COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Colorado Access

Regions 2, 3, and 5

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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. Summary of On-Site Discussions

Introduction and 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 promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the healthcare system and to make smarter use of every dollar spent. Serving as the primary vehicle for delivering quality healthcare to Health First Colorado members, the ACC has shown real progress in creating a healthcare delivery program for improving health outcomes and care coordination while cultivating the member and family experience and reducing costs. The four primary goals of the ACC program are to (1) ensure access to a focal point of care or medical home for all members; (2) coordinate medical and nonmedical care and services; (3) improve member and provider experiences; and (4) provide the necessary data to support these goals, to analyze progress, and to move the program forward. A core component of the program involves partnerships with seven Regional Care Collaborative Organizations (RCCOs), each of which is accountable for the program in a designated part of 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.

The State began enrollment of eligible adults through the Affordable Care Act of 2010; and ACC enrollment has grown to approximately one million members, including the Medicaid expansion population. Beginning in September 2014, the ACC: Medicare-Medicaid Program (ACC: MMP) demonstration provided for integration of individuals eligible for Medicare and Medicaid. All RCCO contracts were amended in July 2014 to specify additional requirements and objectives related to the integration of ACC: MMP members and to increase incentive payments while reducing guaranteed per member per month payments.

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. This report, focused on **Colorado Access**, documents results for fiscal year (FY) 2016–2017 site review activities, which included evaluation of lessons learned—challenges and successes by each RCCO since inception of the ACC program—related to community partnerships and collaboration, provider networks and provider participation, member engagement, care coordination, and balancing Department-driven and community-driven priorities. In addition, the Department requested a presentation by each RCCO of care coordination cases demonstrating "best practice" examples of comprehensive care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2016–2017 site review as well as HSAG's

observations and recommendations. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2016–2017 site reviews. Appendix A contains the Focus Topic Interview Guide used to facilitate on-site discussions. Appendix B contains summaries of each care coordination case presentation. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

Summary of Results

The care coordination case presentations focused on a sample of Health First Colorado members with complex needs including but not limited to members of the ACC: 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.

The Focus Topic Interview Guide (Appendix A) was used to stimulate on-site discussions of lessons learned related to the focus content areas: Community Partnerships/Collaboration, Provider Network/Provider Participation, Member Engagement, Care Coordination, and Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities. Following are summaries of results for each content area of the 2016–2017 review.

Summary of Findings and Recommendations by Focus Area

Community Partnerships/Collaboration

Lessons Learned—Successes and Challenges

Colorado Access has leveraged agency contacts developed through its multiple lines of business—three RCCOs, two behavioral health organizations (BHOs), one single entry point (SEP) (Regions 3 and 5), and Access Medical Enrollment Services (AMES). Each program has afforded **Colorado Access** contact and increasing familiarity with persons within a variety of other State agencies and community organizations. In Region 2, the RCCO, North Colorado Health Alliance (NCHA) and Weld County SEP share office space. The RCCOs' relationships with community-centered boards (CCBs) have evolved over time. Most relationships are centered around either coordinating care for individual members or participation in special programs or grants that foster interagency cooperation. **Colorado Access** has focused its engagement with other organizations on defining mutual constituents served and exploring the supportive role that the RCCO may offer in managing these members. Over the years of the RCCO, **Colorado Access** has expended considerable time and energy educating other organizations on the ACC program and functions through activities such as participation in local forums and on committees,

one-on-one meetings, conference attendance, and networking among partners to enable a warm introduction of one organization to another. Staff stated that responsiveness of organizations to RCCO priorities and projects has varied based on other organizations' familiarity with the RCCO and that, as partners understand mutual roles and goals, the level of partnership for projects and programs has accelerated. Common themes in developing partnerships have been defining shared members, sharing of data and personnel, and resource availability to support symbiotic care management referral and support systems. In addition, the RCCOs have acted as funders, conveners, and leaders for a number of special collaborative programs.

