COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2016–2017 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.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The Colorado Department of Health Care Policy & Financing (Department) implemented the Accountable Care Collaborative (ACC) program in spring 2011 as a central part of its plan for Health First Colorado (Colorado's Medicaid program) reform. The ACC was designed to improve the member and family experience, improve access to care, transform incentives and the healthcare delivery system into a system that rewards accountability for health outcomes, and make smarter use of every dollar spent. Central goals for the program are to: (1) ensure access to a focal point of care or medical home for all members; (2) coordinate medical and non-medical care and services; (3) improve member and provider experiences; and (4) provide the necessary data to support these goals, analyze progress, and move the program forward. A key component of the ACC program is partnership with seven Regional Care Collaborative Organizations (RCCOs), each of which is accountable for the program in a designated region of the State. Each RCCO develops region-specific innovations in order to address variations in populations, community providers and resources, and member needs in diverse geographic areas across the State. The RCCOs maintain a network of providers; support providers with coaching and program operations; manage and coordinate member care; connect members with medical and nonmedical services; and report on costs, utilization, and outcomes for their members. An additional feature of the ACC program is collaboration—among providers and community partners, among RCCOs, and between RCCOs and the Department—to accomplish program goals.

Serving as the primary vehicle for delivering quality healthcare to Health First Colorado members, ACC enrollment has grown to approximately one million members in 2017, including the Medicaid expansion population. In addition, the Medicare-Medicaid Program (MMP) demonstration project provided for integration of members eligible for Medicare and Medicaid. Effective July 2018, the Department will implement new ACC contracts commensurate with responses to a request for proposal (RFP), which will transition RCCOs into Regional Accountable Entities (RAEs), incorporating within the RAE responsibilities of the State's behavioral health organizations (BHOs). Each year since the inception of the ACC program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO's challenges and successes in implementing key components of the ACC program.

Methodology

Between February and May 2017, HSAG performed a site review of each RCCO to assess progress toward implementing the ACC program during its sixth year of operations. Fiscal year (FY) 2016–2017 site review activities included evaluation of lessons learned—challenges and successes by each RCCO since inception of the ACC program—related to five focus topics: community partnerships and collaboration, provider network and provider participation, member engagement, care coordination, and balancing central (Department-driven) and regional (community-driven) priorities. In addition, the

Department requested a presentation by each RCCO of care coordination cases demonstrating "best practice" examples of successes and challenges related to comprehensive care coordination. This report documents the aggregate findings and recommendations to provide a statewide perspective of RCCO operations and progress toward ACC program goal achievement.

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. Each RCCO presented to HSAG 10 care coordination cases (the exception being 15 total cases for Regions 2, 3, and 5 combined) focused on a sample of Health First Colorado members with complex needs including, but not limited to, members of the MMP population, members with care coordination performed by delegated entities, and members who may have presented significant challenges to care coordinators. Care coordination cases were selected by each RCCO, and results were not scored. HSAG summarized results of each care coordination case in the *Coordination of Care Record Review Tool*, which documented member characteristics and needs, care coordinator activities, member engagement, involvement of other agencies and providers, and outcomes of care coordination efforts. Section 2 includes the summary of care coordination findings for each RCCO.

HSAG and the Department developed a *Focus Topic Interview Guide* to stimulate on-site discussions to explore with each RCCO, regarding each focus topic, the "lessons learned"—including changes over time, influence of recognized challenges and successes on RCCO operations, and the role of the Department in influencing RCCO operations—since the inception of the ACC program. During the on-site portion of the review, HSAG conducted group interviews of key RCCO personnel using a semi-structured qualitative interview methodology to elicit information pertaining to the Department's interests related to each focus topic. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing systemwide issues and associated outcomes. Results of these discussions were not scored. Section 2, in "Summary of Activities and Progress by Focus Area," includes the summary of focus topic discussions with each RCCO.

HSAG analyzed information obtained during the on-site interviews to identify common experiences or concerns across RCCO regions, then developed statewide recommendations for continued successful implementation of Colorado's ACC program. The statewide trended results of both care coordination findings and discussions related to each focus topic 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 Care Coordination Record Reviews

RCCO Region	Care Coordination Record Reviews Results
Region 1—Rocky Mountain Health Plan (RMHP)	• All cases included behavioral and/or substance abuse issues. • Homelessness or risk of homelessness was a common occurrence. • Numerous providers and agencies were often involved in the member's care. • Legal and financial challenges were common. • Transportation assistance was generally required. • Member engagement and family support systems were major factors in successes or challenges. • RCCO care coordinators often served as lead coordinators because they had responsibility for comprehensive care coordination, whereas other community agencies/organizations had responsibilities isolated to specific healthcare, behavioral, or other components of an individual member's needs. • Members often require individual accompaniment to appointments and personal assistance with applications and paperwork. • Members with complex needs often consume enormous staff resources from the collective care coordination team.
Regions 2, 3, and 5—Colorado Access	• Profile of cases: six delegated, nine RCCO care coordination, two children, 13 adults (two MMP members). • Profile of diagnosis-related conditions (in addition to multiple chronic or acute medical conditions): six cases had significant co-existing physical health/behavioral health (PH/BH) conditions; two cases involved severe alcohol abuse (neither member was willing to address); two cases were transgender individuals; three cases involved suicidal ideation or attempts; three cases involved frequent use of the emergency department (ED). • All cases included arranging referrals and appointments, and care coordinators acting as liaisons among healthcare providers. Thirteen of 15 cases also required assistance with non-medical services. • Other trends in needs and interventions included that three cases required foreign language interpretation for all care coordinator interactions and interventions; six cases included care coordinators accompanying members to appointments; three cases required pain management; seven cases required housing resources; four cases required transportation assistance; seven cases required assistance with applications and paperwork; and two cases involved additional care coordinator support for other family members. • Ten members were actively engaged in care coordination, three members were moderately engaged, and two members were minimally engaged.

RCCO Region	Care Coordination Record Reviews Results
	• Most members had resolved issues or were making significant progress toward care coordination goals; three members died. In seven cases, the care coordinator connected the member to needed services and appropriately decreased frequency of contacts (follow-up contacts maintained). In two cases, the member was transferred to a new coordinator while needs remained high. In several cases, care coordinators dedicated extreme time and energy to successfully help the members.
Region 4—Integrated Community Health Partners (ICHP)	• ICHP staff members presented 10 coordination of care cases. Most cases involved members with multiple complex diagnoses and who appeared to truly benefit from coordinating care among multiple providers. Other care coordination services most commonly provided included transportation, housing, and assistance with filling out and tracking paperwork and applications. In every case, the member's willingness to participate proved critical to successful outcomes. • Record reviews demonstrated that care coordinators routinely assisted members with securing transportation, housing, food, clothing, and financial assistance with utilities and prescriptions.
Region 6—Colorado Community Health Alliance (CCHA)	• Profile of cases: three delegated, seven RCCO care coordination; of those, three children and seven adults (including four MMP members). • Four of ten members were identified to the care coordination (CC) team through the Service Coordination Plan (SCP) assessment process; three members were referred to CCHA by the primary care medical provider (PCMP); one case was referred to CCHA from another agency; and two cases were identified through routine delegate processes. • The profile of primary member needs included: three members with significant physical disabilities; four members with multiple behavioral health conditions; three members with alcoholism, including two members who sustained injuries due to intoxication; one member with cognitive issues. In addition, four cases identified multiple additional complex needs upon initial assessment. • Two cases involved homelessness of the member, and two additional cases identified the need for housing resource information. • Primary CC interventions were categorized as follows: six cases were coordinated with mental health and/or substance abuse providers; four cases involved coordinating primarily with physical health providers; one case included coordinating extensive social and community supports; two cases—both delegated cases—had limited CC needs. • Additional patterns of CC interventions included: four cases involved transitions of care following ED visits, hospitalizations, or skilled nursing facility (SNF) care; three cases required repeated care coordinator efforts resulting from interruption in care plans—e.g., hospitalizations or non-compliance issues; in four cases, the care coordinator accompanied the member to multiple appointments or meetings; in three cases, the care coordinator provided extensive education regarding member diagnoses or medications; in two cases, the care coordinator provided additional services for other family members; in seven cases, the care coordinator worked with external State agencies—three which were unrelated to referrals, and four related to referral approvals; and two cases involved transferring the member to a new PCMP.

RCCO Region	Care Coordination Record Reviews Results
	• At the time of on-site review, outcomes of CC coordination efforts demonstrated: five successful cases; three partially successful cases; four cases with ongoing challenges; one, member refused to participate; three cases associated with extensive barriers or challenges; two cases involved appeal of a behavioral health organization (BHO) denial; and one additional case involved an appeal of other denied services.
Region 7—Community Health Partnership (CHP)	• Profile of cases: four delegated, six RCCO care coordination; of those, one child, nine adults (including three MMP members). • Primary needs of members: physical health—two members; behavioral health—two members; social needs—one member; physical/behavioral/social—two members; physical/social—two members; behavioral/social—one member. In addition, two of the 10 members had legal issues. • Three of 10 cases involved homelessness of the member. • Member engagement was high in four cases, moderate or inconsistent in three cases, and low in three cases. • Care coordination needs were minimal in two cases, moderately complex in four cases, and highly complex in four cases. • Eight cases were complicated by lack of cooperation or responsiveness by providers or agencies: PCMP—two cases; BHO—two cases; Veterans Administration (VA)—two cases; single entry point (SEP)—one case; care facility—one case.

Summary of Activities and Progress by Focus Area

RCCO Region	Community Partnerships/Collaboration
Region 1—Rocky Mountain Health Plan (RMHP)	• RMHP made collaborating with community partners a major theme in its operations since inception of the RCCO, beginning with designation of community-based care coordination teams (CCTs) which are guided by local healthcare leadership teams. • RMHP is working with eight SEPs and six Community Centered Boards (CCBs) across the region to address individual member-specific needs and, as applicable, to engage collaboratively on special community-based program initiatives. In order to facilitate these relationships, RMHP took the lead in sharing information with the CCBs and SEPs and conducted meetings regularly with the CCTs, SEPs, and CCBs—to understand the scope and services of each agency. • RCCO care coordinators support the SEPs and CCBs in providing services to individual members and reported that these agencies frequently reach out to the RCCO for assistance with individual members. • RMHP's integration with community partners has grown and become the foundation for multiple locally-driven and regionwide programs and projects of the RCCO. RMHP used the base of care coordination for individual members to launch broader community and agency cooperative ventures. • RMHP acts as played a variety of roles in these initiatives—leader/convener, active partner/participant, provider of staff expertise/resources, or funder/fiscal agent in multiple community and regional initiatives. • RMHP has secured its community partnership activities through formal agreements to ensure that roles and responsibilities as well as any applicable financial obligations are clearly outlined. • RMHP's predominantly rural region not only necessitates diverse community-based solutions, but also enjoys the advantage of community partners inherently dedicated to serving the members and their communities at-large. • RMHP initiates pilot projects to test programs and solutions that may be transferrable to other communities. • RMHP highlighted several projects demonstrating recent collaborative community partnerships: COP project in La Plata and Montezuma counties to connect members to services addressing social determinants of health; COP Pinon Project to provide multiple services and education for children and families through the Family Resource Center; Intellectual and Developmental Disabilities (IDD) Crisis Services to address gaps in the State crisis system for persons with disabilities; Essette Care Management software to enhance care coordination among community partners; Mountain Family Health Services to fund a mobile dental van; Larimer County Community Corrections halfway house project to reduce the excessive ED utilization rate of halfway house residents; Health Engagement Teams (HET) to employ community health workers as extensions of PCMP practices, targeting high ED utilizers in the community.

RCCO Region	Community Partnerships/Collaboration
	• RMHP appears to have designed a robust, interactive, and inclusive RCCO partnership strategy with many effective outcomes. RMHP has developed a network of community partners across the region over time and will continue to do so. • RMHP credited the Department for resisting attempts to be prescriptive in processes and resources, thereby affording development of community-based collaborative processes and programs. • RMHP credited the Department with partnering at the statewide level to facilitate relationships—e.g., criminal justice system, CCBs, and SEPs—when efficiencies can be better realized at a State level. • RMHP suggested that the Department should further pursue mechanisms for sharing raw data (e.g., long-term supports and services data)—not analytics—among agencies and with the RCCOs.
Regions 2, 3, and 5—Colorado Access	• Colorado Access' multiple lines of business have afforded Colorado Access contact and increasing familiarity with persons within a variety of other State agencies and community organizations. • Colorado Access has evolved relationships with SEPs and CCBs as well as with public health agencies in all three regions. • Most relationships are centered around either coordinating care for individual members or participation in special programs or grants that foster inter-agency cooperation. Common themes in developing partnerships have been defining shared members; and sharing data, personnel, and resource availability to support symbiotic care management referral and support systems. • Due to agency perceptions that contract responsibilities were duplicated, RCCOs were most successful defining their roles as being supportive and complementary to the activities and responsibilities of other organizations. • Colorado Access expended considerable time and energy educating other organizations about ACC program and functions. Responsiveness of organizations to RCCO priorities and projects has varied based on the organizations' familiarity with the RCCO. • Colorado Access has engaged with other agencies and organizations to fulfill program opportunities that are either Department-driven or individual regional priorities. All three regions have developed relationships according to the needs of the region, and with various partners. • Colorado Access has acted as a funder, convener, or leader for a number of special collaborative programs. • While relationships with human service agencies in Region 2 and Region 5 abound, additional relationships within Region 3 need to be established. • Colorado Access needs to add relationships with select community organizations—e.g., energy assistance programs, child care programs—to enhance care coordination. • Colorado Access provided examples of partnerships primarily related to care coordination: county agency child welfare programs and county criminal justice divisions (jails and courts); public health agencies through programs such as Health Care Program (HCP) for Children and Youth with Special Needs, Healthy Communities, Nurse-Family

RCCO Region	Community Partnerships/Collaboration
	Partnership, Spanning Miles In Linking Everyone to Services (SMILES) dental project, and Women, Infants, and Children (WIC) program; No Wrong Door pilot project (Regions 3 and 5); interagency care coordination conference; supporting scarce resources of Region 2 SEPs and CCBs ; Home Health Roundtable (Region 2); and Colorado Opportunity Project (COP) to engage multiple school districts in coordinating services for at-risk youth. • Colorado Access provided examples of partnerships primarily related to funding or leadership: health alliances in Regions 3 and 5, Rural Solutions meetings, University Hospital emergency department (ED) care coordinators, Denver Social Impact Bond (supportive housing), and interagency oversight groups (IOGs)—Region 2. • Colorado Access cited major success in sharing data, funding streams, governance, and collaborative care coordination among Colorado Access' product lines—three RCCOs, two BHOs, one SEP—and county agencies. Colorado Access cited success with external community partners working with COP, wherein COP resources can be devoted to some of the community partner organizations. • Colorado Access noted that challenges in community partnerships included legally compliant use of shared data, basic understanding of the ACC program and Health First Colorado among community agencies, competing priorities of multiple partners, lack of sufficient resources to accomplish all that is being requested of each community partner, Colorado Access' need to structure internal Colorado Access resources across three regions while remaining sensitive to the unique agency and community environment in each region, and the Family Educational Rights and Privacy Act (FERPA) barrier with school districts. • The RCCO's per member per month (PMPM) funding model does not generate enough additional funding to sustain the enhanced staffing, infrastructure, and resources necessary to address the challenges of scarce and financially-strained resources in rural areas—Region 2. • The RCCOs need centralized Department-level support and legal assistance with interagency contracts and agreements. The agreement between the Department and Department of Corrections (DOC) was essential; moving the SEPs, CCBs, and Healthy Communities to Department oversight was very advantageous. Ongoing relationships with local public health departments may be more efficiently leveraged at the State level versus the RCCO level. • Colorado Access complimented the Department's responsiveness over the years to system issues identified by the RCCOs, and cited examples of Department initiatives to: clarify the roles of SEPs, CCBs, and Healthy Communities and align contract language and expectations; send Department representatives out to the regions to engage with other community-based organizations; work with Colorado Regional Health Information Organization (CORHIO) on admit, discharge and transfer (ADT) issues; provide access to the Benefits Utilization System (BUS); facilitate the Medicaid benefits cross-walk project; troubleshoot non-emergency medical transport (NEMT) issues; and support pilot project proposals to enable funds for exploring mechanisms to get special programs "off the ground."

