented at the time of on-site review, although most projects were active.

Region-specific projects reviewed included:

- Co-location of care coordination resources in local emergency departments (two regions).
- Dorcas Program and faith-based clinics for criminal justice-involved (CJI) members (included discussion of alternative programs for CJI members).
- Partnership with Vivage Quality Health Partners (SNF facilities).
- Practice performance scorecards.
- Patient registries for pain management, adults with diabetes, children with diabetes.
- Crimson Care Management system.
- Improving delegate compliance with comprehensive care coordination requirements.
- Integrating RCCO members into Denver Health.
- Transferring Transition of Care program to delegates.
- Transferring the B4 Babies program to other communities.
- Expanding the Healthy Harbors program to other communities.

Integration With Behavioral Health Services/BHOs

With the exception of Region 1, all RCCO regions were geographically aligned with a single BHO. With the exception of Colorado Health Partners (CHP) and Access Behavioral Care—Northeast (ABC-NE), each BHO region was geographically aligned with a single RCCO region. All BHO and RCCO partners participated in some shared governance functions. However, the primary functional and strategic partnerships in all regions occurred between the CMHCs and the RCCO. Mind Springs Health tended to be the primary partner in Region 1, Mental Health Center of Denver in Region 5, Jefferson Center for Mental Health and Mental Health Partners in Region 6, and AspenPointe in Region 7. Regions 2, 3, and 4 collaborated with multiple CMHCs. All regions had integrated or collaborative CMHC/BHO and RCCO care coordination teams.

All regions identified that co-located behavioral health services existed in numerous practice locations, including the larger PCMPs. At least one CMHC in all regions except Region 3 was noted to have a physical health provider on-site for behavioral health clients. At the time of on-site review, every region—with the exception of Region 1—estimated that more than 50 percent of RCCO members had access to co-located BH/PH services. Although the model of integrated services varied by practice, the most common models were CMHCs employed and co-located BH practitioner(s) in the PCMP, or PCMPs employed and embedded the BH practitioner(s) in the practice. Co-located BH practitioners were available to all patients of the PCMP, not just Medicaid members.

All RCCOs were engaged in initiatives to increase the number of primary care practices with co-located BH. Regions 1 and 4 offered financial incentives to providers to support BH practitioners while Regions 2, 3, and 5 facilitated enhanced reimbursement mechanisms to support BH practitioners. All regions were supporting a variety of innovative programs to advance BH/PH integrated care within their regions. Examples include but were not limited to tele-behavioral health e-consult programs for PCMPs; integration of community health workers into practices; physician training programs for integrated care; and mobile, community-based behavioral health teams.

All regions noted that payment reform models were required both to sustain integrated BH care in primary care practices and in anticipation of ACC Phase II.

The designated crisis support centers in all RCCO regions were CMHCs with which each RCCO had pre-existing relationships for care coordination and other collaborative initiatives. All crisis support centers provided hotline and walk-in crisis support services, and mobile units provided crisis services to broad geographic areas within the regions. All RCCOs trained staff members regarding the crisis support system and services. Regions 1 and 7 participated in developing enhanced crisis support systems within their regions. However, due to the broader population served and different funding mechanisms for the crisis support centers, RCCOs did not have formal mechanisms of communication or other formal relationships with the State crisis support system.

Care Coordination Record Review

HSAG conducted on-site review of care coordination for MMP members focused on compliance with the high-priority elements of the SCP. The Department selected a record review sample of 10 records with 10 oversample records, using a targeted sampling methodology as follows:

- Ages 65 and over (four clients)
  - SEP or CCB Waiver (two clients)
  - Clinical risk group (CRG) > 70 (one client)
  - BHO Utilization (one client)
  - One of above is also delegated care coordination
- Ages 25 to 64 (four clients)
  - SEP or CCB Waiver (two clients)
  - CRG > 70 (one client)
  - BHO Utilization (one client)
  - One of above is also delegated care coordination
- Ages under 25 (two clients)

Record review criteria focused on designation of a lead coordinator, assessment of member's comprehensive needs, interventions to address assessed needs, follow-up with the member, transition of care planning, outreach to external care managers and providers, and overall effectiveness of the SCP in documenting the member's care coordination.