Colorado Access provided several examples of interagency activities including, but not limited to:

- Relationships with county agency child welfare programs and county criminal justice divisions (jails and courts) for collaborative care management, including collaborative care reviews.
- Relationships with public health agencies through programs such as Health Care Program (HCP) for Children and Youth with Special Needs; Healthy Communities; Nurse-Family Partnership; Spanning Miles In Linking Everyone to Services (SMILES) Dental Project; and Women, Infants, and Children (WIC) program.
- Recent "No Wrong Door" pilot project in collaboration with CCBs and human service agencies in Regions 3 and 5.
- Interagency care coordination conference organized by **Colorado Access**.
- Providing funding and leadership for health alliances in Regions 3 and 5.
- Providing funding for University Hospital emergency department (ED) care coordinators.
- Providing resources to community partners through the Colorado Opportunity Project (COP).
- Participation in Denver Social Impact Bond to provide innovative financing for supportive housing to the 300 individuals incurring the most cost in the system—a two-year collaboration of Mental Health Centers of Denver and Colorado Coalition for the Homeless.
- Providing AMES program (medical assistance site) backup to Weld County DHS.

Within Region 2:

- The RCCO and NCHA have strong relationships with the Weld County CCB, Envision, holding regular meetings and sharing care management services for members.
- Throughout the region, CCBs had initially expressed concerns about inefficiencies related to the overlap between the RCCO and CCBs; the RCCO helped the CCBs understand the supportive role of the RCCO.
- The RCCO has long hosted the Home Health Roundtable to regularly discuss multidisciplinary system issues.
- In rural areas, resources provided by SEPs and CCBs are spread thin. The SEP in Sterling, Colorado, covers nine counties; therefore, RCCO care managers provide support wherever possible to the SEPs and CCBs.

- RCCO care managers also participate in quarterly Rural Solutions meetings among the Centennial Community Mental Health Center (CMHC), DHS, public health agencies, and the RCCO to bridge relationships and address gaps in services.
- The MMP program provided the impetus for Region 2 RCCO to develop relationships with the smaller SEPs, CCBs, and community organizations, resulting in numerous formal memorandums of understanding.
- The COP provided an opportunity to engage with multiple school districts in relation to coordinating services for at-risk youth. While the RCCO has been able to integrate with school nurses to enable referral of members to the RCCO, staff stated that the Family Educational Rights and Privacy Act (FERPA) proved a barrier to accomplishing additional "much needed" collaboration.
- Staff described the implementation of interagency oversight groups (IOGs) as instrumental in understanding mutual goals and working relationships among all safety net providers in the region. Staff stated that IOGs provide macro-level collaboration, and care management provides case management planning among multiple agencies and partners.

Staff members cited that major successes in collaboration among agencies were shared data, funding streams, governance, and collaborative care coordination among **Colorado Access**' product lines—three RCCOs, two BHOs, one SEP—and county agencies associated with AMES. Staff also noted success with external community partners working with the COP, wherein COP resources can be devoted to some of these organizations. Staff stated that while relationships with human service agencies in Region 2 and Region 5 abound, additional relationships within Region 3 need to be established. In addition, staff identified that additional relationships with recreation providers, job training programs, nutrition providers, energy assistance programs, and childcare organizations will be targeted to enhance care coordination efforts. Major challenges that **Colorado Access** has experienced in developing or managing relationships with external organizations included delineating legally compliant use of shared data, achieving among community agency representatives basic understanding of the ACC program and Health First Colorado, identifying competing priorities of multiple partners, lack of sufficient resources to accomplish all that is being requested of each community partner, and **Colorado Access**' ability to structure internal resources across three regions while remaining sensitive to the unique agency and community environment in each region.

Colorado Access provided examples of lessons learned while developing collaborative community partnerships, including that:

- Language used in communications is very important—terms such as "transforming system" are perceived as threatening by other agencies
- Various State agencies (e.g., Healthy Communities and SEPs) appeared overwhelmed with tasks and commonly perceived that the RCCOs "had the money" and that contract responsibilities were duplicated. RCCOs were most successful defining their roles as supportive and complementary to the activities and responsibilities of other organizations, mutually serving communities and members.

- The Department's definition of "mandatory partners" gave RCCOs an increased footprint in the Medicaid system and exposed the RCCOs to numerous additional organizations.
- The RCCOs need centralized Department-level support with interagency contracts and agreements and legal assistance—that is to say multiple lawyers for each agency and organization complicate and slow collaborative processes; the executed agreement between the Department and Department of Corrections (DOC) was essential; moving the SEPs, CCBs, and Healthy Communities to Department oversight was very advantageous. In addition, while providing technical assistance to local public health agencies (LPHAs) regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA)-related concerns, **Colorado Access** identified that this information, and ongoing support for LPHAs, may be more efficiently leveraged at the state level versus RCCO level so that RCCOs do not have to repeat the process with each LPHA.