RCCO Region	Community Partnerships/Collaboration
	• Colorado Access suggested that priorities for future Department activities should include: continuing to facilitate macro-level interagency relationships—e.g., Department of Education regarding FERPA issues; deploying Department staff to engage with partners within each region; continuing work to facilitate interagency data sharing, including access to state-controlled databases; and identifying payment reforms that allow for flexibility in diverse geographies to financially support community and region-specific cooperative initiatives. • When working in inter-agency environments, RCCOs should be measured and evaluated based on issues within their control. Ultimately, the ACC needs strategic alignment with all State agency partners.
Region 4—Integrated Community Health Partners (ICHP)	• ICHP is a largely rural and frontier region geographically dispersed among three sub-regions, each with unique cultural nuances. • At the inception of the RCCO, misperceptions of communities throughout the region regarding the role of the RCCO created an unwelcoming environment for the RCCO—agencies were resistant and resentful. ICHP overcame this by partnering with the federally qualified health centers (FQHCs) and community mental health centers (CMHCs) already well-established in the communities. • ICHP staff members attended numerous meetings across the region introducing ICHP as a resource and representing themselves as willing collaborators. • ICHP established agreements whereby the CCB and/or SEP maintained its role as the primary care coordinator while ICHP served as an additional support resource for the CCBs and/or SEPs. Relationships are now very strong; agencies frequently contact ICHP care coordinators for help with cases. • One benefit to working in rural areas is that relationships among the FQHCs, CMHCs, Departments of Human Services, Departments of Social Services, and child and adult protective services pre-dated the RCCOs. These agencies have been collaborating for years to address needs of shared members. Care coordinators from each agency meet individually, as needed, to address needs for specific cases, while directors meet quarterly to address system issues and track developments. • ICHP provides this diverse and active group of local community agencies with updates from the State, shares data and trends specific to the region, and helps troubleshoot challenges facing these communities. • COP provided an opportunity to work more closely with agency social programs including WIC; Baby and Me, Tobacco Free; Nurse Family Partnership; Colorado Family Planning Initiative; Family Resource Center; and Temporary Assistance for Needy Families (TANF). • ICHP provided examples of community collaboration: Alliance for Food Access program to improve access to fresh, healthy food; Directing Others To Services (DOTS) program in collaboration with the Pueblo Fire Department to connect frequent ED utilizers with alternative services; Pueblo Interagency Community Council (PICC)/Pueblo Early Childhood Council (PECC) to reduce obesity-related chronic illness and teen pregnancies; Southeast Colorado Transitions Consortium to address causes of

RCCO Region	Community Partnerships/Collaboration
	readmissions and inappropriate use of EDs; several coalitions and committees to address housing issues and to deliver support services to homeless families. • ICHP recognizes the potential of working more closely with the faith-based community to outreach to members and to provide wellness and prevention programs. ICHP began working with area schools to offer internships and to develop care coordination curriculum. ICHP continues to work with area agencies to address lack of transportation. • ICHP experienced less success in working with the criminal justice system in 19 counties and noted that the Department could have provided more direction and preparatory work in anticipation of this initiative. • Years of perseverance have resulted in ICHP's integration into the communities it serves as a respected and valuable partner in promoting healthy communities.
Region 6—Colorado Community Health Alliance (CCHA)	• CCHA had established relationships with both SEPs and both CCBs in its five-county region as well as with public health agencies and Departments of Human Services (DHS) in all counties. • Agency relationships were primarily fostered through collaborative care coordination of shared members and are secured through formal data sharing business associate agreements (BAAs). • CCHA's initial challenges with agencies included turf issues with SEPs and CCBs regarding care coordination. County agencies had been operating for many years prior to existence of the RCCO and had pre-established relationships in their areas, and the multitude of programs managed through county agencies made it difficult for the RCCO to get the attention of leadership. • CCHA implemented a community organization liaison position, intended to educate all county agencies regarding the RCCO as well as to determine and clarify roles of each entity in care coordination efforts. • CCHA recognizes the SEP or CCB as the lead coordinator in collaborative efforts and supports the agencies by addressing care coordination gaps to fulfill members' unmet needs. • Building interagency relationships for effective care coordination was a multi-year "organic" process that required multiple contacts, staff perseverance, and successful interpersonal relationships to build and sustain. Joint home visits by SEP and CCHA care managers to MMP members to complete SCPs led to a bi-directional referral relationship between coordinators. CCHA hosted "meet and greet" sessions with care managers of each SEP and CCB to promote cross-agency education and discussions of roles and responsibilities. SEP partnerships have also generated further opportunities and introductions to multiple agencies and programs administered by the counties. • COP drove partnership arrangements with multiple county social support programs. • Over the past several years, CCHA has employed "community liaisons" to maintain relationships with multiple community resource organizations that provide services frequently needed by members—e.g., food banks, transportation vendors, community resource centers.

RCCO Region	Community Partnerships/Collaboration
	• CCHA provided examples of collaborative projects with community partners: Boulder County GENESIS and GENESISTER grant-funded programs regarding teen pregnancy; Boulder County Hoarding Task Force to accompany code enforcers and assess persons for mental health needs; Jefferson County Hot-spotting Alliance; Clear Creek County to facilitate a process for establishing a primary care clinic in Idaho Springs; funding of NEMT in Clear Creek County; Nederland clinic project to provide practice coaching and co-locate BH providers in the practice; Boulder Valley School District to establish a well-child check incentive pilot program; Jefferson County Action Center—food distribution and placement of on-site care coordinator; Longmont Re-entry Initiative and the DOC Intervention Community Corrections Program (half-way house program) to engage criminal justice-involved (CJI) members. • As a result of multiple collaborative community partnerships to coordinate care for members, CCHA's initial focus on the primary care medical home (PCMH) has shifted to the "health neighborhood." Hundreds of members are being referred to resources through health neighborhood partners. • CCHA described challenges and lessons learned, including that building trust between organizations requires tremendous time, effort, and energy at both the leadership and individual staff levels; the number of potential community partners is nearly unlimited, requiring that CCHA resources be judiciously applied; the level of engagement in "partnerships" differs from a resource referral relationship; and that counties have large, convoluted departmental and agency structures and community relationships to be understood and considered. • All counties consider homelessness to be a major current and future community priority. • CCHA's goal is to collaborate with community alliances and partners to strategically align goals across community service entities. • CCHA noted that RCCOs need the Department's support to reduce barriers between State systems. Suggestions for the Department included encouraging RCCOs to bring community-identified issues to the Department to obtain support, inviting RCCOs and community partners—both leadership and individual staff—to provide input into Department level initiatives to bridge cross-agency relationships, and contractually requiring State agencies to partner across multiple systems. • The presence of Department staff in the community "carries weight" with community partners. CCHA suggested that the Department elevate its visibility in local community partnership discussions. • CCHA suggested the Department consider a state-level strategic planning initiative to align cross-agency objectives, roles, and responsibilities.
Region 7—Community Health Partnership (CHP)	• CHP was initially structured as a partnership organization with community providers and community organizations. From inception, CHP was built on a foundation of established relationships with community organizations. Over time, those relationships have grown—due to networking among various agencies and community providers—and have steadily matured as the RCCO has convened and/or funded multiple collaborative initiatives within its region.

RCCO Region	Community Partnerships/Collaboration
	• CHP has extended nearly 63 percent of its RCCO contract revenue to support collaborative initiatives that fill gaps in services or build better systems of care for members. • Most CHP community partnership initiatives have been focused in the region's population base—El Paso County. • CHP has established relationships with Options for Long Term Care (OLTC)—SEP, The Resource Exchange—CCB, El Paso Department of Human Services (DHS), and county public health agencies in El Paso and Teller counties. • Much of the collaboration between agencies and community partners has been driven by the need for care coordination for shared members with complex needs. The "No Wrong Door" concept has been "years in the making" among multiple community organizations. Collaborative strategies have resulted in a variety of models for care coordination throughout the region. • One of CHP's major contributions to community initiatives and partnerships has been provision of valuable member healthcare data otherwise unavailable to partners but available to the RCCO through multiple Department databases. CHP's health information exchange (HIE) objectives include developing mechanisms to share care coordination records and CHP database information with community partners. • CHP provided several examples of collaborative initiatives which illustrated both successes and challenges in community partnership projects, including: a major multi-agency collaborative to redirect funds to improve access to resources for the disabled; Rocky Mountain Rural Health (Park County) to perform outreach services to members, provide a mobile van for health screenings and education, and implement alternatives for transportation; El Paso County Public Health to fund an on-site public health department care coordinator position for foster children and families; Urban Peak—services and shelter for homeless youth—to locate a CCHA coordinator on-site; and DOC—community care case manager—to work collaboratively with a RCCO care coordinator to engage individual parolees in Medicaid services. • Many CHP program and project initiatives have been successfully implemented and sustained. All community partners agree that the relationships developed through collaboration have laid the foundation for a community-driven integrated healthcare system. • CHP identified common challenges in executing collaborative community initiatives: county offices are not easily accessible to members without transportation; varying industry language used among agencies complicates cross-system communications; and many initiatives at the local level have been inhibited by the siloing of priorities, responsibilities, operational functions, and funding streams within multiple State agencies. • CHP provided suggestions for future Department initiatives: integrating the multiple voices of community organizations and agencies into Department leadership and strategic structures, recognizing financial disincentives in the system and aligning funding and functional responsibilities among agencies, implementing presumptive eligibility of Regional Accountable Entity (RAE) members for benefits needed anywhere in the Medicaid system, integrating performance measures systemwide, considering

RCCO Region	Community Partnerships/Collaboration
	reassessment of the per-capita rate for non-emergency medical transportation (NEMT) services or mechanisms for funding for other sources of transportation in rural areas, and resolving gaps in information and services between the Medicaid and DOC agencies. • CHP suggested that the Department consider developing a process to elevate and mimic at the State level the community collaboration efforts demonstrated at the regional level. A "No Wrong Door" system among State agencies and departments to align objectives, funding, and performance measures would be very advantageous for advancing integrated community care models within the regions.

RCCO Region	Provider Network/Provider Participation
Region 1—Rocky Mountain Health Plan (RMHP)	• From inception, RMHP contracted with almost every primary care practice in the region. Both the primary care providers and specialist providers available in the region have remained relatively unchanged. Region 1 experiences the challenge of attracting additional primary care providers to practice in a rural region. • RMHP has engaged over the past several years in a provider network strategy focused on expansion of capacity within the existing provider system, which includes an advanced practice training and support program, providing data resources and information for provider decision making, and integrating physician extenders into primary care practices. RMHP's advance practice program expanded to 70 practices (including 30 specialist practices) during 2016. • For the past two to three years, RMHP's primary focus has been integrating behavioral healthcare practitioners into practices. RMHP provides funding to practices and then allows the individual practice to determine how to structure and implement behavioral healthcare within the PCMP. • Behavioral healthcare specialists operating within the practices free up significant time for primary care providers (PCPs) to care for other patients, enhance overall services available to members in the practice, and serve as important tools for recruiting additional primary care providers to the practice. • RMHP assists practices in implementing a quality improvement (QI) program in the practice. Providers stated that physicians want to practice in an environment that delivers quality healthcare; therefore, investing in quality improvement programs helps retain and grow providers within the practice. • Providers need RMHP's support and resources to maintain practice transformation; RMHP's flexibility in allowing practices to define how each practice accomplishes its objectives was essential. • RMHP recognized that practice transformation cannot be accomplished without additional investment, professional support, and payment reform. • RMHP identified that separation of the BHO from the rest of the provider system presents problems with reimbursement for behavioral health services in primary care practices.

RCCO Region	Provider Network/Provider Participation
	• RMHP credited the Department with doing the "right thing" by allowing the RCCO flexibility in how to support provider practices to meet the demands for increased capacity in the provider network and to improve the provider's experiences of working with Medicaid members. Providers also appreciate the Department's Medicaid workgroups. • RMHP stated that the following actions by the Department could positively influence provider participation in the Medicaid program: (1) clarify the State's intentions for reimbursement of PCPs; (2) align coding, billing, and data sources across all pay sources; (3) streamline attribution of members to practices; and (4) streamline programs and performance measures in order to reduce repetitive provider reporting and analysis.
Regions 2, 3, and 5—Colorado Access	• Colorado Access initiated the provider network through practitioners associated with its other lines of business, with particular emphasis on FQHCs. • PCMPs were initially reluctant to contract with the RCCO because of lack of understanding the RCCO program and past difficulties with the Medicaid program. • The PMPM financial incentive was—and continues to be—perceived as a positive stimulus for those practices already serving Medicaid—i.e., "just give us the money." • Colorado Access invested considerable time and resources to educate providers on the RCCO program. As depth of understanding of the RCCO's role and initiatives of the program increased, PCMP recruitment gained momentum. • Region 2—Consisting of a concentration of providers in the Weld County area, with the remainder of the region being rural and frontier counties, the provider networks were initially established primarily through the FQHCs, North Colorado Health Alliance (NCHA), and major primary care providers (PCPs) in the Greeley area. Following two to three years of building the network in the rural areas, the RCCO had succeeded in establishing one or more PCMP(s) in every county. Further expansion of the network has not been aggressively pursued. RCCO works to facilitate financial sustainability of numerous providers in the region. • Region 3—Consisting of most suburban areas of Denver, the region includes extensive diversity—Adams County includes many low-income and ethnically diverse populations and a general lack of health services of any type. Arapahoe and Douglas counties include wealthier metropolitan neighborhoods and growing populations and are experiencing robust development of healthcare services. However, most providers focus on serving non-Medicaid clients. A customized approach was required to establish the RCCO's value to each practice and to encourage practices to expand their Medicaid populations. • Region 5—Limited to Denver County, the inner-city Medicaid population tends to access services through established providers of the underserved. The relationship with Denver Health took some time to evolve due to competition with Denver Health Medicaid Choice managed care program. Extensive exploration by RCCO staff to determine appropriate working relationships within Denver Health system was also a necessity. • Colorado Access expressed that current provider networks appear to be sufficient to serve the populations of each region.

RCCO Region	Provider Network/Provider Participation

	• Colorado Access' focus has shifted to building more in-depth relationships with existing network providers.
	  − Region 2—RCCO staff travel to multiple community-based subregions to increase providers' involvement in the RCCO. Attention is placed on provider financial sustainability, population health, and expanding telehealth.
	  − Regions 3 and 5—Some providers lack interest in increased involvement with the RCCO, considering serving the members to be enough; some providers want to be more involved, seeking more knowledge and understanding.
	• Providers regularly attend quarterly provider meetings in all regions. In 2016–2017, Colorado Access is establishing a regional governance council in each region for key providers to participate in strategic decisions.
	• While each region experiences unique challenges with diverse providers and interests, financial return and sustainability are the uniform interests and primary focus of all providers participating in the ACC.
	• Colorado Access focuses on opportunities for enhanced primary care reimbursement and key performance indicators (KPIs), including introducing grant-funded opportunities to practices, streamlining reporting requirements, and aligning performance measures.
	• Most providers now value the support that the RCCO can provide—connecting their members to community resources, bringing usable data to practices to enhance their performance, assisting practices with attribution and reimbursement issues, reducing inefficiencies and costs associated with caring for Medicaid members, and improving services within their practices—e.g., integrated behavioral healthcare and telehealth.
	• Colorado Access progressively adjusted internal resources to support practices. The most recent phase in evolving practice transformation strategies restructured internal provider relations and practice support program and personnel to transition to one central support department for all providers, regardless of product line. One staff person is assigned to each practice for face-to-face contact with the practice, communications regarding any line of business, presentation of data and KPIs, and offering resources and programs that align with the individual practice's needs and interests.
	• Both providers and Colorado Access have learned lessons over time—providers have learned that they have to perform to be paid and have recognized that they have a need to improve performance in some areas; Colorado Access has learned to adjust its resources to meet individualized practice and provider needs and to assist providers in improvements wherever possible.
	• Colorado Access noted that lack of Department prioritization in multiple projects presented to providers and lack of coordination among different State initiatives' measures, outcomes, deliverables, and processes have resulted in much additional work and "innovation fatigue" for practices.
	• Colorado Access credited the Department with:
	  − Recognizing the PCMH as the center of the ACC.
	  − Reinforcing providers through the PMPM and other financial incentives.
	  − Respecting the individual RCCO's role in working with its providers.

RCCO Region	Provider Network/Provider Participation
	– Maintaining a collaborative relationship with the RCCOs and being responsive to provider concerns. – Moving KPIs to the provider level. – Introducing new programs and funding opportunities for provider participation in RCCO objectives. • Colorado Access provided suggestions for Department consideration: – Continue to work toward better alignment of initiatives and measures and more innovative reimbursement methodologies. – Consider future payment reform methodologies to provide more flexibility to RCCOs in how services are paid. • Through multiple programs, projects, resources, and support offered to providers, it appears that all Colorado Access regions have established positive working relationships with the provider community.
Region 4—Integrated Community Health Partners (ICHP)	• ICHP found many providers outside the Pueblo focus community initially unwilling to participate in the RCCO network. Providers had previously experienced failed managed care programs and were skeptical of the ACC/RCCO model. • ICHP slowly increased its network, which today covers all 19 counties and includes 48 PCMPs—including all FQHCs, 108 practice sites, and more than 300 rendering providers. • Providers participate on ICHP's Board and in key leadership committees. • ICHP is heavily invested in the integrated BH/PH care model through participating FQHCs and CMHCs and has co-located BH in additional PCMPs. This process has evolved to interdependency of BH and PH practitioners in integrated practices. • ICHP identified challenges associated with BH integration as being difficulty with finding BH providers that are the right fit for a primary care practice model and inability of behavioral health providers to bill for services delivered in the medical system. • Over the years, ICHP learned that many of its provider performance improvement initiatives did not align with individual providers' goals and initiatives. During early years of operation, ICHP expected all providers to implement projects uniformly, which was viewed as ICHP policing practices. • In recent years, ICHP has successfully shifted its performance improvement focus to what the provider deems most important, resulting in a paradigm shift in provider relations and practice transformations. • As providers have positive encounters with ICHP, they share those experiences with other providers. • ICHP initiated a project to offer providers a facility disability assessment to evaluate the facility's compliance with Americans with Disabilities Act (ADA) specifications and to refer providers to grants and funding resources required to make any necessary changes. • ICHP credited the Department with:

RCCO Region	Provider Network/Provider Participation
	– The Department's recent physical staff presence throughout the region having been a great benefit, as providers and stakeholders seek more direct communication from the Department. – The Department's tolerance of incremental improvements in practice transformations. • ICHP provided suggestions for Department consideration: – ACC staff and contract managers should increase clinic visits and attend community meetings. – The Department could revisit efforts to expand hospital participation in CORHIO. – Ongoing issues with attribution could be mitigated by allowing staff from each RCCO to access and update the State data system with accurate attribution and contact information. – The Department should involve RCCOs and providers in the process of identifying statewide initiatives, enabling RCCOs and providers to identify barriers early in the process.
Region 6—Colorado Community Health Alliance (CCHA)	• In the initial year of CCHA operations, the base of PCMPs primarily consisted of primary care practices of its partner independent practice association (IPA)—Primary Physician Partners (PPP)—265 providers at 62 locations. • FQHCs and large provider systems in the region initially opposed contracting with CCHA due to a challenging provider political environment. In addition, many private practices were initially interested in limiting their Medicaid panel sizes, several large practices remain ambivalent about participation in Medicaid program, and outlying counties have limited or no primary care practices. • In early years of operation, the ACC/RCCO model was generally poorly understood by providers. CCHA invested considerable energy in provider marketing and education regarding the RCCO concept. • Despite ongoing challenges to network development, CCHA has steadily increased the number of PCMPs and practice sites. At the time of on-site review, CCHA reported that 75 percent of all Medicaid providers in the region had contracted with CCHA and that the provider network consisted of 1,190 providers at 235 locations, including all large safety net providers and most practices with a large Medicaid population. • Most PCMP recruitment efforts are now focused on practices with fewer than 50 members. • In addition to lack of primary care providers in Clear Creek and Gilpin counties, rural counties also lack social support services, behavioral health providers, and transportation services. CCHA used collaborative approaches and innovative initiatives to improve services available—including a new integrated care clinic and NEMT services. • CCHA has shifted emphasis to building quality in-depth relationships with existing providers and is encouraging network providers to increase their Medicaid panel sizes. • CCHA identified having limited leverage to encourage provider participation in the RCCO and needing to define mechanisms to bring "value" to practices. • CCHA experienced several iterations of evolving practice transformation approaches and areas of focus. CCHA significantly enhanced its provider transformation program to

RCCO Region	Provider Network/Provider Participation
	include on-site practice transformation teams assigned to individual practices and a provider incentive program. CCHA is currently engaged with 40 practices serving 80 percent of members. • CCHA diversified expertise in its practice support team and intensified activities—monthly practice coaches to consult on technical issues (e.g., billing and coding problems), assist with Medicaid provider revalidation, review practice data reports and KPI performance, and establish multidisciplinary QI teams. • CCHA identified that it could bring added value to practices by addressing provider-defined needs and interests. Practice support teams now offer to assist practices with a project of their choosing. • CCHA used its KPI reimbursements to fund additional provider incentive payments. Practice agreements define structured criteria, performance thresholds, and related payments. Staff reported these processes as very successful. • PCMPs participate in leadership forums, ACC workgroups, and the CCHA Provider Advisory Council. Initial focus on PCMHs has shifted to broader health neighborhood concerns. • Access to specialists will be a continuing challenge as long as Medicaid members compete for specialty access with patients in better-paying systems. From inception, Centura Health provided CCHA members access to its specialists. CCHA implemented mechanisms to alleviate stressors on specialists who see Medicaid members and continues to participate in community alliances to address specialist access. • CCHA noted several continuing challenges with provider access or participation, including: lack of home-based care providers, access to behavioral health providers, transportation barriers in rural areas, provider panel limits, many practices yet to achieve medical home performance, confusion over Department systems issues, practice distress with data requirements for ACC deliverables, and practices overwhelmed with practice coaches associated with multiple entities. • CCHA credited the Department with: – Adequately preparing providers and responsiveness to provider concerns regarding information system conversion. – Department-sponsored forums for provider participation in RCCO decisions. – Transparency and involvement of Department personnel within individual regions. • CCHA provided suggestions for Department consideration: – Conduct community-based provider forums to roll out ACC 2.0 and educate providers about RAEs. – Continue to send staff representatives into the regions to engage with providers and staff in individual RCCOs; Department staff should go out into the provider community to familiarize themselves with the diversity of practices in the regions. – Develop mechanisms to routinely obtain provider input when designing performance measures or other requirements that impact providers. – Improve consistency in communications with providers by communicating directly with providers regarding major program initiatives, ensuring that provider input and

RCCO Region	Provider Network/Provider Participation
	messaging are communicated along the full continuum of internal departments and staff members.
Region 7—Community Health Partnership (CHP)	• CHP's provider network and provider-related activities are primarily focused in the region's population base of El Paso County. In its first year of operation, the PCMP base consisted of CHP's partner organizations—Peak Vista Community Health (Peak Vista) and Colorado Springs Health Partners (CSHP). • Between 2011 and 2014, CHP's network continuously expanded to over 40 practices to incorporate providers in the rural counties. The network has remained relatively stable since 2014. • While adequate numbers of providers exist in the network, CHP experienced challenges with the capacity of individual practices to accept new members. At the time of on-site review, staff members estimated that 50 percent of practices were closed to new Medicaid members; 50 percent remain open, but fluctuate between open and closed to new Medicaid members. • Other dynamics of the network included: several practices closed or merged; urgent care clinics drew members away from PCMPs; 33 of the 96 practices in the region declined to join the network; and many smaller practices were willing to grow the Medicaid population in their practices. • PCMPs participate in leadership of the RCCO through the Board, advisory groups, and special program initiatives. Thirty-eight practices participated in some level of practice transformation. • CHP focused on opportunities for additional provider reimbursement to incent entry or active provider participation in the RCCO. Providers most actively engage in RCCO objectives associated with financial incentives. • CHP transitioned to providing internal resources for practice transformation. The CHP practice transformation team provides training and works one-on-one with practices to optimize opportunities for additional reimbursement, which include: delegation of care coordination, KPIs, CHP pay-for-performance (P4P) measures, and enhanced PCMH factors. CHP also maintains an ongoing relationship with and provides funding to the El Paso Medical Society to support practices with billing and coding issues, staff development, credentialing, and other areas of expertise. • CHP P4P measures are determined annually based on input from providers. Over 80 percent of PCMPs participated in P4P in 2015 and 2016. • Twelve of the larger practices are delegated to perform care coordination. These practices have developed intense, one-on-one relationships with CHP's practice transformation team as enhancements in provider accountability requirements have evolved. Delegates have commonly upgraded their electronic health record (EHR) systems to integrate care coordination requirements. • CHP has a three-year history of working with PCMPs to co-locate BH therapists within PCMP practices and to improve referral communications with AspenPointe. • Challenges experienced over time:

RCCO Region	Provider Network/Provider Participation
	– Provider recruitment was inhibited by lack of provider awareness regarding the RCCO. – Provider staff turnover requires continual re-education of practice staff members and results in fluctuating commitment to RCCO priorities. – From inception of the RCCO, CHP has been engaged in a challenging provider environment, experiencing competing priorities and alliances among local community providers and an overall stressed capacity in primary care and specialty practices. – Purchase of practices by corporations results in uncertainty of commitments to participate in RCCO initiatives. – Department and RCCO communications to providers introduced many new acronyms, resulting in much confusion to providers. – RCCOs must be sensitive to how much participation they expect from practices when providers are not being adequately reimbursed. Providers that are not being properly paid respond poorly to additional RCCO and Department expectations. – Practices are increasingly experiencing the administrative burden of participating in multiple RCCO programs and initiatives. • Increasing RCCO priorities, frequent changes in priorities or provider expectations, and inadequate advance notification of program changes have resulted in provider perceptions that the RCCO is reactive rather than proactive. • CHP provided suggestions for Department consideration: – Ensure timely payments to providers for claims, KPI performance, and other financially-related factors of the RCCO program. – Consider achievability of performance metrics prior to implementation. – Develop marketing communications for providers that are well-designed "facing" materials and use consistent, clearly defined language; keep communications simple and do not change common industry language. – Improve the timeliness of information concerning new programs or changes in programs that impact providers. – Consider more frequent visits from Department staff to the region for interaction with providers. Face-to-face visits improve the credibility of the Department with providers.

RCCO Region	Member Engagement
Region 1—Rocky Mountain Health Plan (RMHP)	• RMHP invested in multifaceted approaches to increasingly engage members in the RCCO's objectives. RMHP implemented many traditional approaches to member engagement, such as a member website communications and tools (e.g., newsletters, provider directory), quarterly member advisory council meetings, customer service welcome calls, and member brochures. • RMHP conducted staff and provider trainings to improve competencies for providing services to Medicaid members, including Bridges Out of Poverty, cultural competency, disability-competent care, and motivational interviewing. • PCMPs implemented patient activation measures within their practices; participation of providers and members steadily increased between 2013 and 2016. • RMHP developed the MyDigital MD telehealth application to provide individual members with text or video access to physicians who provide urgent care advice in lieu of the member accessing the ED. • RMHP care coordination staff members participated in monthly orientation sessions for parolees. • RMHP determined that understanding member experience requires more than surveys, measurement, and committee meetings, and that the RCCO needed to move "beyond competent to conversant" with diverse member populations. Therefore, RMHP significantly elevated its member engagement processes in 2016 to more directly interact with representatives of diverse member populations and to learn more about the needs and barriers for these populations—members with disabilities, the deaf and hard-of-hearing community, and monolingual Spanish-speaking members. – RMHP conducted a qualitative study— "The Voice of Medicaid"—to gather feedback from members in the field and "in their voices" regarding member experiences with RMHP and the Medicaid system at-large. – RMHP gathered information from the monolingual Spanish-speaking community regarding access to healthcare and social support needs. The process used "promotores" to informally engage members in the community and to identify the unique needs and perceptions of members who do not speak English. – RMHP engaged deaf and hard-of-hearing individuals through the Larimer County Group for Deaf Rights in Healthcare to understand and address barriers to care for the deaf community. The process included two town hall meetings with the deaf community. • In response to the Accountable Health Communities Model (AHCM) federal grant opportunity, RMHP developed a consortium of numerous clinical, community, and advisory organizations to participate in providing leadership to systematically address social determinants of health and health disparities within Western Slope communities. • Care coordination and access to correct information remain key elements in successful member engagement. Through both its care coordination interactions with members and forums for direct member feedback, RMHP identified and committed to understanding social determinants of health as a priority.

RCCO Region	Member Engagement
	• RMHP identified several interesting conclusions gleaned from member perceptions gathered through member forums, including: – Meeting people "where they are" is essential. – Members need to assist the RCCO in understanding how to help members, rather than the RCCO educating members on how to use the system. • RMHP believes that member engagement is most meaningful and effective at the community or regional level—not the State level. • RMHP offered suggestions for Department consideration: – The Department's production of measurements, charts, and graphs for RCCO response is a distraction from allowing networks and structures for member engagement to evolve in communities. – The Department could facilitate sharing of local learning experiences and solutions among regions or statewide. – The Department's strategy with the future Regional Accountable Entities (RAEs) should be to provide tools and resources to the RAEs to pursue flexible community-based solutions. • RMHP appears to be at the forefront of advancing Medicaid member engagement.
Regions 2, 3, and 5—Colorado Access	• Colorado Access' philosophy of member engagement is to "meet members where they are," provide them a voice in their own healthcare, and provide opportunities for member input into the organization's member engagement mechanisms. The goal is to support member self-determination in personal health and well-being. • Colorado Access operationalized member engagement through customer service and care management contacts with individual members, and mass outreach communications such as newsletters, interactive voice response (IVR) calls, targeted mailings, website communications, and community-based events to distribute RCCO information. • Colorado Access used a variety of approaches to obtain feedback from members, including member/family advisory boards in each region, member representation on boards and committees, and surveying members on what is important to them. • Advisory board meetings in Regions 3 and 5 have grown to over 200 participants, using headsets for diverse language interpretation. • Region 2 member advisory board meetings are held in six subregions. The Region 2 outreach strategy also includes use of a mobile van to participate in community events, which staff described as excellent opportunities to directly interact with members within diverse local communities. • Colorado Access trends member feedback gathered from all organizational points of engagement. • Many member engagement activities over the years have been associated with the RCCO's objective to attribute members to a PCMP. • Colorado Access has invested increasingly in population health initiatives to engage members in participating in their health. Colorado Access recognizes that these are prescriptive RCCO objectives rather than member objectives.

RCCO Region	Member Engagement
	• Colorado Access is sensitive to the differences in member needs among diverse populations and is implementing a "Special Populations Group" to share information learned from individual members about the cultural differences of various ethnicities and religions. Colorado Access is also considering collecting information from culture-specific members who tend to congregate within select geographies and provider practices. • Colorado Access is transitioning to an external community-based focus for member engagement activities. • Colorado Access identified that lessons learned include: – Members may be engaged at multiple touchpoints in the system, resulting in the need to integrate member engagement opportunities across all Colorado Access lines of business. – The homeless population, CCB members, and members with incorrect contact information remain difficult to engage in RCCO initiatives. – Regular participation of members in member engagement committees and surveys has become a burden for some members and includes no reimbursement or financial incentive. – Colorado Access may need to scale down the size of Regions 3 and 5 member advisory meetings and consider using select representatives to provide input on specific RCCO initiatives. – Region 2 will continue to have challenges with any forums for member engagement due to the widely dispersed geography. – Department-level strategies for direct member input—such as the state-level committees—are limited by geographic challenges and cost issues for members. • Colorado Access offered suggestions for Department consideration: – Improve coordination among RCCOs regarding member engagement strategies and activities, including sharing statewide the member feedback trends obtained within individual regions. – Incorporate input from the RCCOs into Department member engagement initiatives. – Pursue an information technology solution to clean up and maintain current member contact information across systemwide databases.
Region 4—Integrated Community Health Partners (ICHP)	• ICHP staff defined "member engagement" as outreach to members (e.g., dialog between member and care coordinator) and as an individual's active participation in his or her own healthcare. • ICHP considers member engagement as primarily a function of providers interacting with their members. ICHP supports the providers with training, assessments, and feedback. • ICHP offers staff and providers training including motivational interviewing, solution-focused interventions, and a variety of cultural competency training opportunities. • ICHP recognized that newsletters and brochures do not engage members. • ICHP's member services department hosts quarterly forums in each subregion, where members are invited to meet with the care coordinators, customer service, and other

RCCO Region	Member Engagement
	ICHP staff to ask questions and learn about health topics. ICHP staff seek member input on "How can ICHP serve you better?" • ICHP intends to empower members by offering opportunities for prevention and wellness education, and has hosted prevention and wellness forums across the region. • ICHP increased the number of members who participate in the Performance Advisory Committee (PAC) from two to five and continues to actively recruit additional members. • ICHP described requesting one member to share with providers his experiences as an immigrant. • ICHP communicates the member perspective to providers through articles in provider newsletters. • Over the past two years, ICHP care coordinators have increasingly transitioned to operating in the field and engaging members face-to-face in the doctor's office, in the home, and in the community. • ICHP commended the Department on its member newsletters, website, and the simplicity of the new handbook. • ICHP offered suggestions for Department consideration: – The Department could improve member engagement by ensuring that Health First Colorado customer service calls are answered promptly and that staff members are courteous and helpful. – The Department could assist RCCOs by providing more timely and accurate data regarding member utilization, attribution, and contact information.
Region 6—Colorado Community Health Alliance (CCHA)	• CCHA defines "member engagement" as person or family centered interactions which invite the member to participate in his or her healthcare. • CCHA understands that engagement is not one-way communication; the member must "participate" in order to be considered engaged. • CCHA has designed appealing member-facing materials on a variety of topics. All outreach communications are carefully designed to promote member response and engagement, providing information on how members can interact with the Department, with community resources, with their doctor, and with care coordinators. • CCHA has continuously evolved its member outreach and engagement mechanisms throughout the term of the RCCO contract, based on lessons learned. • CCHA reinvested in personnel and mechanisms to build a robust and increasingly sophisticated member engagement program through the call center. – The call center transitioned to responding to IVR-initiated inbound calls in order to achieve productive encounters with members. – IVR calls, targeted to specific member populations, are scripted to encourage member interaction with the CCHA call center. Once a member contacts the call center, individual member "engagement" is initiated. – Member engagement requires developing trust with the member; therefore, staff have been extensively trained in how to best elicit a member response.

RCCO Region	Member Engagement
	– Once a basic trust is developed, call center staff proceed to conduct assessments, assist members with PCMP attribution or needed referrals, or triage the member to care coordination staff. – Select call center staff have been trained as subject-matter experts in specific program areas. – Since 2013, IVR campaigns have generated over 100,000 inbound calls to the call center. • Care coordination is a primary factor in member engagement and is conducted face to face with the member on a very in-depth level. Care coordinators commonly engage with members in their homes or, increasingly over recent years, in community settings or provider offices. • CCHA care coordination processes are designed to encourage members to participate in their healthcare by allowing members to establish their own care plan goals and to independently pursue services whenever they are willing and capable. • CCHA has a member advisory committee through which members provide input into CCHA policy and program decisions and provide feedback on member communications. CCHA has also scheduled an upcoming telephonic town hall for members. • CCHA's growing strategy is to engage individual members through community partners and schools. CCHA highlighted several programs to do so—Dispatch Health, AmeriCorps program, Jefferson County Action Center, Emerald Elementary School pilot program. • CCHA has progressively improved its member website to include information identified through monitoring of member inquiries and other member input sources. • CCHA identified that some member populations are easier to engage than others, noting that Hispanic members present challenges with language and cultural norms; young, healthy members never use the system; and parents of children are too busy with everyday life to participate. Conversely, staff stated that people who use the healthcare system, including MMP members, are easier to locate and tend to be more engaged in their healthcare. • CCHA believes engagement with individual members is most appropriate at the local level. • CCHA desires to continuously enrich and expand member engagement activities, acknowledging that RCCOs are only in the initial stages of understanding and effectively engaging members in the ACC. • CCHA also foresees the need to elevate the use of technology to communicate with members, complimented the Department on the PEAKHealth application, and noted the potential of additional interactive phone applications. • CCHA believes that effective member engagement is a challenging objective in its infancy compared to other objectives of the ACC program and should remain a primary objective of the ACC in the future. • CCHA offered suggestions for Department consideration: – Include the RCCO contact number on member ID cards.