RCCOs scored 97 percent overall compliance with care coordination requirements statewide, ranging from a low of 93 percent in Region 5 to a high of 100 percent in Region 2. Many individual records scored 100 percent; 31 percent of the SCP requirements were scored *Not Applicable*. All RCCOs had incorporated the elements of the SCP document into an electronic care management database. Delegates documented SCP elements in the PCMP EHR system. All SCPs were thoroughly documented by all RCCOs. All RCCOs completed initial SCPs within the required time frame after enrollment or as soon thereafter as the member could be contacted. Most SCPs were completed through face-to-face meetings with members; although in many cases family members, caregivers, or care facility staff also participated in the completion of the SCP. In several cases, HSAG observed that the SCP was completed using documentation obtained through the SEP rather than direct communication with the member. RCCOs routinely assigned a care coordinator, and in most cases it was apparent that a lead coordinator had been designated.

HSAG identified the following common themes in statewide record reviews:

- Coordinators consistently documented a comprehensive needs assessment.
- Few MMP members demonstrated complex needs or identified unmet needs and goals. Many were well established with needed services.
- Many members were connected with SEP or CCB case managers prior to the RCCO becoming involved.

- When the member was associated with a pre-existing care coordinator through the SEP, CCB, or long-term care facility, all or the majority of the member's needs were being addressed through the external care manager. In these cases, the SCP process appeared to be duplicative of other care management resources.
- When limited or no needs were identified, member goals tended to be vague or non-actionable.
- When the member was linked with an external care coordinator and no additional unmet needs were identified, the RCCO care coordinator routinely deferred to the external case manager as the lead coordinator.
- In most cases the RCCO care coordinator contacted (or attempted to contact) the external care manager, although there was frequently little evidence of ongoing collaboration or the need for it.
- In most cases, there was no need for the care coordinator to contact providers involved in the member's care.
- During the review period, few members experienced a "critical incident" requiring transition of care follow-up. When members did experience an unplanned hospital visit, HSAG reviewers noted that—in regions 2, 3, 5 and 6—ADT information was not always effective for timely follow-up with the member.
- Although most members were cooperative with completing the SCP with the RCCO coordinator, in cases with minimal or no unmet needs the SCP process served primarily to introduce the coordinator to the member or to complete required SCP documentation. In some cases, the member denied the need for further involvement by the RCCO coordinator.
- RCCOs prescriptively scheduled six-month follow-up with members after initial SCP completion.

4. Conclusions and Overall Recommendations

Observations and Conclusions

All RCCOs identified the general shortage of specialists statewide as a complex issue and an all-payor concern. Specialist referral protocols applicable to Medicaid members only were generally not considered implementable by either PCMPs or specialists, except in Region 7. Specialist referral patterns remain largely dependent on personal and professional relationships among select provider groups. Insufficient Medicaid reimbursement for specialists complicates competitive access to specialty services for Medicaid members. Although RCCOs were participating in all-payor community alliances to improve access to specialists, most RCCOs were focused on addressing region-specific access issues—i.e., improving member transportation, implementing e-consults, or developing specialty programs for select population groups.

All RCCOs and the BHOs and/or CMHCs within the regions were well-aligned both organizationally and functionally. RCCOs and CMHCs were actively engaged in numerous strategic partnerships. RCCO and BHO leadership in each region appeared to be examining models for formally integrating the organizations in anticipation of ACC Phase II contracting. All RCCOs and BHOs recognized the necessity of payment reform to support the activities of the proposed Regional Accountable Entities (RAEs).

All RCCOs demonstrated significant accomplishments in integrating behavioral health into primary care practices. Integrated or co-located behavioral health/physical health (BH/PH) primary care practices were prevalent statewide, with the exception of smaller practices and remote rural regions. At the time of the on-site review, the majority of members in all except one RCCO region had access to co-located BH/PH services. Integration of physical health into behavioral health locations also appeared to be an emerging trend. Models of practice integration varied and were noted as requiring flexibility according to the characteristics of individual practices. All RCCOs were testing innovative mechanisms to transform practices and exploring reimbursement support for integrated practices. RCCOs noted that practice transformation for integrated behavioral health services must apply to all members of the practice—i.e., diverse payor sources—in order to be effective.