The RCCO's per member per month (PMPM) funding model may not be the most effective platform for rural providers. The typically small size of their ACC panels does not generate enough additional funding to sustain the enhanced staffing, infrastructure, and resources necessary to help foster transformation and address the challenges of scarce and financially-strained resources in rural health care. **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 and provide access to the Benefits Utilization System (BUS); facilitate the Medicaid benefits cross-walk project; and troubleshoot non-emergency medical transport (NEMT) issues. **Colorado Access** also acknowledged support of the RCCOs' pilot project proposals to enable funds for exploring mechanisms to get special programs "off the ground." Staff members offered the following recommendations for future Department support for ACC partnerships:

- Continue working at the macro level to facilitate interagency collaboration. **Colorado Access** suggested that integration with the Colorado Department of Education might be essential to address FERPA barriers and enable RCCOs to provide member services within the schools. Staff stated that the number of school district touch points is not manageable by each RCCO alone, and would inhibit the potential benefits of the COP.
- When working at the macro interagency level, the Department should explicitly define the system-wide issues to be addressed at the State level versus those issues that are local RCCO expectations; and RCCOs should be measured and evaluated based on issues within their control. Ultimately, the ACC needs strategic alignment with all State agency partners.
- Continue deliberate work to enhance information and data sharing among organizations, including access to state-controlled databases, access to user-friendly shared records, and access to BHO information by EDs.
- Acknowledge the need for and define payment reforms that are customizable to the diverse geographies of various regions.

- Continue to dispatch Department personnel to work with the RCCOs within local communities, demonstrating Department visibility and support for locally-defined healthcare challenges.

Observations and Recommendations

Colorado Access has utilized relationships developed over the years through its multiple lines of business to inform and enhance working relationships with SEPs, CCBs, public health departments, and county agencies, as well as community organizations associated with those agencies. Establishing these relationships has been motivated by mutual goals of care management for shared clients and of positioning RCCOs in supportive roles related to other agencies' care management responsibilities and activities. In addition, **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. Initial challenges to partnership development were based on lack of understanding of the ACC program and its role with Medicaid members. As partners have increased their understanding of the purpose and role of the RCCOs, the level of partnership activities has increased. It appears that each partnership seems to open the door to opportunities with additional community partners. With all that has been accomplished, **Colorado Access** recognizes that much work remains in exploring and developing community alliances in every region. **Colorado Access**, having learned many lessons over time regarding the ability to manage within a collaborative environment, described primary challenges as data sharing barriers among agencies and the need for the Department to facilitate macro-level interagency relationships statewide. Related to collaborative care management for individual members, **Colorado Access** cited numerous examples of collaborative programs involving community partners and appears to have achieved success within every region related to collaborative care management for individual members. Based on **Colorado Access**' suggestions for Department activities to support collaboration among organizations, HSAG observed that the priorities for future Department activities should include continuing to facilitate macro-level interagency relationships, deploying Department staff to engage with partners within each region, continuing work to facilitate interagency data sharing, and identifying payment reforms that allow for flexibility to financially support community- and region-specific cooperative initiatives.

Provider Network/Provider Participation

Lessons Learned—Successes and Challenges

Colorado Access initiated early provider network development by capitalizing on its provider relationships associated with the Child Health Plan *Plus* (CHP+), previous Medicaid, and Medicare lines of business, with particular emphasis on the federally qualified health centers (FQHCs). Initially, primary care medical providers (PCMPs) were reluctant to join because of lack of understanding the RCCO program and past difficulties with the Medicaid program. However, for those practices that already served a large Medicaid population, the PMPM financial incentive was—and continues to be—perceived as a positive stimulus to gain additional reimbursement for members that those practices were already serving—i.e., "just give us the money." **Colorado Access** invested considerable time and

resources to educate providers on the RCCO program; and as the depth of understanding of the RCCO's role and initiatives of the program increased, PCMP recruitment gained momentum. During the first several years of the program, contract managers for each region were charged with face-to-face recruitment and education of potential PCMPs. The expansion of the Medicaid population over time made the RCCO a more significant presence in provider practices. **Colorado Access** noted that the region-specific differences in the evolution of the PCMP networks were as follows:

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, NCHA, and major primary care providers (PCPs) in the Greeley area. The contract with Banner Health physicians required considerable energy as the relationship with Banner Health system required corporate-level engagement. Following two to three years of building the network in the rural areas, the RCCO had succeeded in establishing one or more PCMPs in every county. Further expansion of the network has not been aggressively pursued; several providers have been approached repeatedly and are "unmovable" in their lack of motivation to join the RCCO. Despite the anti-government political attitudes and geographic challenges prevalent within the region, the RCCO continues to work with community consortiums 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 diverse populations, with a considerable refugee population (over 200 languages spoken) and a general lack of health services of any type. Arapahoe and Douglas Counties include some of the wealthier metropolitan neighborhoods with growing populations. In recent years, providers—including large facilities—have expanded into these counties, resulting in robust development of healthcare services; however, most providers in these counties are focused on serving non-Medicaid clients. Provider recruitment in the region required a customized approach to establish the RCCO's value to each practice and to encourage practices to expand their Medicaid populations through the support services and programs that could be provided through the RCCO.

Region 5—Limited to Denver County, the inner-city Medicaid population tends to access services through established providers of the underserved—e.g., Denver Health Medical Center, Colorado Coalition for the Homeless, Stout Street Clinic, and Clinica Tepeyac—with the largest number of RCCO members attributed to these PCMPs. The relationship with Denver Health took some time to evolve as the competition with and confusion over member attribution associated with the Denver Health Medicaid Choice managed care program were resolved. In addition, this relationship required extensive exploration by RCCO staff to determine appropriate working relationships within the complexity of the Denver Health system.

Colorado Access expressed that current provider networks appear to be sufficient to serve the populations of each region and that **Colorado Access**' focus has shifted to building more in-depth relationships with existing network providers. Major areas of provider involvement include:

- Providers regularly attend quarterly provider meetings in all regions. **Colorado Access** continues to provide education on RCCO initiatives, enhanced primary care reimbursement opportunities, and

key performance indicators (KPIs). In 2016–2017, **Colorado Access** is establishing a regional governance council in each region, through which key providers—PCMPs, BHO providers, and hospitals—will participate in strategic decisions guiding RCCO priorities within that region.

- Within Region 2, RCCO staff continue to travel to multiple community-based sub-regions to discuss RCCO initiatives and to support local concerns regarding the financial sustainability of healthcare providers and services for members. The RCCO has been organizing and participating in community multidisciplinary consortiums to increase providers' involvement in the RCCO. Staff members described that the primary focus in the rural communities is "anything the RCCO can do to facilitate financial survival" of healthcare providers and to improve the overall health of people in the community. To that end, staff provided examples of assisting in implementation of population health initiatives—e.g., cancer screenings and education, assisting communities with improved NEMT services, and expanding telehealth in the region.
- Within Regions 3 and 5, staff categorized provider involvement as follows: (1) some providers lack interest in increased involvement with the RCCO, considering serving the members to be enough; (2) some providers want to be more involved (although not yet delegate-ready), seeking more knowledge and understanding, and generally interested in delivering overall better health to members; (3) some practices are actively invested in data and KPIs, participating in new RCCO initiatives and assuming increased responsibility for managing patients within the PCMP.
- All regions have several PCMPs delegated to perform care coordination for RCCO members and demonstrating ability to adequately manage comprehensive care from within their practices. These practices tend to be the larger providers with the resources and systems in place to respond to the Department's comprehensive care coordination requirements.
- Most providers now value the support the RCCO can provide to support their mission of taking care of the underserved, connecting their members to community resources, bringing data to practices to enhance their performance, assisting practices with attribution and reimbursement issues, and improving services within their practices—e.g., integrated behavioral healthcare.

Colorado Access characterized lessons learned over time by providers and the RCCO as follows:

- Providers initially perceived participation in the RCCO as a mechanism to obtain additional funds for the care of Medicaid members and were frustrated by the inaccuracy of member attribution because it affected their payments. **Colorado Access** spent considerable energy helping providers understand and accept the accuracy of the attribution data.
- Early adopters, such as FQHCs, perceived themselves as high-functioning Medicaid providers that were "infallible" in providing services to Medicaid members. When attribution data, underperforming KPIs, or inadequate care coordination risked lowered payments to the practice, these providers recognized areas for improvement that they might not otherwise have considered. Partnership with the RCCOs proved instrumental in identifying and addressing these issues, leading to improved performance.
- **Colorado Access** recognized that the RCCOs were a unique resource for data and information regarding Medicaid fee-for-service members.