RCCO Region	Member Engagement
	– Use the Nurse Advice Line point of contact to refer members back to the RCCO and/or provide cross-referencing tools for the Nurse Advice Line to use to align members with region-specific programs and services when appropriate. – Develop mechanisms beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-1] surveys to obtain feedback from members. – The Department, RAEs, providers, community organizations, and members should work together to determine the appropriate role of each entity in member engagement.
Region 7—Community Health Partnership (CHP)	• CHP defined "member engagement" as "meeting people where they are," which was interpreted as understanding and assisting members to meet their needs—not the RCCO's interpretation of needs—and encouraging members to take active roles in their personal health. • CHP cited building trust with members is a critical component in member engagement and is a step-by-step process; face-to-face contact is an important factor in building trust with members; and motivation of members to assume responsibility for their own health is often a slow and complex process. • Initially CHP focused primarily on getting information about the RCCO and Medicaid benefits out to members. • CHP continues to provide outreach information and promote activities to members through written communications and outreach calls. • CHP has progressively transitioned to meeting with members face to face, and has increasingly focused on engaging members at varying points of service within the community. Substantial mechanisms for member engagement are executed through individual interactions with members in the service center, through care coordination, in community locations, and through community partners—e.g., criminal justice locations, detoxification programs, food banks, and homeless shelters. • Individual interactions with members first focus on identifying the member's hierarchy of needs. • In response to lessons learned, CHP has initiated a variety of mechanisms designed to enhance member engagement: – CHP embedded care coordinators in some PCMPs and EDs to enable deeper conversations with members than individual providers can offer. – CHP has moved assertively to work with community partners to locate care coordinators in community organizations where members receive services. Examples include: Urban Peak homeless shelter for youth; Catholic Charities Marian House food bank; Ascending to Health Respite Care respite care program. – CHP is moving beyond mass communications to target outreach to specific populations.

[2-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

RCCO Region	Member Engagement
	– CHP has used its community partner relationships to advantageously explore and learn about both gaps in services and the hierarchy of needs of special member populations. – CHP also conducted member focus groups regarding barriers to cancer screening. • Staff stated that engaging members through community partners builds on the trust and relationships already in place with members. • Four to five members regularly participate in the CHP Performance Improvement Advisory Committee (PIAC); CHP plans to move its PIAC meetings to various community locations in order to engage different member populations. • A CHP PIAC member representative suggested that CHP develop a peer mentoring program to engage members to work with other members. • CHP expressed that the right combination of people to address member needs and interests must be locally determined. • CHP offered suggestions for Department consideration: – Continue to maintain local flexibility in member engagement initiatives; avoid limiting member engagement by Department-defined measures. – The Department's role in member engagement should include member communications and materials at enrollment. – The Department should enhance the PEAKHealth mobile application or other systems to update member contact information.

RCCO Region	Care Coordination
Region 1—Rocky Mountain Health Plan (RMHP)	• From the inception of the RCCO, RMHP defined community-based CCTs to support the members assigned to PCMPs within a geographic area. The inaugural CCTs were located in four areas of the region. All members and PCMPs unassigned to one of the existing CCTs received care coordination through the central RMHP team located in Mesa County. • As Medicaid ACC membership has steadily increased over the years, RMHP has added significant numbers of care coordination staff, dispersed additional staff into existing teams, and established new teams in communities throughout the region. In 2016, RMHP had nine CCTs supporting all members and PCMPs throughout the region. • RMHP's allocation of funds to support care coordination has also increased over the years, to approximately 50 percent of the RCCO 1 budget. • Each CCT has diffused authority to define functional approaches unique to the resources, community interests, and member characteristics associated with each geographic area. • CCTs partner with RMHP and with community organizations and providers for projects unique to their communities. • Accountability of the CCTs to ACC priorities and goals has been supported by RMHP data sources (e.g., member risk-level identification reports), funding, leadership, and

RCCO Region	Care Coordination
	clear training materials. RMHP holds quarterly regionwide CCT meetings to provide the teams with RCCO direction and to allow teams to share innovative ideas. • Business associate agreements (BAAs) and RMHP's investment in the Essette Care Management software enabled data sharing among the teams and between the teams and RMHP management, and has significantly improved consistency of performance. • In addition, the Essette Care Management system enables the member's care coordination record to be seamlessly shared among diverse members of the care coordination team. • RMHP has evolved the structure of CCTs to include multidisciplinary staff. By 2016, most CCTs had incorporated nursing, behavioral healthcare, and social work professionals into their teams. In addition, community health workers have been integrated into some teams. • RMHP has identified "social determinants of health" as a primary factor in members' care coordination needs, leading to increased emphasis on developing active working relationships with community organizations and other agencies. CCTs have accelerated their understanding of the roles, strengths, and weaknesses of various local resources. • RMHP identified that, within rural areas, lack of healthcare and social support resources in general is a challenge and requires innovative solutions. RMHP noted that lack of transportation resources is a major issue in many communities. • RMHP identified member populations that are particularly challenging for care coordinators—members with pervasive behavioral healthcare issues; members with chronic pain and opiate medication dependencies; members with housing needs; and members transitioning between providers, levels of care, or geographic locations. • Over the term of the RCCO contract, RMHP has developed a regionwide network of CCTs that have evolved into operating as one integrated team. The flexibility afforded through the ACC model has enabled the RCCO to define mechanisms for care coordination that are integrated with community-based resources and to innovatively respond to diverse member populations and individual community needs. • RMHP credited the Department with: – The flexibility that the ACC program has allowed by defining goals and outcomes while not being prescriptive with the processes used to accomplish those outcomes. – Acting as a partner with the RCCOs to resolve policy-driven issues. – Facilitating inter-agency relationships with state-driven agencies and programs such as the SEPs, CCBs, and the Colorado DOC. – Breaking down barriers in developing NEMT services in a remote part of the State. – Working with the statewide HIEs—CORHIO and Quality Health Network (QHN). – Development of the Statewide Data Analytics Contractor (SDAC) data to support the information needs of providers, care coordinators, and RMHP management. • RMHP offered suggestions for Department consideration: – The Department should consistently maintain the flexibility for the RCCO to innovate to accomplish effective care coordination for members. When the Department becomes more prescriptive with processes—i.e., MMP—those processes may be in

RCCO Region	Care Coordination
	conflict with locally driven priorities or inadvertently redirect the use of limited resources or funding. • Care coordination record reviews confirmed that RMHP successfully performed comprehensive care coordination for members with complex needs. RMHP's care coordination model has demonstrated exemplary performance over many years.
Regions 2, 3, and 5—Colorado Access	• From inception of the RCCOs, Colorado Access has delegated care coordination to its larger and most systematically capable PCMPs. The specific delegates have been relatively stable over the past several years and serve approximately 40 percent of the members within the three Colorado Access regions. • Colorado Access has internal care coordination (CC) staff which provide care coordination for approximately 60 percent of RCCO members in its three regions. • Delegated and internal models of CC operate relatively independent of each other. • Colorado Access originally determined CC delegates based on an assumption that larger practices with resources dedicated to care management were capable of performing the complex care coordination requirements of the RCCO. Colorado Access conducted no detailed pre-delegation assessment of a practice's care coordination processes, and expectations and accountabilities of delegates were vaguely outlined in the delegation agreement. • Colorado Access identified early that delegate care coordination processes varied widely among delegates. Delegates commonly interpreted care management as "managing referrals within the healthcare provider system" and often lacked resources to adequately address social determinants of health. • Colorado Access modified its delegate program in 2014 when it defined a pre-delegation assessment aligned with complex care management capabilities, updated care management agreements with detailed expectations and reporting requirements, and implemented annual audits. • Colorado Access organized staff resources to support existing delegated entities with training and consultation to help delegates "grow into" meeting contract expectations. Colorado Access supports gaps in delegate processes, has improved data sharing and information to delegates, and provides guidance and navigation through the system for individual members with complex needs. • Delegates are engaged in quality improvement processes and meet regularly in all regions to share best practices. • Colorado Access reported that significant improvements in CC have been made by delegates. • In addition to three RCCOs, Colorado Access has multiple lines of business which all (including CHP+, BHOs, and SEP) require some form of care management. As Medicaid enrollment expanded and the comprehensive nature of RCCO care coordination expectations were better understood, care management staffing requirements across all lines of business grew exponentially. • Colorado Access experienced difficulties in the early years of RCCO operations related to effective data-driven stratification methodologies to identify members requiring care

RCCO Region	Care Coordination
	management. In addition, ADT data were not available from all hospitals. Colorado Access has progressively explored several data manipulation methodologies and data system enhancements. • Due to infrastructure challenges, Colorado Access experienced several phases of reorganization of its internal care coordination structure: – Phase 1—A team of generalist care coordinators performed only telephonic interventions, with no identified focus on specific populations. This process was determined inadequate. – Phase 2—Transitioned from a generalist model into teams divided by lines of business: SEP, BHO, CHP+, Medicare Access Advantage, and RCCO. However, teams were siloed by product line, each with varying contract requirements for interventions. During this phase, Colorado Access also introduced a hybrid model of integrated care teams for some special population groups such as pregnant women, foster children, and MMP members; and implemented a transitions of care team. This model resulted in member confusion and operational inefficiencies. – Phase 3—Colorado Access hired a consulting firm to assist in developing a multi-year roadmap for care management transformation to realign care management teams across lines of business and assign integrated care teams to members according to their levels of need. Transformation has been introduced in an iterative manner, with each step being thoughtfully planned and monitored. At time of on-site review, Colorado Access had implemented several components of model, but was still evolving toward completion. • Colorado Access also embedded care coordinators in strategic clinical and non-clinical provider sites within Regions 3 and 5. • A northeast care management team—Region 2—is configured to address medical, behavioral, and social determinants of health through a five-member team that includes RCCO and BHO care managers, is assigned to members based on geographic considerations, and is readily integrated with SEPs across the region. • The expansive geography and general scarcity of resources within Region 2 requires that care coordinators collaborate with other agencies and community providers to innovate solutions for individual member needs. • Colorado Access identified member populations particularly challenging for care coordinators: members who are homeless, members with substance use disorders or both physical health and mental health needs, and members with low engagement or motivation levels. • Colorado Access commended the Department for having patience and responsiveness to Colorado Access' several iterations of restructuring internal processes and having the foresight to develop the SDAC database, providing assistance in gaining access to CORHIO data. • Staff members stated that the Department's early expectation of every member being a candidate for care coordination presented significant challenges and suggested that the Department and RCCOs continue to work together to define the most appropriate care management populations.

RCCO Region	Care Coordination
	• On-site care coordination presentations indicated that both delegates and Colorado Access staff in all three regions are performing successful comprehensive care coordination for members with complex needs.
Region 4—Integrated Community Health Partners (ICHP)	• ICHP's model for care coordination has remained relatively unchanged since inception of the RCCO. • ICHP implemented full delegation of care coordination from the inception of its contract by aligning already existing FQHC care coordinators with already existing CMHC care coordinators and assigning each team to a local geographic subregion. • Approximately one year into the contract, ICHP hired additional staff and the CMHCs assumed responsibility for coordinating care for members affiliated with non-delegated PCMPs. • Teams were located in local community subregions; therefore, each team was afforded intimate understanding of the cultural nuances within the community. This understanding—paired with pre-established, community-based relationships—proved exceptionally effective for care coordination activities. • ICHP identified that the ability of care coordinators to access clinic EHRs when they are embedded within a practice facilitates successful care coordination. • ICHP progressively invested in and improved care coordination documentation systems over the years. • ICHP hosts monthly workgroups wherein care coordinators from across the region meet to share information and troubleshoot difficult cases. • ICHP identified that care coordination challenges have included varying provider perceptions of the role of the care coordinators who are integrated into practices—while some practitioners fail to see the value of care coordinators and underutilize them, others require care coordinator "double-duty" (providing both behavioral health services and care coordination). • ICHP identified member populations that have been particularly challenging for care coordinators, along with reasons for the challenges: – Medicare-Medicaid Program (MMP) members—care coordinators invested countless hours collecting information already available in various documentation systems and sometimes encountered insurmountable barriers accessing members in SNFs. – CJI members—lack of availability of accurate data; difficulties locating members. – Substance use disorder (SUD) members—inadequate transition planning from substance use treatment facilities resulted in members returning to communities with little to no follow-up care or support. • Care coordination record reviews confirmed that ICHP successfully performed comprehensive care coordination for members with complex needs. ICHP's care coordination model has demonstrated exemplary performance over many years.

RCCO Region	Care Coordination
Region 6—Colorado Community Health Alliance (CCHA)	• CCHA provided coordination for approximately 65 percent of the member population (non-delegated and unattributed members), with the remaining 35 percent of members receiving care coordination through seven delegated PCMPs. Designated delegates have remained relatively consistent over time. • Delegated entities maintain their own unique processes for providing care coordinator services to members. Delegates are invited to request CCHA care coordinator assistance to support complex needs members. • The CCHA care coordination program includes staff members with varying levels of expertise: Health Partner I—telephonic outreach, Health Partner II—social workers (SW), and Health Partner III—registered nurses (RNs). RN/SW teams are assigned to support members according to geographic location. • CCHA has also defined designated programs of care coordination activities related to specialized needs of members. • CCHA has assigned to the care coordinator "single point of contact" for each PCMP. • Since inception of the RCCO contract, both the CCHA internal care coordination program and the delegate program have undergone several iterations of evolution. • Internal care coordination: – Initially, performed telephonic outreach to all members—to achieve attribution to PCMP, to conduct a limited health risk assessment, and to triage members to either a SW or RN for home-based detailed assessment. – Midway through contract, expanded relationships with external agencies and community organizations and co-located care coordinators in its high-volume Medicaid practices (numerous practices have some level of on-site care coordinator support). – Within recent years organized care coordinators into program-specific teams and expanded the diversity of professional expertise—e.g., behavioral health, long-term care services, social programs—of care coordinator staff. • Delegate program: – Initially, delegated care coordination to FQHCs and major provider systems—aligned with delegation strategy of other RCCO regions with whom these providers were contracted—passed entire per member per month (PMPM) payment to delegates, allowed delegates to perform care coordination in accordance with each entity's systems and operations, and used KPIs as measures of the delegates' care coordination performance. – Evolved to enhance CCHA internal processes to improve delegate care coordination processes and programs and increase accountability. These included using an assessment tool to evaluate comprehensive care coordination capabilities of potential delegates, enhancing delegate contracts to more specifically outline expectations, implementing audits of care coordination processes, and developing a dedicated delegate partner liaison position to meet with individual delegates. – Moved away from increasing the number of delegates to improving depth of delegate relationships—developed data dashboard for each delegate, designated an IT single

RCCO Region	Care Coordination
	point of contact for each delegate, offered to fill gaps in delegate care coordination processes, and now holds delegates accountable primarily through KPIs. • CCHA continues to evaluate how to improve care coordination processes among delegates and how to increase accountability of delegates for RCCO care coordination. • CCHA's care coordination documentation systems have improved significantly over the term of the RCCO contract. This is due to investing in the Essette Care Management software; adapting the system to accommodate the extensive assessment and care plan elements required for the MMP; applying that care planning document as best practice for all members with complex needs; and developing specialized program assessments—e.g., maternity program. • CCHA's care coordination data system goals include allowing external partners to access and update shared member care coordination records. • CCHA identified that care coordination challenges over the years included: – The PCMH model of care coordination focuses primarily on management of clinical referrals for members and does not sufficiently address the comprehensive ACC care coordination requirements. – Differences in care coordination expectations among RCCOs confused PCMPs. – Widely diverse size and scope of delegate practices rendered ineffective the meetings to share best practices. – Lack of hospital ADT data was a significant early deterrent to effective care coordination processes. – PCMPs had to adjust to using co-located care coordinators in daily practice routines, requiring CCHA to define expectations of the practices in order to make the investment worthwhile. – Staff turnover at RCCO and within delegate sites created challenges in developing ongoing inter-organizational relationships. – Contract amendments related to care coordination requirements and evolving priorities of the Department required major operational adjustment and re-training of staff. – Family-based rather than individual needs assessments are essential for understanding and addressing members' needs. – Members transferring from one RCCO region to another poses a challenge for members and care coordinators. – Contact with homeless persons and SUD members remains an issue. Veyo transportation services are unreliable, resulting in access issues. • CCHA is striving to achieving a balance between evaluating the time-consuming content work of quality care coordination as opposed to outcome measures which are numbers driven—i.e., deliverables that focus on number of members, number of assessments, number of interventions.