All RCCOs continue to fund or participate in a variety of region-specific pilot programs to fill gaps in services, overcome performance issues, or generally improve the health of Medicaid members. Partnership activities with community-based providers and organizations continue to be a strength of all RCCOs. If initiatives languish or fail to meet objectives, RCCOs expediently target resources elsewhere.

Six of seven RCCOs had direct contract relationships with the HIE to obtain daily ADT information, and three of seven RCCOs had in-depth database integration and other projects in development with the HIE. RCCOs with direct working relationships with the HIE considered the relationship very valuable for developing clinical databases and access to ambulatory provider information. A shared concern of all RCCOs is the need for standardization of laboratory data across the state; laboratory data are essential for core clinical applications and measures of RCCO

clinical quality. If RCCOs are able to accomplish their ambitious goals with CORHIO or QHN, results will potentially advance the capabilities of not only the RCCOs but the HIEs as well.

Overall, it appeared that the majority of MMP members in the record review sample had few complex or unmet needs requiring involvement with RCCO care coordinators. HSAG acknowledges that these findings might be attributed to this year's sampling methodology, which targeted review of MMP members also receiving SEP, CCB, behavioral health, or nursing facility services. HSAG's review indicated that many of these members' priority needs were already being met. Many members also had significant family supports and involvement and were well-established with medical providers. In these cases, MMP care coordination record reviews demonstrated potential duplication of RCCO care coordination resources with other agencies, leading to inefficient use of scarce and expensive staff resources for completion of the SCP. HSAG suggests opportunities may exist for the Department to reduce SCP requirements for members already associated with external case managers and/or for members with few unmet needs identified upon initial assessment. It is important to note that during on-site interviews HSAG confirmed with staff members that many other MMP members—not included in the sample—do demonstrate unmet needs requiring RCCO care coordinator attention. Member goals are an important feature of the SCP. Members who demonstrated few unmet needs often defined goals that were vague or not actionable. HSAG suggests this may be attributed to a member feeling forced to identify goals when, in fact, the member perceived that he/she had no identifiable needs. Nevertheless, member goals enabled care coordinators to target interventions toward meeting those goals rather than using care coordinator resources to implement actions considered of little benefit by the member.

The SCP guidelines suggest that the RCCO care coordinator should contact the member's providers or any external case manager involved with the member's care. However, when no need to coordinate responsibilities was apparent, care coordinators often did not attempt to contact providers or other case managers, citing that interrupting other "busy" resources involved with the member did not seem reasonable. HSAG agreed with care coordinators' judgement in these circumstances.

The SCP requirement to follow up with members every six months was being applied rather prescriptively by RCCO care coordinators. While the six-month required update intends to ensure periodic monitoring of member needs, HSAG observed that targeting follow-up with the member according to pre-defined time frames may tend to take precedence over care coordinator judgements regarding the most appropriate follow-up based on individual member needs.

Overall Opportunities for Improvement and Recommendations

Due to the statewide shortage of specialists and all-payor competition for access to already overburdened specialists, HSAG agrees that the most promising near-term solutions for improving access to specialty services for Medicaid members are through work-around initiatives—i.e., increased capacity, provider satisfaction in specialist practices that work with protocols, and efficiencies realized practice to practice; continued development of alternative specialty service programs to off-load demand on specialists by select populations; and increased development and implementation of e-consults for primary care providers and members.

HSAG applauds the accomplishments of the RCCOs and BHOs in advancing the integration of behavioral health practitioners into primary care practices across the state. CMHCs have been active and willing partners with the RCCOs in support of behavioral health integration. RCCOs were also using tele-behavioral health consultations and community health workers as viable alternatives to support behavioral health care in small or rural primary care practices, which HSAG suggests should both be further promoted through RCCO-specific or statewide initiatives. Due to commonly expressed concerns about the need for modified payment mechanisms to sustain integrated BH/PH in practices, the Department might anticipate region-specific or statewide payment reform mechanisms as an essential component of the implementation of RAEs.