- **Colorado Access** recognized that practice support services had to be applicable to all patients of a practice and could not be segmented for Medicaid members.

Colorado Access progressively adjusted internal resources to support practices through initiatives designed to help providers succeed in achieving performance that would maintain or maximize financial incentives. These included:

- Overcoming provider struggles with Statewide Data Analytics Contractor (SDAC) data by enhancing **Colorado Access**' information system capabilities to produce data that providers could and would use.
- Providing staff resources to train and support providers in complex care coordination requirements and establishing more formal linkages with other State agencies and community resources for social support needs of members.
- Working with acute care providers and specialists to improve access for Medicaid members through techniques that help members be more prepared for a specialist visit and guaranteeing that members have the commitment and resources—e.g., transportation—to keep appointments.
- Investing over the past two years in developing alternatives to access specialty care, such as telehealth and behavioral health integration into PCMPs.
- Introducing grant-funded programs and other initiatives—State Innovation Model (SIM), Comprehensive Primary Care Plus (CPC+)—to providers to enhance practices and member outcomes and to provide financial reward.
- Working with the Department to streamline reporting requirements and align performance measures to simplify provider requirements and enhance performance payments to providers.

Within the last two years, **Colorado Access** has restructured its internal provider relations and practice support program and personnel to correspond to the emerging needs and interests of providers and to transition to one central support department for all providers, regardless of product line. RCCO contract managers are no longer responsible for direct provider recruitment, contracting, or provider relations. 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. It is the responsibility of the assigned provider representative to be the "door" between the practice and the other resources and expertise available throughout **Colorado Access**, and it is the responsibility of the organization to determine how to provide needed resources to a practice. This strategy is the most current phase in evolving practice transformation strategies offered by **Colorado Access** over the life of the RCCOs—initially through contracts with HealthTeamWorks and Colorado Children's Healthcare Access Program (CCHAP), which offered modules for physician education, later replaced by an internal practice transformation team and practice coaching no longer being assertively deployed into practices. (Staff members noted that some providers already have multiple practice coaches available through other resources.) **Colorado Access**' objectives are to be provider supportive while respecting the many other agendas that exist within a practice, to simplify communications with practices, and to improve efficiencies for both providers and **Colorado Access**.

Staff members stated that the Department has successfully supported RCCO providers over the years by: recognizing the primary care medical home as the center of the ACC and reinforcing this concept through the PMPM and other financial incentives for care of Medicaid members; respecting the individual RCCO's role in working with its providers; maintaining a collaborative relationship with the RCCOs and being responsive to provider concerns; moving KPIs to the provider level; and introducing new programs and funding opportunities that align with RCCO objectives—e.g., SIM, CPC+, MMP, Access KP. However, staff also stated that lack of Department prioritization in multiple projects presented to providers and lack of coordination among different State initiatives' measures, outcomes, deliverables, and processes has resulted in much additional work and "innovation fatigue" for practices already short of resources to care for patients. **Colorado Access** encouraged the Department to continue to work toward better alignment of initiatives and measures and more innovative reimbursement methodologies, noting that outcome measures require long-term commitments in order to be effective. Staff also stated that providers are frustrated by the inability of RCCOs to control Medicaid benefits or the way services are paid in a fee-for-service environment, suggesting the need for the Department to consider future payment reform methodologies.

Observations and Recommendations

After using its pre-existing relationships with providers in all regions, the base of FQHC providers, and the incentive of the PMPM to initiate the provider networks in all regions, **Colorado Access** has transcended to working with existing providers to develop the depth of its relationships and initiatives with the providers. **Colorado Access** is now focusing on providing value to practices through RCCO support services. Value-driven services include improvement in data usable for providers and helping practices improve performance in areas that enable enhanced reimbursement or reduce burden and costs associated with caring for Medicaid members. As providers have learned more about the purpose and scope of the RCCOs, many have exhibited interest in becoming more involved in RCCO initiatives and services, either to improve services to their members or to engage the RCCO to help resolve problems in their practices or healthcare communities. While each region experiences unique challenges with diverse providers and interests, financial return and sustainability are the uniform interests and primary focuses of all providers participating in the ACC. Each region has implemented a variety of strategies and opportunities to give individual and collective providers a voice in the Medicaid program and RCCO initiatives. Both providers and **Colorado Access** have learned lessons over time regarding provider concerns and interests—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. Through multiple programs, projects, resources, and support offered to providers, it appears that all regions have established positive working relationships with the provider community.