RCCO Region	Care Coordination
	• CCHA offered suggestions for Department consideration: – Facilitate partnerships among the RCCOs to provide consistency for providers who have facilities located in multiple regions and to identify areas of mutual concern that merit some cross-RCCO cooperative initiatives. – Define KPIs that align with complex care coordination outcomes. – Identify some methodology for statewide risk stratification of the broad member population that would help to guide RCCOs, delegates, and other agencies toward a more uniform member identification process. – Department and affiliated Medicaid entities should use uniform terminology to describe "care coordination." • CCHA's internal care coordination program appears to be exemplary in meeting members' complex needs through investment in staff expertise; improved documentation and data systems, programs for special member populations; and establishment of strong, supportive relationships with providers and community partners.
Region 7—Community Health Partnership (CHP)	• CHP has progressively transformed through several "eras" of care coordination for members. – CHP initially delegated care coordination to its large PCMP partners, Peak Vista and CSHP—to which most Medicaid members were attributed—and maintained only a small, internal care coordination staff to support these practices. CHP's member service center supported care coordination by focusing on attribution of members and assisting members and providers with specialist referrals. – As the number of PCMPs participating in the network increased, additional larger practices desired the reimbursement afforded through delegated care coordination, and smaller practices needed care coordination of members to be performed through the RCCO. CHP increased its number of internal care coordination staff and developed a practice transformation program. CHP increased its focus on members who frequently used the ED. CHP contracted with Rocky Mountain Rural Health (RMRH) and Teller County Public Health and Environment (TCPHE) to provide health navigation services to members in remote and sparsely populated counties. – From 2015 through 2017, CHP incorporated additional community organization partners into its care coordination model, resulting in multiple community-based care coordination models for homeless persons, members with disabilities, criminal justice-involved members, and foster children and families. CHP also decentralized care coordinator staff to point-of-care locations such as hospital EDs and some primary care locations. • Delegate practice support activities evolved to incorporate increasing mechanisms for accountability. An enhanced delegation contract with practices defined complex care coordination requirements; required care coordination policies, procedures, and data reporting to CHP; and incorporated formal CHP audits of delegate care coordination activities. CHP continues to provide on-site practice coaching. Further expectations will be outlined in delegate contract modifications planned for July 2017. • Internal CHP care coordination staffing has increased significantly over the years. CHP has employed care coordinators with a variety of professional backgrounds to expand the

RCCO Region	Care Coordination
	breadth of knowledge and expertise related to specific member populations. CHP will continue to locate coordinators in dispersed provider locations and will pair CHP coordinators with delegates in support of members with complex needs. Similarly, the service center staff roles have evolved to perform more significant health navigator roles as part of care coordination teams. • CHP has transitioned through multiple iterations of internal care coordination documentation systems. Effective July 2017, CHP will implement the Eccovia Solutions ClientTrack case management system. In addition, through the regional HIE, ClientTrack and CHP database information will be "pushed" by CHP to community partners and providers to enable sharing of care coordination information. • CHP's future care coordination goals include moving from rudimentary measures of care coordination—e.g., ER visits, readmissions rates, numbers of care coordination interventions—to defining mechanisms for measuring the "value" to members, of care coordination. • CHP foresees broadening care coordination initiatives beyond members with complex needs to include mechanisms for engaging the broader Medicaid population in order to connect members to needed services prior to their conditions or situations becoming complex. • CHP identified many lessons learned through its evolutionary care coordination processes: – The PCMH model of care coordination did not equip practices to perform the more advanced model of comprehensive care coordination for Medicaid members, particularly related to needs for social supports. – Practices were not prepared to modify care coordination documentation systems to accommodate only a portion of their entire patient populations. – CHP needed to hold the delegates accountable for the payments extended to the delegates, which required CHP to expand training, practice transformation, and other support services to delegates. – CHP needed to provide consistent messaging to practices regarding complex care coordination requirements. – Over time, CHP implemented multiple changes in practice support based on "filling the needs of the moment." Staffing requirements increased. Staff turnover at both CHP and within practices slowed progress. – Members did not contact CHP in response to the need for attribution; rather, members contacted the service center to receive care coordination and assistance with social determinants of health. – Steady increases in CHP care coordination staff required realignment with the diverse needs of special populations. • CHP commended the Department for appropriately abstaining from defining prescriptive tools and care coordination techniques, which necessarily vary across providers and according to the diversity of the Medicaid population. However, The Department could have provided a clearer and more consistent description and set of expectations regarding comprehensive care coordination from inception of the contract.

RCCO Region	Care Coordination
	• By assertively responding to lessons learned and by working collaboratively with providers and community partners, CHP has evolved into a multifaceted model of care coordination to serve Medicaid members in the region. CHP has improved upon the siloing of care management activities among providers, agencies, and community organizations by integrating its activities and objectives with those entities. CHP's collaborative approach should enable care coordination systems and processes across the community to progress toward increasing consistency and efficiency.

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
Region 1—Rocky Mountain Health Plan (RMHP)	• Since inception of the ACC program, RMHP **r**egularly pursued involvement in grants and program opportunities offered through the Department, other sources, or legislative actions. RMHP engaged in special programs that complemented the overall regional strategy for developing a better health system. • RMHP noted that programs and projects included (but were not limited to): State Innovation Model (SIM), COP, Comprehensive Primary Care Plus (CPC+), MMP, Prime payment reform, Intellectual and Developmental Disabilities Crisis Center, CJI, Easy Care Colorado telehealth, Accountable Health Communities Model, and Health Engagement Teams. • Special programs and projects—offered through the Department or other sources—provide resources to enable initiation and implementation of various components of RMHP**'s** mission. Mission-driven programs are sustainable because of the commitment of people in the system and are not dependent on grants and other programs should those funding streams discontinue. • RMHP stated that being involved with multiple projects and programs is "taxing"—requiring multiple meetings, applications, implementation, evaluation, and reporting. RMHP historically and currently is deliberate in data-driven evaluation of all programs and services. • RMHP noted that the best opportunities are those that allow RCCOs the flexibility to implement programs and projects that are a good "fit" with the unique needs and strategies of each region. • RMHP complimented the Department for: – Identifying opportunities for the RCCO to participate in special programs and projects and for supporting RMHP in pursuit of other pilot opportunities such as payment reform. – Assisting the RCCO in overcoming barriers with statewide organizations and processes. • RMHP offered suggestions for future Department consideration: – Continue pursuing innovation opportunities and advocating for payment reform.

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
	– Share with the RCCOs the raw data from multiple State databases and/or pursue mechanisms to develop crossover or combined program data sources. – Work with ACC regions collaboratively to formulate a proactive, policy-level response to anticipated changes in the national Medicaid program.
Regions 2, 3, and 5—Colorado Access	• Over the duration of the RCCO contracts, Colorado Access has participated in numerous additional projects—both Department-driven programs and projects either self-initiated or associated with other sources. • Colorado Access noted that programs and projects included (but were not limited to)—SIM, COP, CPC+, MMP, Colorado Department of Public Health & Environment (CDPHE) (cancer prevention), Community Health Works (health disparities), ECHO e-consult, Enhanced Primary Care Medical Provider (EPCMP), Healthcare Equality Index (HEI) assessment, and Client Over-Utilization Program (COUP). • Colorado Access considers several factors in making decisions on program participation: the level of importance to the Department; applicability to provider interests and other partner relationships; and, most importantly, whether or not the project supports core strategies of Colorado Access. Colorado Access developed a shared resource matrix model to identify the administrative and practitioner resources and support required for each program and has formal mechanisms for determining the "fit" of special initiatives with Colorado Access' goals as well as evaluation mechanisms for outcomes and sustainability. • Most Department initiatives have been conceptually—although not always functionally—easy to integrate with RCCO strategies. Colorado Access has learned that how an "opportunity" is structured—i.e., reporting responsibilities possibly deterring provider participation and how special program services can be billed or otherwise reimbursed—is another important factor in decision making. • MMP did not merge well with established priorities, primarily due to the prescriptive processes and difficulty of reporting requirements for providers operating within a multi-payer system. Colorado Access that noted even when applicability of a specific program to RCCO objectives was initially questioned—e.g., MMP, COP—results of participation proved beneficial and sustainable. • Colorado Access uses data to track results of all project activities, including return on investment (ROI) of each program, sustainability, and strategic considerations. Many of the concepts and processes realized through special programs will be retained within the RCCOs regardless of continuation of funding. • Colorado Access identified challenges with managing multiple projects to include: managing reimbursement methodologies—e.g., paying for outcomes, but measuring processes; defining billable services—e.g., billing codes for behavioral health interventions in primary care practices and on-site clinical pharmacy services; and encountering contractual and regulatory barriers to doing things differently to achieve outcomes. • Colorado Access complimented the Department for: – Having "a greater vision" to identify projects necessary to push RCCOs forward.

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
	– MMP staff members being highly responsive and transparent concerning identified issues, thereby demonstrating the Department's commitment to "make things work." – Field trips to the regions by Department staff being instrumental in stimulating stakeholder involvement. Having the Department's endorsement of projects elevated the importance and priority level of the program. – The critical importance of outlining program goals while allowing innovation and creativity at the local level. • Colorado Access offered suggestions for future Department consideration: – Continue to dedicate staff resources to assist the RCCOs through special project implementation. – Share the Department's vision concerning select initiatives to assist the RCCOs in establishing priorities. – Include broader participation of RCCOs in Department strategic and structural decisions regarding special programs and initiatives. – Program services and requirements should not be "bucketed" by pay source. – Measures for evaluation and monitoring should not evolve over time; decisions regarding measures should be made up front. – Consider risk of provider and staff "innovation fatigue."
Region 4—Integrated Community Health Partners (ICHP)	• Since inception of the ACC program, ICHP has participated in numerous grants and program opportunities offered or enabled through the Department, other sources, or legislative actions. • ICHP noted that programs and projects included (but were not limited to)—Super Utilizers Program, EPCMP, SIM project, and COUP. • ICHP blended Department-driven initiatives with the priorities of its individual communities and providers. Leadership considers several factors in making decisions on program participation: how the project aligns with existing goals of ICHP, the Department, and ICHP's communities; potential impacts on partners, providers, and member outcomes; availability of resources; how a project's impact will be measured and who will measure it; and whether the project promotes better integration. • ICHP relies on internal committees to provide ongoing feedback as projects are implemented. ICHP believes that partner and provider support of ICHP's involvement in a project is critical to successful implementation and outcomes. • Once approved for implementation, ICHP conducts a pilot project study to identify and address implementations issues and determine amounts and types of resources required. Pilot projects are considered critical in determining if a project should be continued and/or which communities have the resources necessary for implementation. • ICHP carefully monitors data and quickly terminates unsuccessful projects. • Providers often struggle with managing administrative oversight and monitoring multiple programs and projects. ICHP no longer expects that all providers will participate in all

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
	projects, instead encouraging providers to implement programs related to their individual practice goals and priorities. • ICHP used Department initiatives that promised providers added financial resources (e.g., SIM and EPCMP) to gain access to practices otherwise unwilling to work with ICHP. • ICHP credited the Department with the unrestricted manner in which the Department allows each RCCO to operate. Additionally, ICHP staff expressed gratitude for the availability and responsiveness of Department staff members. • ICHP offered suggestions for future Department consideration: – Provide Department staff members to attend community meetings and on-site provider visits to demonstrate to ICHP's partners and providers that the Department is committed to the RCCO programs. Community involvement also affords Department staff a more comprehensive understanding of challenges encountered in the field. – Allow RCCOs and providers to give feedback and guidance prior to implementing new initiatives. Staff members, community partners, and PCMPs have valuable information regarding what systems are already in place. – Align KPIs with best practice literature, and align existing measures across programs. – Streamline communications with the RCCOs—multiple Department committees and subcommittees tend to silo information channels.
Region 6—Colorado Community Health Alliance (CCHA)	• CCHA and its network providers have participated in all grants and special program opportunities presented through the Department. • CCHA noted that programs and projects included (but were not limited to)—SIM, COP, MMP, CPC+, AmeriCorps, Center for Medicare and Medicaid Innovation (CMMI) grant (integrated care for pregnant women). • Simultaneously, CCHA has identified regional priorities through CCHA's community partnerships, resulting in CCHA participation in an estimated 10 to 15 initiatives in each county of the region. • CCHA's priority-setting criteria for determining participation in Department or local regional initiatives included Department mandates, county agency or community priorities, and member needs. Sustainability of programs and programs associated with improving KPI performance are other important considerations in making strategic decisions. • CCHA attempts to strategically and operationally integrate special programs and grants to support RCCO, provider, and/or community priorities. Affiliation with Primary Physician Partners IPA at Board level and input from Health Neighborhood Advisory Committee expedites decisions. • CCHA extends its KPI funds as appropriate to support select community and provider programs. CCHA has a formal contract with each community partner or provider who receives over $5,000 in funding. • Many programs are implemented as pilot projects to test feasibility and sustainability.

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
	• All program outcomes are evaluated. Staff members stated that, due to lack of sustainability or unsatisfactory outcomes, multiple projects have been discontinued. • CCHA identified that challenges associated with particular projects included: – SIM project has engaged practice coaches—Health Team Works and a regional health coordinator—to work independently with practices, resulting in potential conflict with CCHA practices coaches and too many coaches in individual practices. – Hospitals in the region have been difficult to engage in the Colorado Hospital Transformation Program—hospitals cite that health alliances are already configured to meet program objectives and that the hospital provider fee does not improve payment to hospitals for Medicaid members. – Multiple health alliances in the region are in varying stages of maturity, have conflicting initiatives, and are generally unfamiliar with Medicaid objectives—suggesting the need for an "alliance of the alliances." – RCCOs need significant lead time to prepare providers and to offer practice coaching to implement changes impacting payments to practices. • CCHA credited the Department with: – Selecting grant opportunities that promote ACC objectives. – Doing some good work on payment reform mechanisms. – Holding regular meetings between RCCO leadership and the Department's ACC program manager. • CCHA offered suggestions for future Department consideration: – Be selective about opportunities pursued, distinguish whether a program is optional or required, and involve RCCOs in planning implementation processes. – Consider a strategic planning process with the RAEs to outline an overall vision, priorities, direction, and structure for ACC development which will, in turn, provide guidance for associated federal or State program opportunities as well as decisions specific to individual regions. – During phase 2.0 ACC operations, consider establishing a new channel for RAEs to come together to share best practices or exchange ideas.
Region 7—Community Health Partnership (CHP)	• From inception of the RCCO, CHP has enthusiastically responded to opportunities to: participate in every Department-driven program initiative, serve as a pilot implementation site for a variety of programs, and self-initiate grants and programs to meet local healthcare needs. • CHP noted that programs and projects included (but were not limited to)—SIM, COP, No Wrong Door, COUP, integrating with DHS Child Welfare for foster care members, Extension for Community Healthcare Outcomes (ECHO) e-consult program, MMP, CPC, CJI member integration, Healthy Communities/care coordination integration, Enhanced PCMP (EPCMP) program, NEMT system, and adult quality measures.

RCCO Region	Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities
	• In addition, CHP has initiated or supported many local initiatives and community-based programs, noting that CHP and the community at large have cultures that are "willing to try anything." • The smaller size of the region, the streamlined and smaller size of the CHP organization, lack of a long-term organizational history, and established community relationships afforded CHP the "nimbleness" to quickly respond and implement pilot projects. • CHP considered factors such as cost/benefit, the local political environment, Department-mandated participation, and local healthcare needs in its strategic decisions. Programs such as SIM were seen as supportive of other established CHP goals and objectives. Conversely, CHP expressed less enthusiasm for its COP project ("Promote Middle Class by Middle Age") as repetitive of other initiatives. • CHP also identified the importance of considering sustainability of programs. CHP's criteria for participating in new community projects now requires a sustainability plan. • CHP foresees the need for a longer term internal strategic plan to facilitate a more cohesive process and continuity among multiple programs. Projects that have evolved over time required continuous layering of one project on top of another. Participants have grown weary of the administrative burden associated with simultaneously managing multiple and changing initiatives. • Practices are experiencing an increasing administrative burden of simultaneously participating in multiple projects that do not have aligned reporting requirements and measures. • CHP has recognized the need to more deliberately evaluate each project's outcomes and assess the value of the multiple projects and programs in which it has engaged. • CHP acknowledged that the Department is in the unique position of having a statewide perspective for identifying fiscal concerns and opportunities for the Medicaid program. CHP complimented the Department for defining priorities, dollars, and deliverables while local communities within the region determine methods of implementation. • CHP offered suggestions for future Department consideration: – Focus on developing a master strategic plan for the State—longer than a year-to-year horizon—that would guide RCCOs in determining local strategies and priorities. – Department-level decisions concerning programs and projects might consider consistent themes that will minimize disruption to practices, how to best assess the "value" of specific projects, and assessing potential sustainability. – Align similar priorities among State agencies by "de-siloing" funding and functions within multiple agencies and systems. – Align social determinants of health KPIs, incentives, and funding across providers and community organizations by creating a flexible pool of funds to be shared by providers and the community. – Following implementation of ACC 2.0, re-engage in mechanisms to encourage transparency among RAEs and facilitate sharing of deliverables, best practices, and data across RAEs.

3. Trends Related to Discussion Themes

Since the inception of the ACC, HSAG has conducted annual on-site reviews using qualitative interview methodology and care coordination record reviews to document RCCOs' progress and activities related to specific ACC goals and objectives and RCCO contract requirements. Each year, HSAG analyzes information gathered during on-site review to identify trends and make recommendations related to select domains.

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 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 FY 2013–2014, the Department and HSAG determined that priorities for review were to evaluate the evolution of the RCCOs' provider network development and provider support activities as well as progress made in the RCCOs' care coordination programs.

In FY 2014–2015, the Department and HSAG 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, and care coordination programs.

In FY 2015–2016, the Department and HSAG determined that priorities for review were exploration of the RCCOs' activities related to integration with specialist providers, selection of region-specific projects, integration with behavioral health services/BHOs, and implementation of SCPs for Medicare Medicaid Program (MMP) members.

In FY 2016–2017, the Department and HSAG determined that priorities for review were exploration of each RCCO's experiences related to community partnerships/collaboration, provider network/provider participation, member engagement, care coordination, and balance between Department-driven priorities and regional priorities. The remainder of this section contains analysis of the aggregated information obtained during the 2016–2017 site review process to identify the common themes related to each of the identified 2016–2017 focus topic areas.

Care Coordination Record Reviews

Care coordination cases were selected by each RCCO, and results were not scored. HSAG summarized each care coordination case to document member characteristics and needs, care coordinator activities, member engagement, involvement of other agencies and providers, and outcomes of care coordination efforts. The statewide sample of 55 care coordination cases represented diverse medical, behavioral, and social needs of members, and included adults, children, MMP members, and both delegated and RCCO

care coordination cases. RCCOs also included several cases that demonstrated minimal care coordination needs or had less than satisfactory outcomes, primarily due to lack of follow-through by the member.