Due to the varying characteristics and resources in each region, pilot or focus projects should continue to be driven according to the priorities of the individual regions. However, some focus projects implemented within individual regions demonstrated high-value potential to other regions or communities across the state. HSAG recommends that the RCCOs work with the Department to identify a mechanism—e.g., programs committee—to enable RCCOs to routinely promote ready transferability of successful projects among the regions, thereby enhancing dissemination of best practices and diminishing duplication of resources.

Due to the depth and scope of direct contracting between most RCCOs and CORHIO/QHN, RCCOS were not generally using the ADT data feeds facilitated through the Department. HSAG recommends that the Department consider transitioning support from RCCO ADT data feeds to alternative HIE statewide initiatives—e.g., troubleshooting gaps or inaccuracies in data, focusing on new areas of common concern such as standardization of laboratory data, and/or facilitating other "all-payor" HIE projects.

Throughout the on-site interviews, RCCOs identified several project areas that must be applied to patients of all payors—i.e., not limited to Medicaid members—in order to be successfully implemented in provider practices. These included behavioral health integration, HIE initiatives, delegated PCMP care coordination, specialist referral protocols, and e-consult programs. Several RCCOs have implemented practice transformation programs with practices to implement projects applicable to and which will benefit patients of all payors. The Department might consider identifying and facilitating increased opportunities for future all-payor initiatives so that activities related to transforming healthcare in Colorado may be financially supported through more than Medicaid funds only.

HSAG suggests that opportunities may exist for the Department to reduce SCP requirements for members already associated with external case managers and/or for members with few unmet needs identified upon initial assessment. HSAG recommends that the Department work with RCCO care coordinators to obtain input to streamline the SCP requirements and processes in order to apply care coordinator resources most expeditiously. HSAG suggests consideration of the following alternatives:

- Examine improved methods for identifying members most in need of RCCO care coordinator intervention, which might include care coordinators contacting MMP members to complete an initial comprehensive needs assessment and using the needs assessment to determine the need for completing the remainder of the SCP and designating as low priority for completion of the SCP those members identified as established with external care managers and who demonstrate few unmet needs.

- Whether associated with an external care coordination agency or not, members with few unmet needs identified on initial assessment might be educated regarding RCCO care coordinator assistance and encouraged to contact the RCCO care manager as needed rather than completing the entire SCP process.
- Discuss alternatives to documenting contact with other case managers or providers when there is no apparent need to coordinate responsibilities.

HSAG recommends that the Department reconsider the contractual language that requires six-month update of the SCP to ensure that such a time frame serves as a guideline or an "at a minimum" requirement and is not applied prescriptively as the appropriate time frame for follow-up regardless of individual member circumstances. Conversely, while RCCOs must meet the contractual requirement for six-month update of the SCP, RCCOs should also ensure that care coordinators implement more frequent follow-up when needed, as determined by the member's condition and needs.

To address additional opportunities for improvement identified in care coordination record reviews, each RCCO should consider the following, as applicable:

- Although it may have been appropriate for this sample of MMP members, HSAG cautions against RCCOs automatically deferring to SEP as lead coordinator, recognizing that SEP case managers have defined roles and responsibilities that may not entirely fulfill RCCO comprehensive care coordination requirements.
- Member goals are an important factor in directing appropriate care coordinator interventions. RCCOs should determine whether the vague or non-actionable goals were a characteristic of this particular sample of MMP members—i.e., members identified few unmet needs—or are an indicator of the need for improved motivational interviewing techniques.
- RCCOs experiencing continued issues with integration of timely ADT information into the care coordination plan should enhance internal efforts to resolve ADT data problems.

HSAG recommends that the Department work with the RCCOs to identify an alternative sample of MMP members and conduct additional record reviews to verify the efficacy of the SCP process using an MMP population that may demonstrate more intense or more unmet member needs.