Member Engagement

Lessons Learned—Successes and Challenges

Colorado Access' philosophy of member engagement is to "meet members where they are," providing them voice in their own healthcare and to provide opportunities for member input into the organizations' member engagement mechanisms. The goal is to support member self-determination in personal health and well-being at the level most comfortable for each member. This philosophy is operationalized through customer service and care management contacts with individual members or engaging with the member at the provider point of service, such as during an emergency room (ER) or PCMP visit. At a mass communication level, **Colorado Access** uses outreach member communications such as newsletters, interactive voice response (IVR) calls, targeted mailings, website communications, and community-based events to distribute information that the health plan considers meaningful for members. **Colorado Access** also uses data to stratify member populations for targeted outreach—e.g., population health initiatives or care management. Many member engagement activities over the years have been associated with the RCCO's objective to attribute members to a PCMP in order to get them connected to the system using mechanisms such as customer service contacts, IVR campaigns, ED diversion programs—e.g., follow-up calls to members who have frequented the ER, special programs with University Hospital and Banner Health EDs—or engaging members at community contact points such as homeless shelters, health fairs, or social events.

Colorado Access has also implemented a variety of approaches to obtain feedback from members regarding their needs or perspectives on how **Colorado Access** might improve engagement with members. These approaches include member/family advisory boards that meet regularly in each region, member representation on boards and committees—specifically the Department's Performance Improvement Advisory Committee (PIAC) and the **Colorado Access** Quality Performance Advisory Committee (QPAC)—as well as forms distributed at each point of member contact—e.g., member advisory meetings, community outreach activities and events—to survey members on what is important to them. Trends in member feedback are gathered from all organizational points of member engagement—e.g., customer service, care management, member surveys—and reviewed at the PIAC committees as a standing agenda item.

Staff members described that member/family advisory board meetings in Regions 3 and 5 are held at a hotel and have grown to approximately 200 participants, 10 percent of whom are estimated to be new members each meeting. **Colorado Access** advertises the meetings through major providers and invites members through the newsletter. The meeting is a town-hall forum with a guest speaker on various topics; updates to members on RCCO activities; and structured feedback through the town-hall format, written feedback forms, or quasi-focus groups. Due to high participation of members with limited English proficiency, language interpreters with headsets are used to simulcast communications. Member feedback identified the following trends in member needs: issues with bus transportation, access to medications, care management needs, and dental service needs. Feedback from survey forms is forwarded to appropriate departments within the organization for follow-up.

Due to the widespread geography of Region 2, member advisory board meetings are held in six sub-regions (organized by county groupings). The Region 2 outreach strategy also includes use of a mobile van to participate in community events and offer services within local communities across the region; examples included the Greeley Stampede and introducing the COP project in Yuma County with information on the Women, Infants, and Children (WIC) and other public health programs. Staff described local community events as excellent opportunities to directly interact with members within diverse local communities. Member feedback identified the following trends in member concerns within the rural areas: lack of transportation, member privacy issues in small towns, lack of specialty care, and gaps in behavioral health services.

Colorado Access has invested increasingly in population health initiatives to engage members in participating in their health. **Colorado Access** uses claims data and input from staff epidemiologists to identify high-priority health needs and obtains input from member representatives on preferences from the member perspective. In 2016, all RCCOs conducted a major cancer screening and prevention education campaign to engage members to obtain specific cancer screenings and tracked results to determine if "members obtained suggested screenings or services." **Colorado Access** is also considering the most effective member outreach mechanisms to increase well-child visits. **Colorado Access** recognizes these to be prescriptive RCCO objectives rather than member objectives, but considers population health to be an important area of member engagement.

Colorado Access is also 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 provider-based collection of information from culture-specific members who tend to congregate within select geographies and provider practices. Due to the large attendance at the Region 3 and Region 5 member/family advisory board meetings, **Colorado Access** is considering scaling down the size of the meetings to include select representatives to provide input on specific RCCO initiatives and member communications. Region 2 recognizes that it will continue to have challenges with any forums for member engagement due to the widely dispersed geography of the region.