HSAG identified the following common themes in statewide record reviews:

- Most cases were referred to care coordination through the PCMP or other agencies, monitoring for transitions of care, or through the MMP SCP process.
- Common characteristics of members with complex needs included a combination of multiple medical diagnoses, and/or significant disabilities, and/or significant behavioral health or substance abuse needs, as well as related social support needs.
- Care coordination performed through a delegated PCMP tended to focus on managing a member's physical health needs and related referrals. Members with complex physical, behavioral, and social needs were generally provided care coordination through RCCO care coordinators or a team of provider, RCCO, and agency coordinators.
- Complex cases tended to include multiple social support service needs and required coordination with multiple external agencies and organizations.
- The RCCO care coordinator tended to assume the lead coordinator role, although several RCCOs reported deferring to the SEP whenever possible to avoid competitive concerns among agencies.
- Common needs and interventions included:
  - Transportation.
  - Housing assistance.
  - Coordinating among multiple providers and organizations.
  - Accompanying members to multiple appointments.
  - Facilitating completion of extensive paperwork.
- The most challenging issues presented in complex cases involved:
  - Members with alcoholism and other substance use disorder (SUD) issues.
  - Members with severe behavioral health issues.
  - Homelessness or need for housing alternatives.
  - Pain management.
  - Unreliable or unavailable transportation.
  - Poor responsiveness of other agencies or providers.
- Less frequent but significant care coordination challenges included:
  - Member legal issues.
  - Suicidal ideation or attempts.
  - Communicating with members who do not speak English.
  - Support required for other family members.
  - The need to appeal denied but necessary services.

- Care coordinators across the RCCOs demonstrated significant commitment and perseverance to accomplish care coordination goals. Most cases demonstrated successful outcomes.
- Members with complex physical, behavioral, and social needs often consumed enormous staff resources from the collective care coordination team.
- Case presentations demonstrated varying levels of member participation in care coordination efforts. Member engagement was the most significant contributing factor in successes or challenges associated with care coordination.

Community Partnerships/Collaboration

HSAG used the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from staff in broadly-defined subject areas. Variations in regional characteristics and historical development among RCCOs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding the multitude of community partnerships in which each RCCO had engaged; therefore, consistency in discussion topics varied across the regions. Several RCCOs invited multiple community partners to participate in the on-site discussions. Nevertheless, HSAG noted the following common themes regarding community partnerships and collaboration across the RCCOs.

- **All** RCCOs have established active relationships with the Single Entry Points (SEPs), Community Centered Boards (CCBs), county public health departments, and DHS within their individual regions. The quantity of such relationships varied according to the geographic size and structure of the regions—from a limited number of counties in Regions 3, 5, 6, and 7 to a vast number of counties in Regions 1, 2, and 4.
- **All** RCCOs described multiple, locally-driven community partnership initiatives with other community organizations to address regional priorities.
- Regions 1 and 7 had established relationships with community-based organizations prior to inception of the RCCO, and have accelerated relationships with other organizations through those connections.
- The focus of most collaborative relationships in **all** regions was related to coordinating care for members, either through shared care coordination processes or through broader initiatives that were identified and stimulated by care coordination processes. However, each region described some community partnership activities unaffiliated with care coordination.
- During on-site review, each RCCO highlighted in detail multiple specific projects and collaborative activities with numerous community partners related to both care coordination and to other community-based programs and services. Six of seven RCCOs specifically described collaborative programs associated with the Colorado Opportunity Project (COP).
- Community partnerships highlighted in Regions 2, 3, and 5 (Colorado Access) and Region 4 tended to exist primarily with agencies and community providers. Regions 1, 6, and 7 described numerous community partners in addition to agencies and community providers. Regions 2, 3, 4, and 5 identified that specific additional community partnerships need to be developed.

- While regions that were primarily rural experienced challenges with widely dispersed agencies that were small and under-resourced, RCCOs in more urban areas were challenged by the size and complexity of the agencies in large population bases.
- Most RCCOs (the exception being Regions 1 and 7) described spending considerable time and energy initially educating other organizations about the ACC and the role of the RCCO in order to overcome misunderstandings of the objectives and intent of the ACC program. Region 6 described this challenge in the context of "being late to the game" in already established interagency activities; Region 4 described that it has joined as a participant in already-established workgroups within its local subregions rather than organizing new initiatives to meet RCCO-driven priorities.
- Regions 4 and 6 specifically cited initial difficulties with establishing working relationships with SEPs, CCBs, and other county agencies. **All** RCCOs have established a posture of supporting the care managers in SEPs and CCBs as lead care coordinators for shared members, while filling gaps in other services needed by members. Regions 1 and 4 stated that these agencies often make referrals back to the RCCO, and Regions 2 and 6 described development of team-based care coordination with SEPs.
- Beyond care coordination activities, RCCOs commonly performed roles of participant, convener/leader, data provider, and financial funder related to community partnership initiatives: RCCOs 1, 2, 3, 5, and 7 described initiatives in which the RCCO was the convener/leader; most RCCOs (the exception being Region 6) identified that overtly providing data and analytics was a frequent RCCO role; Regions 1, 6, and 7 regularly extended RCCO funds to support select community initiatives, while Regions 2, 3, 4, and 5 extended funding to a lesser degree.
- Regions 1, 6, and 7 routinely secured partnership initiatives with formal agreements which outlined roles, responsibilities, and funding for specific projects.
- **All** regions described frequently designing pilot projects to test the efficacy and sustainability of initiatives, and all used data to track and evaluate outcomes.
- Community partnership initiatives in widely rural regions experienced unique challenges and generated varying responses from the RCCOs: Regions 1 and 4 described a high level of commitment from community organizations to address challenges within their communities; Region 2 described that community organizations and providers are trying to survive and lacked resources for participating in programs. Region 1 assisted in leading and funding implementation of diverse locally-driven solutions; Region 4 provided personnel resources to participate in and support sub-regional initiatives, but extended minimal financial support; Region 2 participated in and convened meetings within communities to identify and troubleshoot local healthcare issues.
- Regions 4 and 6 specifically identified housing issues as a priority collaborative community concern; Regions 1, 2, and 4 specifically identified transportation as a priority community partner concern.
- Several RCCOs credited the Department with allowing the flexibility for each region to address community partnerships and collaborative efforts in a locally-driven manner. Several RCCOs also credited the Department with facilitating relationships among State agencies. Regions 2, 3, and 5 also complimented the Department on responding to system issues identified through the RCCOs, including troubleshooting NEMT issues, facilitating the relationship with CORHIO, and sending Department staff into the regions as necessary.

- RCCOs provided suggestions to the Department to facilitate strengthening of interagency and community partnerships in the future:
  - **All** regions encouraged the Department to continue to facilitate cross-agency relationships at the macro level, with two RCCOs specifically noting the need for further work with the Department of Corrections (DOC).
  - Five regions specifically identified the need for increased data sharing among agencies and access to all agency databases.
  - Two regions suggested involving RCCOs and community partners in Department initiative discussions.
  - Two regions strongly suggested that the Department consider a state-level strategic planning initiative to de-silo agencies—aligning cross-agency objectives, roles and responsibilities, and funding.
  - Individual RCCOs suggested that the Department increase visibility of Department staff in community-based partnerships and initiatives, reassess the funding formula for transportation in rural areas, implement presumptive member eligibility for benefits needed anywhere in the Medicaid system, and contractually require agencies to partner with each other.

Provider Network/Provider Participation

HSAG used the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from staff in broadly-defined subject areas. Variations in regional characteristics and historical development among RCCOs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding provider participation in each region; therefore, consistency in discussion topics varied across the regions. Nevertheless, HSAG noted the following common themes regarding provider networks and provider participation across the RCCOs.

- **All** RCCOs used pre-existing provider relationships to initiate the provider network. Regions 2, 3, 4, 5, and 7 focused significantly on FQHCs.
- Most RCCOs (the exception being Region 1) reported that lack of provider understanding of the RCCO and/or past provider difficulties with the Medicaid program hindered recruitment of additional providers early in the term of the RCCO contract.
- Regions 2, 3, 5(Colorado Access) and 6 reported spending considerable time and energy educating providers about the RCCO and ACC program.
- Regions 6 and 7 noted that early challenges also included competing provider priorities. Regions 2, 6, and 7 described lack of available providers or stressed capacity of providers as additional early challenges.
- Regions 2, 3, 5, and 7 stated that the per member per month (PMPM) reimbursement provided the financial incentive for providers to join the network.

- At the time of on-site review, **all** RCCOs were contracted with an adequate number of PCMPs and/or nearly all available or willing primary care providers in the region. However, Region 7 experienced capacity issues within individual practices.
- Provider networks in Regions 1, 2, 3, 4, and 5 have remained relatively stable over recent years, with limited recruitment of additional practices. Regions 6 and 7 have been slightly less stable, experiencing provider mergers or closures. Region 6 continues to recruit practices with small Medicaid member populations.
- Regions 1, 3, 6, and 7 focus on opportunities to expand capacity within existing practices.
- **All** regions noted initiatives to integrate behavioral health practitioners into primary care practices. Regions 1, 2, and 4 noted that reimbursement of PCMPs for integrated behavioral health services is a challenge.
- **All** regions have shifted from recruitment to building more in-depth relationships with existing providers.
- Regions 3, 4, and 6 identified that the RCCO needed to demonstrate "value" to individual practices.
- Regions 2, 3, 5, and 7 identified that providers are primarily motivated by initiatives that improve reimbursements to practices.
- Most RCCOs (the exception being Region 4) have invested significant resources in organized practice transformation programs. Practice transformation programs were robust and engaged on-site with an extensive number of practices in each region.
- Region 4 had adapted its practice support services to respond to individual practice priorities and needs, but tended to be involved with a limited number of individual providers.
- Most RCCOs (the exception being Region 4) described a focus on PCMP reimbursement and financial issues. Regions 6 and 7 had implemented provider incentive payment programs.
- Most RCCOs (the exception being Region 4) described regularly addressing KPIs with individual practices.
- Regions 1 and 6 assisted practices in establishing quality improvement programs.
- **All** RCCOs had mechanisms to assist practices with RCCO operational issues such as attribution, billing and coding, data support, and care coordination support.
- **All** RCCOs customized practice transformation activities to address regionally-defined or individual practice needs and considered regional flexibility a key factor in successful practice transformation.
- Over time, **all** RCCOs have established positive working relationships with the provider community.
- Most RCCOs credited the Department with allowing each RCCO the flexibility to determine how to best support provider practices within the regions. Several regions noted that the Department was responsive to provider operational concerns. Regions 2, 3, and 5 complimented the Department on reinforcing providers with financial incentives and introducing new funding and program opportunities for provider participation. Regions 1 and 6 noted that providers appreciate the Department's Medicaid workgroups. Regions 4 and 6 credited the Department with increasing the presence of Department staff in the region.

- RCCOs provided suggestions to the Department to improve the provider experience in the future as follow:
  - Five regions identified the need to reduce repetitive provider reporting requirements and streamline provider performance measures.
  - Three regions recommended involving RCCOs and providers early in the Department process of identifying statewide initiatives and/or performance requirements.
  - Three regions suggested increasing the presence and interaction of Department staff with providers in the region.
  - Three regions suggested that the Department consider payment reform to provide RCCOs more flexibility in payment to providers.
  - Two regions noted the need for the Department to streamline attribution.
  - Two regions noted the need for improving the consistency or timeliness of Department messaging to providers.
  - Individual RCCOs suggested that the Department align coding, billing, and data sources across all pay sources; clarify the State's intentions for primary care provider reimbursement; provide regionally-based education to providers regarding the RAEs; ensure timely payments to providers; and revisit efforts with CORHIO to expand hospital participation in the HIE.

Member Engagement

HSAG used the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from staff in broadly-defined subject areas. Variations in regional characteristics and historical development among RCCOs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding member engagement experiences within each RCCO; therefore, consistency in discussion topics varied across the regions. Several RCCOs invited member representatives to participate in the on-site discussions. Nevertheless, HSAG noted the following common themes regarding member engagement across the RCCOs.

- Most RCCOs (the exception being Region 1) defined "member engagement" as the member participating in his or her own healthcare, and most regions (the exception being Region 4) included "meeting members where they are" in their definitions.
- Region 1 defined "member engagement" as understanding the member experience and "moving beyond competent to conversant" with diverse member populations.
- **All** RCCOs maintained traditional outreach methodologies and member communications—e.g., newsletters, interactive voice response (IVR) calls, targeted mailings, member website, customer service outreach calls.
- **All** RCCOs engaged members one-on-one through care coordination. Regions 1, 4, 6, and 7 noted being in process of increasingly moving to engaging members in community settings.
- **All** RCCOs engaged members one-on-one through a call center. With the exception of Regions 6 and 7, call centers were primarily used for routine inbound and outbound calls. Regions 6 and 7 had

invested significant resources and increased sophistication in call center activities and considered the call centers an essential component of care coordination and member engagement.

- **All** RCCOs had member advisory committees to obtain member input on RCCO activities and member communications. In many regions—the exception being Regions 2, 3, and 5 (Colorado Access)—a limited number of select members participated in member advisory meetings. Regions 2 and 4 noted that member advisory meetings were being held in diverse locations throughout the region, and Region 7 stated intentions to do similarly.
- Regions 1 and 4 noted that the RCCO offered staff and provider trainings—e.g., cultural competency, motivational interviewing—to support effective member engagement. Only Region 1 cited widespread implementation of patient activation tools. Regions 6 and 7 conducted extensive in-depth training of call center staff.
- Regions 2, 3, 5, and 6 routinely tracked and used member feedback data to improve member engagement mechanisms.
- **All** RCCOs indicated that effective member engagement requires individual contact with the member. Regions 6 and 7 identified establishing member trust as a key component in effective member engagement. Region 7 noted that member trust is enhanced when engaging members through community partners.
- Regions 1, 4, and 6 were incorporating technology—mobile phone applications, social media—into their member engagement and communications strategies.
- Regions 2, 3, 5, 6, and 7 noted that past member engagement activities had been significantly associated with member attribution.
- Regions 2, 3, 4, 5, and 7 noted integrating population health initiatives into member engagement strategies.
- **All** regions had recently implemented mechanisms to explore or track the diverse needs of specialized populations.
- Regions 1, 2, 6, and 7 had implemented mechanisms to solicit direct input from members in the field regarding member needs and perceptions. Region 1 designed specific targeted initiatives with select population groups; Region 2 interacted with members at community events and using a mobile van; Regions 6 and 7 interacted with members through community partners; Region 7 also conducted a focus group.
- **All** RCCOs identified difficulty engaging members who were hard to locate or had no contact information. In addition, one or more RCCOs noted difficulty engaging members of select populations: homeless members, members with language barriers, members associated with CCBs, young healthy non-users of the system, parents of children.
- Additional challenges included geographic challenges in rural, widely dispersed regions and lack of reimbursement or financial incentive for members to participate in committees or surveys.
- Regions 1, 6, and 7 specifically noted that member engagement is most effective at the local level.
- Region 7 observed that the Department's role in member engagement is appropriately member communications and materials. RCCO 4 complimented the Department on its member materials and website; RCCO 6 commended the Department on the PEAKHealth mobile application.

- RCCOs provided suggestions to the Department to improve member engagement in the future as follow:
  - Five regions recommended that the Department develop mechanisms to clean up and maintain current member contact information in Department databases.
  - Four regions suggested that the Department facilitate sharing of learning experiences and member feedback information across RCCOs.
  - Three regions suggested incorporating input from the RCCOs into Department-level member engagement strategies.
  - Two regions noted that the Department should maintain flexibility for RCCOs to define locally-driven member engagement solutions.
  - Individual RCCOs suggested that the Department improve its internal customer service operations; develop mechanisms beyond CAHPS surveys to obtain member feedback; collaborate with RCCOs, community organizations, providers, and members to determine the roles of each entity in member engagement; include RCCO contact information on member ID cards; and have Department points of contact with members—e.g., Nurse Advice Line—ensure that they refer members back to the appropriate RCCO.
  - One RCCO observed that the Department's submission of member feedback data to the RCCOs for a response is a distraction from efforts to allow member engagement to evolve in communities.

Care Coordination

HSAG used the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from staff in broadly-defined subject areas. Variations in regional characteristics and historical development among RCCOs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding care coordination programs within each region; therefore, consistency in discussion topics varied across the regions. Most RCCOs invited several care coordinators from the field to participate in on-site discussions. Nevertheless, HSAG noted the following common themes regarding care coordination across the RCCOs:

- **All** regions performed care coordination through a variety of care coordination structures which included both delegated entities and internal care coordination staff to varying degrees.
  - Regions 2, 3, 5(Colorado Access), 6, and 7 maintained a centralized care coordination staff—who supported an estimated 60 to 65 percent of members—combined with delegated entities, which were primarily large practices and FQHCs. In these regions, RCCO care coordination and delegate care coordination operate relatively independently of one another. HSAG observed limited common characteristics between structures and processes of delegate and RCCO care coordination programs.
  - Regions 1 and 4—geographically large and highly rural—have, from inception of the RCCO, designated community-based and geographically-dispersed care coordination teams associated with partner organizations and providers already operating within the region; however, these

teams—considered neither fully delegated nor non-delegated—were highly integrated with and responsive to the leadership of each RCCO.

- **All** RCCOs held delegates accountable to RCCO priorities, either through formal delegate agreements or through provision of support resources. Regions 1 and 4 held delegates accountable primarily through provision of support resources and highly engaged, interactive working relationships among the teams and with RCCO leadership. Regions 2, 3, 5, 6, and 7 relied on formal written agreements with delegates. These regions also ultimately defined structured delegate support programs and have experienced significant evolutionary delegate program modifications over the term of the RCCO contract.
- Designated delegated entities have remained relatively unchanged in **all** regions over many years.
- At inception of the ACC, Regions 2, 3, 5, 6, and 7 determined delegation of practices primarily based on the assumption that primary care medical homes (PCMHs) could perform care coordination requirements of the ACC contract and had the resources to do so. No region performed a pre-delegation assessment of the care coordination programs of these delegates, and delegation agreements vaguely defined expectations. Delegates in all regions were allowed to maintain care coordination systems already in place and applied to their overall patient populations.
- Regions 2, 3, 5, 6, and 7 identified that, while delegates adequately performed coordination of clinical referrals in accordance with the PCMH model, delegates were not prepared to perform the comprehensive care coordination requirements of the ACC contact—particularly related to the social determinants of health and "coordinating the coordinators" among community organizations and agencies.
- Midway through the RCCO contract period, Regions 2, 3, 5, 6, and 7 implemented a pre-delegation assessment tool, modifications to existing delegate agreements to include increased specificity of delegate expectations, and periodic audits of care coordination programs and member records. Each of these RCCOs increased staff support resources for delegates, shared data, and provided training and on-site consultation.
- At the time of HSAG review, Regions 2, 3, 5, 6, and 7 reported improvements in delegate care coordination performance, yet maintained that additional improvements were still required. No RCCO had suspended or terminated a delegate contract.
- Regions 2, 3, 5, 6, and 7 have also experienced significant evolutionary modifications in internal RCCO care coordination programs over the term of the RCCO contract. Regions 1 and 4 have maintained relatively stable structures and models for care coordination. **All** Regions have experienced significant increases in care coordination staffing and budgets.
- Regions 2, 3, 5, 6, and 7 have implemented several iterations of reorganization of staff resources for care coordination. Colorado Access has experienced three phases of restructuring since inception of the contract, primarily motivated by the need to organize care management resources across multiple product lines. Regions 6 and 7 have progressively re-oriented care coordination resources, motivated by lessons learned and improving care coordination for members.
- Regions 1, 4, 6, and 7 have invested in new, enhanced care coordination software. Regions 2, 3, and 5 made some upgrades to pre-existing software for documenting care coordination. Regions 1, 6, and

7 noted the intent to develop a shared care coordination record among the RCCO and community partners.

- At the time of on-site review:
  - Most RCCOs (the exception being Region 4) noted that care coordination functions were integrated with community organizations, agencies, and partners. Regions 3, 4, and 5 had embedded RCCO coordinators in select community partner sites; Regions 6 and 7 had embedded care coordinators in diverse community partner sites.
  - Regions 1 and 4 noted that structures and models for care coordination varied according to the "best fit" for the populations served within diverse communities or geography.
  - Regions 1, 2, 4, 6, and 7 had integrated multidisciplinary expertise and variety of professional backgrounds of coordinators –e.g., nursing, behavioral health, social work, long-term services and supports (LTSS), legal—into their care coordination teams. Regions 6 and 7 had also expanded the diversity of expertise in call center staff.
  - Regions 2, 3, 5, and 6 had defined care coordination teams for select specialized populations—e.g., maternity, MMP members.
  - **All** RCCOs demonstrated that care coordinators successfully performed comprehensive care coordination for members with complex medical, behavioral, and social support needs.
- RCCOs identified several challenges experienced in care coordination processes:
  - Lack of provider and community resources in rural communities
  - Either inadequate or non-existent NEMT services
  - Prescriptive processes of the MMP
  - Obtaining consistent ADT data from hospitals (early in the term of the RCCO contract)
  - Stratification methodologies for identifying members with complex needs
  - Operational adjustments and retraining required for modifications in Department requirements or priorities
  - Differences in PCMP care coordination expectations across RCCOs
  - Providers' misunderstanding of the role of on-site care coordinators in the practice
- RCCOs identified several member populations that commonly presented challenges for care coordinators:
  - Member housing needs
  - Members with serious behavioral health issues
  - Members with SUD
  - Members with chronic pain, lack of pain management alternatives, opioid dependence
  - Members with low engagement
  - Criminal Justice Involved (CJI) members
  - Members transitioning between providers or geographic locations
- Several RCCOs credited the Department for its work with the health information exchange and for developing the SDAC data for use by RCCOs. Regions 1 and 7 credited the ACC program for

allowing flexibility for regional innovation in care coordination processes. Regions 2, 3, and 5 appreciated the Department's patience with the RCCO throughout numerous design and re-organization strategies. Individual RCCOs acknowledged the Department for assistance with regional NEMT challenges, facilitating interagency relationships, and assistance with resolving Department policy-driven issues.

- RCCOs provided suggestions to the Department to improve care coordination efforts in the future as follow:
  - Four regions suggested that the Department work with RCCOs on improved methods for stratifying or identifying the most appropriate candidates for member care coordination.
  - Two regions noted the Department should maintain flexibility and non-prescriptive processes for care coordination.
  - Individual RCCOs suggested that the Department facilitate cross-RCCO cooperative initiatives based on shared providers or common concerns, define KPIs aligned with care coordination requirements, implement uniform terminology to refer to care coordinators across all Medicaid entities, and clearly and consistently define comprehensive care coordination expectations.
- Regions 6 and 7 stated having objectives to evaluate the quality and value rather than the quantity of care coordination processes.

Balance Between Central (Department-Driven) Priorities and Regional (Community-Driven) Priorities

HSAG used the Department-approved *Focus Topic Interview Guide* to provide a semi-structured format to solicit input from staff in broadly-defined subject areas. Variations in regional characteristics and historical development among RCCOs necessitated that the HSAG facilitator allow for flexibility in the focus and depth of discussion regarding the multitude of Department–driven and community-driven priorities in which each RCCO had engaged; therefore, consistency in discussion topics varied across the regions. Nevertheless, HSAG noted the following common themes regarding the balance between Department-driven and community-driven priorities.

- **All** regions participated in all program and project opportunities presented by the Department over the term of the RCCO contract.
- **All** RCCOs participated in additional region-specific projects, grants, and other opportunities to address community-driven priorities.
- **All** regions reported that special programs and projects in which the RCCO participated correlated with established objectives of the RCCO and were supportive of other strategies and provider or community interests in the region.
- Regions 1, 6, and 7 regularly extended organization funds to support regional programs and projects.
- Regions 2, 3, and 5 (Colorado Access) had established formal structured processes for determining, managing, and evaluating special programs and projects.

- RCCOs noted multiple criteria considered in determining the strategic priority of participating in a special program or project as follow:
  - **All** Regions except Region 1—Department priority or Department "mandated."
  - **All** Regions except Region 1—applicability to provider or partner interests.
  - Regions 1, 2, 3, 4, and 5—"good fit" with the unique needs and strategies of the region or supports the core strategies of the RCCO.
  - Regions 4 and 6—potential impact on providers, partners, or member outcomes.
  - Region 1—allows flexibility in implementation processes.
  - Region 4—promotes better integration of services.
  - Region 4—how results are measured and by whom.
  - Region 6—associated with improving KPIs.
  - Region 7—cost/benefit.
  - Region 7—local political climate.
- Most regions (the exception being Region 4) noted considering sustainability of a program in decisions as follows: Regions 1, 2, 3, and 5 stated that projects were integrated into RCCO operations and/or communities and were not dependent on grants or other programs when funding streams were discontinued; Region 6 stated that it discontinued participation based on lack of sustainability; Region 7 stated that each potential project required a sustainability plan.
- **All** regions used data to evaluate program and project outcomes. (Region 7 noted that it recognized the need to more deliberately evaluate the "value" of multiple program initiatives in which it participated.)
- Regions 4, 6, and 7 commonly implemented programs as pilot projects.
- Region 4 stated that it used special programs and projects to engage additional providers in the region.
- RCCOs noted varying challenges experienced with participation in multiple programs and projects:
  - Regions 1 and 7 noted that the meetings, applications, operational implementation, evaluation, and reporting requirements of managing multiple projects are demanding and that participants may be growing weary of multiple programs, suggesting the need for better alignment of programs and projects.
  - Regions 4 and 7 noted that providers struggle with the administrative burdens associated with oversight, monitoring and measuring, and reporting for multiple programs.
  - Regions 2, 3, and 5 noted that, while programs may be readily integrated conceptually, some programs are functionally difficult to integrate.
  - Regions 2, 3, 4, 5, and 6 noted that the prescriptive processes of the MMP did not merge well with other priorities of the organization, yet each of those regions stated that results of participation were beneficial and sustainable.
  - Regions 2, 3, 5, and 7 initially questioned applicability of its COP project.
  - Region 6 noted that the SIM program has resulted in too many practice coaches involved with provider practices.

  - Regions 2, 3, 5, and 6 noted challenges with managing reimbursement methodologies for some programs, including issues with billable services, outcome measures, and the need for significant lead time to prepare practices.
  - Region 6 noted difficulty engaging hospitals in the region to participate in Colorado Hospital Transformation Program.
  - Regions 2, 3, and 5 reported encountering contractual or regulatory barriers with implementation of innovative approaches for some programs or regional projects.
  - Region 6 noted that multiple hospital alliances had varied interests and implementation maturity, indicating the possible need for an "alliance of alliances."
- **All** RCCOs except Region 4 specifically credited the Department with having a "greater vision" for identifying statewide ACC priorities and associated opportunities for grants and participation in special programs. **All** RCCOs except Region 6 specifically credited the Department with maintaining flexibility for regional, innovative implementation of programs. Additional compliments about Department activities included:
  - Regions 2, 3, 4, and 5—mentioned responsiveness of Department staff concerning identified implementation issues.
  - Regions 1 and 6—noted Department support of the RCCO in obtaining funds for select regional initiatives as well as work on payment reform.
  - Regions 2, 3, and 5—recognized Department staff field trips to the region to stimulate stakeholders, noting that Department endorsement is important.
  - Region 1—appreciated Department assistance with barriers involving State organizations (e.g., DOC and SEPs).
  - Region 6—expressed positivity about regular meetings between RCCO leadership and the Department's ACC program manager.
- RCCOs provided suggestions to the Department regarding participation in multiple programs and projects in the future as follow:
  - Five regions suggested that the Department involve the RCCOs in strategic, structural, and implementation decisions regarding special initiatives. Two regions suggested that the Department implement a strategic planning process with the RAEs to establish overall vision, priorities, and structures for ACC development—i.e., a statewide master plan—thereby providing guidance for statewide initiatives and regional priorities. One region suggested that the Department work with RCCOs/RAEs to proactively formulate a policy-level response to changes in the national Medicaid program.
  - Four regions recommended that the Department continue to dedicate staff resources to assist RCCOs with regional issues and regularly send staff into the regions.
  - Four regions cautioned about provider and staff "innovation fatigue."
  - Three regions suggested that the Department share with the RCCOs its vision concerning initiatives.
  - Three regions stated that the Department should avoid bucketing services and requirements by pay source.

- Three regions suggested that decisions on program measures be defined up front and not evolve over time.
- Two regions recommended aligning KPIs and other measures across programs and projects.
- Two regions recommended that, during ACC 2.0, the Department establish new channels to share best practices and ideas among the RAEs.
- Two regions identified the need for the Department to address payment reform.
- Individual RCCOs suggested that the Department continue to pursue opportunities for grants and special programs; be selective with opportunities identified, and designate whether participation is optional or required; share with the RCCOs raw data from all State databases, or develop a combined program data source; align social determinants of health measures, incentives, and funding across multiple providers and community organizations—i.e., flexible pooling of shared funds; de-silo finances and functions across multiple agencies and systems; and streamline and de-silo communications with the RCCOs.

4. Conclusions and Overall Recommendations

Conclusions

Over the course of the ACC contract period, RCCOs have embraced learning experiences and challenges and have responded with many region-specific program innovations that have resulted in a statewide program that in many ways exceeds original expectations of the ACC model. HSAG believes that ACC outcomes demonstrate some rather dramatic differences between the current ACC program and traditional managed care plans nationwide. Some of the more significant characteristics that differentiate the ACC from managed care plans include that:

- Care coordination for members with complex needs has evolved into a significantly more "social needs" model than traditional medical management model.
- Successful collaborations with community organizations, agencies, and providers will serve as a solid foundation for continuing reform of many components of the health delivery system.
- Multiple grant opportunities implemented through the RCCOs have resulted in improvements in healthcare delivery mechanisms that will be sustained in the future.
- RCCOs recognize the diversity of specialized populations as an essential and increasing priority.
- Maintaining a regional non-competitive organizational model and respect for local flexibility in implementing the goals of the program have proven invaluable to the development of community-based healthcare solutions throughout the state.
- RCCOs have become a major source of previously inaccessible data needed by providers and other community partners.
- Ongoing collaborative efforts between RCCOs and the Department have been significant and largely positive and are somewhat unique to the Colorado Medicaid program environment.

HSAG's conclusions related to each specific focus area follow.

Collaboration With Community Partners

- Having successfully established relationships with SEPs, CCBs, county public health departments, and Departments of Human Services essential for care coordination and other program activities, RCCOs have also engaged in multiple locally-driven community partnerships.
- Some regions have developed extensive community partner relationships over the years that surpass those required for care coordination and have also established a strong foundation of support from diverse community organizations. These partnerships will allow for expedited responses to future RCCO/RAE objectives and for meeting the needs of populations in local communities.
- RCCOs experience an interesting rural/urban dichotomy in community and agency relationships. Rural areas tend to be characterized by lack of resources to meet the needs of Medicaid populations

in local communities. Regions with large rural populations tend to readily form collaborative partnerships due to ongoing dedication of organizations to creatively use limited resources to meet local member needs. Conversely, urban area partnerships tend to have resources, but are challenged by the complexity and size of organizations. This slows implementation of programs, with processes inclined toward being organizationally and functionally focused rather than member focused.

- Partnerships must be designed according to the needs and resources in individual communities. Coordination of care is a prevalent theme driving many partnerships, especially with other State agencies. Flexibility of the RCCOs is critical to building successful partnerships and responding to community-based needs.
- Initial lack of familiarity with the ACC required extensive educational and negotiation efforts by RCCOs to establish working relationships among organizations. In most cases, RCCOs have responded by assuming a supportive position in collaborative initiatives in order to foster positive working relationships, especially related to care coordination. However, bi-directional interagency cooperation has increased and progressed in recent years.
- Some RCCOs have generously extended RCCO funds to partners to facilitate development of needed services and programs for members, while others have provided RCCO support resources but limited funding. The flexibility of RCCOs in funding high-priority needs of communities has had a very positive impact on engaging community partners in meeting RCCO objectives and filling gaps in needed services and programs for members. Those RCCOs that have not typically extended needed funding have experienced slower growth in implementation of community partnerships and services.
- The making available and sharing of RCCO data with partners have emerged as significant and valued contributions of the RCCOs in collaborative partnerships.
- Pilot projects to test initiatives appear to be the most effective manner for RCCOs to readily implement and remain nimble in responding to community or regional priorities and shared interests. RCCOs have become disciplined in using data and other mechanisms to evaluate feasibility and sustainability of projects. Most collaborative initiatives have been successful; however, RCCOs are also carefully assessing projects in order to modify engagement as necessary.
- Transportation needs, housing issues, and improved coordination with criminal justice-involved members and agencies were the most frequently defined unresolved partnership priorities across the state.
- Although community partnerships must be locally developed, RCCOs valued the role of the Department in facilitating relationships among State agencies and in assisting RCCOs in trouble-shooting issues, the resolutions to which can be expedited by Department participation.

Provider Participation

- With isolated exceptions, all RCCOs have established provider networks that have been relatively stable over the past several years and which include a mix of FQHCs, large provider systems, and smaller independent providers. Most willing providers have been recruited; therefore, RCCOs have

increasingly emphasized strengthening relationships with the provider community and increasing the capacity for Medicaid members within existing practices—both worthy causes.

- Many providers were initially unfamiliar with the ACC program, causing RCCOs to spend extensive time educating providers.
- The primary concern of providers—both primary care and specialists—is the level of reimbursement for care of Medicaid members. Providers are inherently motivated by financial issues, and therefore are most responsive to RCCO initiatives, such as KPIs and provider financial incentives, which are oriented to increasing reimbursements for Medicaid services. Similarly, providers are highly sensitive to any actions that may negatively impact provider payments or efficiencies.
- Integrating behavioral health into primary care practices has been embraced by all RCCOs and appears to be one of the most successful endeavors for improving services for members and for improving provider practice satisfaction. Such efforts require innovation and flexibility based on variations in practice styles and community needs and resources. Provider reimbursement barriers associated with integrated BH services have been identified and need to be addressed.
- Most RCCOs have invested significant resources and expertise in robust practice transformation efforts to support providers with data, practice coaching, care coordination, and addressing individual practice concerns. Such efforts assist practices in understanding that increased efficiencies in operations can be both financially advantageous and result in increased provider satisfaction. However, these efforts are also challenged by the reality that practices deal with members of diverse payors, are unable or unwilling to change operational functions for a segment of their total patient population, and are exceedingly busy simply caring for the medical needs of patients. Some practices are also inundated by practice coaching from multiple sources.
- Common challenges that frustrate the provider experience are: continuing attribution issues, changing KPI measures, and the multitude of reporting requirements for ACC programs. RCCOs are continuously attempting to demonstrate the "value" of participating in the ACC by assisting individual practices with attribution issues and KPI performance as well as flexibly responding to individually-defined practice needs.
- It appears that all RCCOs have established positive working relationships with most of the provider community and have established foundations for continuing to build in-depth relationships with providers. It remains to be seen whether or not RCCOs' considerable investments in practice transformation activities result in actually transforming practices or building additional capacity for Medicaid members.

Member Engagement

- Most regions similarly defined "member engagement" as "members participating in their own health" and "meeting members where they are," which was most commonly implemented through care coordination activities with individual members. Region 1 expressed a more forward-thinking definition of "member engagement" as "understanding the member experience within diverse

populations," moving beyond member communications, and moving beyond being "competent" to becoming "conversant" with diverse member populations.

- In addition to care coordination for select members, RCCOs also operationalized member engagement through traditional outreach communications and materials. HSAG observed that outreach communications are primarily "push" strategies to communicate RCCO-defined messages or attain RCCO-defined objectives, with the expectation that the member will respond. HSAG suggests that these approaches may not equate to member engagement. For example, member attribution does not equate to members accessing care, member outreach communications—largely one-way messages—do not necessarily gain attention of the member or motivate the member to act, and population health programs do not ensure member response.
- In order to obtain direct input from members ("pull" strategies), each RCCO involved members in member advisory groups; however, the number of members participating tended to be limited and agendas were structured to enable member feedback on RCCO-defined objectives or communications. Several RCCOs had identified the need to move member advisory meetings or other member dialogue initiatives to various locations throughout the regions in order to broaden the opportunity for member involvement. Most regions also were increasing exploration of the needs of specialized populations through various mechanisms.
- Region 1 had recently initiated and facilitated processes to converse with diverse member populations in community-based settings to gather information regarding their perceptions and experiences with the Medicaid program. This approach most closely approximates efforts to gain a fundamental understanding of members' needs, desires, and experiences without a presumed agenda for member engagement, and has generated some "enlightening" findings.
- All RCCOs had defined specific member populations that were difficult to engage—the most common problem identified was the inability to contact members due to lack of accurate contact information.
- Several RCCOs were increasingly employing technology—texts, video, social media, or mobile phone applications—in member communication strategies. Technology-assisted mechanisms may also provide for enhanced interactive communications with members, and would appear to have significant potential in future member engagement initiatives.
- Effective member engagement requires individual member contact and interaction. Direct engagement with members must be executed at the local level to maintain the flexibility to accommodate diverse cultural and community-based environments and perspectives.
- While member outreach communications may be driven from both the regional or State level, the Department's most useful role in member engagement initiatives appears to be in distributing state-wide mass communications to members and improving its internal customer service functions for inbound inquiries from members.
- HSAG agrees with the premise expressed by some RCCOs—that true member engagement is in its infancy as a component of the ACC program. Opportunities prevail to modify traditional and long-historical assumptions regarding members' relationships with the healthcare system, their needs and interests, and what might be involved in meeting the ACC program objective of "improving the

member experience." HSAG refers to the Department and RCCOs a quote from a member advocate— "the system does not need to engage members to meet RCCO objectives, rather the RCCO needs to understand how to meet members' objectives."

Care Coordination

- Over the term of the RCCO contract, each RCCO has incorporated lessons learned and invested significant energy into improving care coordination programs—sometimes through multiple operational redesigns—to significantly enhance comprehensive care coordination for members. The original and continuing focus of the ACC on comprehensive care coordination has produced significantly sophisticated programs that are integrated with community organizations and providers.
- Members with complex needs are receiving needed services that far surpass what the primary care medical home (PCMH) model originally envisioned as the hub of care coordination for members. RCCOs have increasingly identified that the social determinants of health often play a major role in members with complex needs and have adjusted care coordination efforts to address comprehensive care coordination needs beyond the typical PCMH model. The degree to which RCCO care coordinators support PCMPs—delegated and non-delegated—appears to be a factor in effective care coordination for members with complex needs.
- RCCO care coordination programs for members with complex needs have grown significantly in size and scope since inception of the ACC. RCCO care coordinators demonstrate a high level of expertise and commitment to meeting member needs. RCCOs have hired care coordinators with varying backgrounds to act as subject-matter experts and to cross-train their teams to broaden access to that expertise. Care coordination, even in geographically dispersed rural regions, has transitioned from a telephone outreach model to a largely one-on-one, interpersonal approach with members. RCCO care coordination documentation systems have evolved to significant levels of sophistication and will likely continue to evolve to support community-based care coordination, as technology allows. Due to the fact that the RCCOs' care coordination responsibilities are applicable to the comprehensive medical, behavioral, and social support needs of members—i.e., not siloed to specific agencies or member populations—RCCOs effectively perform as the convener or facilitator among multiple care manager resources, assume the lead coordinator role, or act in a capacity of supporting agencies or providers and filling gaps as necessary. Care coordinator "teams" are commonly used to execute a care coordination plan for members with complex needs.
- In order to deliver one-on-one care coordination most effectively, most RCCOs are embedding an increasing number of coordinators in PCMP sites and community-based partner locations. This model appears to be very effective in building necessary trust with individual members.
- Delegate PCMPs continue to adequately perform care coordination of member's medical needs and related referrals in accordance with the PCMH model. However, PCMHs are typically unprepared and under-resourced to assume the full scope of ACC contract requirements related to the comprehensive medical, behavioral, and social support needs experienced by Medicaid members—especially the social determinants of health and "coordinating the coordinators" among external agencies and organizations. It appears unlikely—and perhaps even inappropriate—to expect that

PCMPs will emerge as the sole or primary source of care coordination for Medicaid members with highly complex needs.

- Regions that from inception delegated PCMPs to independently perform care coordination requirements of the RCCO contract have since developed more formalized approaches and support mechanisms for holding delegates accountable, but are expending significant resources to do so and need to continue to progress toward accomplishing RCCO care coordination objectives with particular delegates. If members of delegates are to have their comprehensive non-medical needs met, it is likely that these regions will need to increasingly provide direct care coordination services to some members to fill gaps in delegate services.
- Due to the complexity of the structure of the healthcare and social support systems in the State, complicated by members' lack of familiarity with such services and systems, it is highly unlikely that members with complex needs could successfully navigate the system without care coordinator assistance. The need for completing multiple applications and forms, following up on approvals from multiple sources, and coordinating services among agencies is significant.
- The most common challenges that repeatedly complicate care coordination for individual members are lack of housing resources, lack of SUD resources, lack of or inadequate NEMT resources, and lack of adequate pain management resources. Improvement in access to these services in all regions seems imperative.
- Despite BAAs to share care coordination information on Medicaid members, access to and coordination with mental health providers remain issues in several regions; access to and coordination with SUD providers are even more significant challenges. Perhaps some of these issues may be resolved within the integrated BH/PH structure of the RAEs.
- Members with complex needs not only consume large amounts of healthcare resources, but require extensive time, energy, and commitment of the collective care coordination team. Each RCCO will undoubtedly have to continue to evaluate the question of "When is enough enough?" and to manage the dynamic tension between limited care coordination resources and the desire to achieve ultimate success in improving the life of any individual member.
- At this point in the evolving ACC model of care, care coordination is a solidly established and effective component of the ACC and demonstrates a commitment to innovative approaches that work for members and communities in individual regions.

Balancing Department-Driven and Regional Priorities

- RCCOs consistently participated over the years of ACC operations in all major program initiatives presented through the Department, interpreting these opportunities as Department "mandates." All RCCOs had mechanisms to evaluate the value—applicable to regional strategies, providers, and partners—and operational feasibility of participating in both Department-driven and regionally determined initiatives.
- RCCOs reported that Department-driven programs and projects were largely supportive of strategic priorities of the region, and credited the Department with having a "greater vision" to identify grant

and program opportunities for RCCO implementation. The symbiosis between Department-driven programs and regional strategic priorities contributed to the relative ease of balancing State and regional projects.

- Access to additional funding resources to support regional strategic priorities enabled implementation of services for members or enhancements to the health delivery system that may not otherwise have been achievable. Most programs and projects allowed for implementation of fundamental changes within the system that would be sustained beyond the expiration of special funding sources.
- Flexibility for implementation of programs in a manner that integrates with the individual RCCO's structure and regional characteristics was essential. Implementation design of programs varied by region. Pilot programs were commonly employed prior to regionwide implementation or used to evaluate the continuing feasibility of community-based initiatives.
- While RCCOs appreciated and benefited from the opportunities presented through special programs, grants, and regionally-driven initiatives, regions were beginning to experience "innovation fatigue" resulting from the cumulative effects of ongoing management of a multitude of both Department and regionally-driven special projects. To that end, several RCCOs recommended that the Department consider a strategic planning process with the RAEs to outline the overall vision and priorities for the ACC to guide both state-level and regional-level decisions regarding special initiatives.
- Functional and operational issues associated with program implementation were often challenging and consumed extensive RCCO staff and partner implementation and support resources. Monitoring, reporting, and outcome measure requirements sometimes presented burdens for both providers and RCCOs participating in multiple initiatives. In addition, RCCOs encountered barriers to implementation in some programs—e.g., misaligned system reimbursement mechanisms for behavioral health in PCMPs, regulatory constraints for some innovative regional solutions, multiple external practice coaches assigned to support providers, and inadequate data and personnel resources to support effective integration of CJI members into Medicaid programs and services.
- All RCCOs used data and other mechanisms to monitor and evaluate program outcomes. Most regions were developing a more deliberate approach for holding all participating entities accountable and were considering a more methodical global review and evaluation regarding the value of participating in multiple programs and projects.

Overall Recommendations

HSAG provides the following recommendations related to RCCOs or to RCCO and Department collaborative processes:

- HSAG finds that internal care coordination processes for members with complex needs are exemplary and will likely continue to evolve successfully. Each RCCO will need to continue to determine and manage the balance between limited care coordination resources and members consuming a large amount of care coordinator resources—i.e., When is enough enough? RCCOs

should also ensure that members without complex needs have access to care coordination when requested.

- Each RCCO should maintain an emphasis on improving independent delegate performance. Establishing KPIs or other financial incentives that align with comprehensive care coordination requirements would likely elicit the most rapid improvement in delegate performance. RCCOs which have not already done so might consider care coordination models that pair RCCO coordinators with delegate PCMPs when members require extensive interagency coordination or social support resources as this has long been an area of challenge for independently functioning PCMHs.
- As care coordination programs continue to evolve, RCCOs and the Department might anticipate challenges and examine mechanisms to improve care coordination among LTSS providers—especially SNFs, home care agencies, and durable medical equipment (DME) providers.
- HSAG encourages continuous expansion of integrating BH services into primary care environments. RCCOs and the Department should work collaboratively to address BH reimbursement issues that have been encountered in integrated practices and to develop professional training channels for both behavioral health therapists and primary care practitioners to work effectively in an integrated environment.
- Providers most readily respond to increased reimbursement opportunities for serving Medicaid members; therefore, RCCOs should consider increasing regional provider financial incentive programs—beyond statewide KPIs—to address specific regional objectives. In addition, RCCOs and the Department should work collaboratively to streamline and minimize provider reporting requirements for participation in multiple ACC projects. The Department should involve RCCOs and providers in streamlining provider KPIs and other financial incentives and maintain consistency in measures and processes that impact provider payments.
- While member information, communications, and outreach are essential, these actions do not guarantee member engagement in the healthcare system or with their own health. HSAG encourages both the Department and RCCOs to conceptually separate outreach member communications from true member engagement.
- Each RCCO should consider defining and operationalizing member engagement mechanisms which go beyond achieving member responsiveness to RCCO objectives and move toward implementing more mechanisms for direct member involvement in providing direction to the RCCOs. Member input regarding member experiences, needs, and perceptions may more effectively engage members in the healthcare system and improve member experience with the Medicaid program. With Department facilitation, each region might be encouraged to conduct some fundamental research with members (similar to that done by Region 1) to gain a statewide perspective and better understanding of member experiences with the healthcare system before defining RCCO member engagement objectives.
- HSAG endorses RCCO efforts to implement more widely disseminated opportunities for engaging individual members throughout the regions. HSAG also supports the trend toward increasingly

employing use of technology in member communications and encourages moving toward applications that enable interactive communications with members.

- Most RCCOs have developed numerous, solid, working relationships with agencies and community partners within each region, particularly stimulated by member care coordination needs. Collaboration with other points of service is often the most expeditious and effective mechanism to address members' healthcare needs. Moving forward, HSAG perceives that, increasingly, community partnerships will be associated with addressing substantive challenges and needs within local healthcare systems. HSAG encourages all RCCOs (or RAEs) to extend financial resources, as appropriate and necessary, to support community partner initiatives that expedite program objectives as well as meet high-priority needs of members and local communities. HSAG similarly recommends that the Department maintain funding mechanisms for the RAEs that encourage sharing of RAE financial resources with community partners.
- Regarding social determinants of health, RCCOS and the Department might consider aligning measures and financial incentives across multiple community organizations, and possibly designate a flexible pool of funds to be shared among all those—providers, community organizations, and agencies—serving as participants in the provision of such services.
- Implementation issues related to multiple Department and regionally-defined programs presented the biggest challenge for individual RCCOs participating in multiple programs. HSAG recommends that the Department and RCCOs work collaboratively on pre-implementation planning at the Department level to ensure that policy-level barriers to implementation are considered and/or resolved prior to the implementation of special programs within the regions.

HSAG provides the following recommendations related to the Department:

Over the term of the ACC contract, individual RCCOs have successfully developed collaborative processes and relationships with providers, agencies, and many community partners. As a result, RCCOs and partner organizations have also identified barriers that are beyond the capabilities of individual regions to resolve and which most likely need to be addressed by the Department or at other State policy levels. HSAG anticipates that the ACC Phase II era may well be the era of major Department strategic or other planning efforts needed to address issues unable to be resolved at a regional level during the initial ACC contract period. While regions have demonstrated the ability develop collaborative relationships among agencies and other community organizations, a similar effort should be elevated to the Department level to complement and further regional accomplishments and to improve the delivery system. HSAG recognizes that completing such strategic initiatives—involving RCCOs/RAEs, State agencies, providers, community organizations, and other stakeholders as appropriate—would require intensive commitment of dedicated resources. However, HSAG also believes that such efforts may be required to significantly advance the ACC model going forward. As such, HSAG encourages the Department to seriously consider the following planning processes:

- Organize a state-level strategic planning initiative to work collaboratively with other State agencies to de-silo agency objectives, financial incentives, systems, and functions related to shared member populations, common interests, or shared responsibilities to achieve statewide Medicaid program goals.

- Work collaboratively with RAEs to develop a statewide master plan—shared vision, anticipated priorities for special programs and initiatives, and targeting pursuit of funding resources to initiate and sustain changes in the strategic direction of the delivery system. Such an effort will provide guidance at both the Department and regional levels concerning decisions on special programs and projects.
- While RCCOs have worked with many community partners to address lack of needed services within each region, the Department may need to facilitate policy-level discussions with RCCOs and community partners to examine innovative initiatives to effectively address common social support system challenges or lack of adequate resources for Medicaid members throughout the state—e.g., low-income housing, NEMT, SUD services, and pain management resources. Such issues present ongoing and repeated challenges for members, providers, RCCOs, and communities.
- Care coordination is highly localized activity; therefore, the major role of the Department to support care coordination going forward will be to continue facilitating relationships among State agencies or major provider systems (e.g., LTSS providers, mental health providers, DOC), as necessary to break down systems-level data sharing or functional barriers among coordinators. The Department might also facilitate a process to streamline interagency paperwork requirements, as significant care coordination resources are consumed by completion and follow-up of multiple applications and members cannot be expected to independently navigate these systems effectively.
- As recognized through the original design of the ACC, healthcare is predominantly community-based and varies significantly across the regions; however, RCCOs consistently acknowledged that the Department "carries weight" with providers, agencies, and community organizations and that increased presence of Department personnel in the regions is positively received. HSAG strongly recommends that the Department decentralize or allocate and deploy Department personnel with increasing frequency to participate in and/or troubleshoot issues with providers, community organizations, or RCCO staff within the regions. Presence of Department personnel in the regions demonstrates support for providers, community partnerships, and special program initiatives. Such activity would also increase awareness of the Department regarding the diversity of the statewide healthcare environment and issues.
- HSAG believes that true member engagement requires face-to-face interactions with members, most effectively implemented at the local level. However, the Department has an opportunity to embrace and promote the concept of "understanding" Medicaid members' perceptions, interests, and experiences before outlining engagement strategies or measuring member engagement. To that end, HSAG recommends that the Department review the Region 1 *Voices of Medicaid* report and consider either developing or encouraging each RCCO to replicate similar primary research with members in each region. Such a policy-level approach would advance meaningful and forward-thinking hypotheses regarding member engagement beyond conventional member feedback and communication strategies and would also assist RCCOs in expanding the meaning of "meeting members where they are."
- The Department should maintain a role in member communications and outreach through distribution of centralized program materials and Department call center communications. HSAG

supports recommendations of the RCCOs that the Department improve the quality of its call center communication operations.

- The Department should determine how to resolve existing and future attribution issues expediently or consider an alternative mechanism for increasing provider reimbursements for the Medicaid population served—i.e., disassociate attribution and provider reimbursements.
- Provider and community partner confusion regarding the ACC program required major education efforts by individual RCCOs throughout the initial ACC contract period. In order to avoid replication of such re-education efforts across RCCOs, the Department should consider dispatching Department staff to conduct, prior to implementation of the RAEs, regionally-based education regarding ACC 2.0 goals, the role of the RAEs, and any changes that impact members or potential relationships with other organizations.
- Whether through the strategic planning processes previously described or as independent initiatives, the Department should address the major issues encountered by the RCCOs in implementation of special programs and initiatives. HSAG recommends that the Department, with input from the RCCOs:
  - Pursue solutions to expediently correct inaccurate member contact information in State data systems.
  - Facilitate increased data sharing across State agencies and databases.
  - Develop a shared data resource, accessing data from all State databases to support special program initiatives and community partners.
  - Define consistent program measures and align measures across multiple programs to the degree possible.