Staff members stated that learning experiences related to member engagement over the last several years have resulted in:

- Changing and increasing mechanisms for effective member communications.
- Creating more and varied opportunities for member participation and feedback.
- Growing appreciation of the varied perspectives and strategies necessary to engage diverse populations.
- Moving to an external community-based emphasis for member engagement activities.
- Recognizing that members may be engaged at multiple touch points in the system, resulting in the need to integrate member engagement opportunities across all lines of business—e.g., piloting a project to integrate **Colorado Access**' medical assistance (enrollment) sites as a source of interaction with members to distribute information and gain information about members and integrating care management across all lines of business.

Staff members stated—citing examples of the homeless population, CCB members, and members listed with incorrect contact information—that specific member groups remain difficult to engage in RCCO initiatives. Staff also stated that regular participation of members in member engagement committees and surveys has become a burden for some members, who are "being asked to do a job" without any reimbursement or financial incentive. As Department expectations for member engagement increase, **Colorado Access** suggested that the Department could be helpful by providing guidance to the RCCOs regarding the high priority areas of member engagement as well as any legal or regulatory guidelines related to reimbursement of members for time and expenses.

Staff members expressed that Department-level strategies for direct member input—such as the State-level PIAC—are limited by geographic challenges and cost issues for members. However, staff suggested that future opportunities for the Department to support RCCO member engagement activities might include:

- Creating an opportunity to share statewide the member feedback trends or survey information obtained within individual regions.
- Incorporating input from the RCCOs into Department member engagement initiatives. Improving coordination among RCCOs regarding member engagement strategies and activities.
- Mapping out all levels of member input.
- Exploring options to resolve statewide issues with member engagement—creating an information technology solution to clean up and maintain current member contact information across system-wide databases.

Observations and Recommendations

Since inception of the RCCOs, **Colorado Access** has maintained multiple mechanisms for outreach and communications with members as well as member involvement and feedback mechanisms related to **Colorado Access**' initiatives. **Colorado Access** has experimented with and evolved its member engagement strategies over time based on lessons learned by tracking member responses to outreach activities and regularly surveying members at various points of member contact. Member engagement approaches vary by RCCO region according to unique challenges—Region 2 has adjusted its strategies to accommodate its wide geography; Region 3 and Region 5 have each adjusted to accommodate wide ethnically diverse and other special populations. Many member engagement activities and communications over the years have been based on RCCO-defined objectives—e.g., *we want* you to self-determine how you will engage in your health and well-being; *we want* you to be attributed; *we want* you to avoid using the ED, *we want* you to understand the RCCO and its programs—and have involved many traditional "push" strategies—i.e., newsletter, outreach calls, customer service contacts, meetings with members to discuss RCCO-defined topics, and preventive care campaigns. However, **Colorado Access** has evolved its goals of member engagement to include "meeting our diverse members where they are and giving them a voice in their own health and within **Colorado Access**." To that end, **Colorado Access** has implemented more "pull" strategies—obtaining feedback from members through open-ended surveys and feedback forms at multiple points of contact, providing more wide-spread opportunities for members to participate in member/family advisory meetings, and interacting

with individual members through community-based events and care management—which have identified trends in member-defined needs and concerns that are considered in **Colorado Access** initiatives. HSAG encourages **Colorado Access** to continue its emphasis on creating opportunities to truly give members a voice in defining and addressing member priorities as opposed to RCCO priorities.

Care Coordination

Lessons Learned—Successes and Challenges

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**' operations related to care coordination activities at both the **Colorado Access** and delegate levels have continuously evolved over the past several years, improving processes in response to identified challenges.

Delegates

Colorado Access' philosophy at the inception of the RCCOs was that care management for individual members was best provided within the primary care medical home whenever possible. Care coordination delegates were originally determined 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 with providers. Delegates were expected to independently provide adequate care coordination for members with very limited interface with **Colorado Access**. However, early external audits of delegates' complex care coordination cases identified that delegate care coordination processes varied widely among delegates in member stratification and identification of members for care coordination, care coordination documentation systems, member needs assessments, and depth of care coordination interventions. Delegates commonly interpreted care management as managing referrals within the healthcare provider system and often lacked resources to adequately address social determinants of health.

As a result, in 2014, **Colorado Access** modified its delegate program. A pre-delegation assessment was developed to better assess the appropriateness of delegating complex care management to a PCMP, and care management agreements were updated to: more clearly outline expectations for care coordination aligned with the Department's care coordination requirements, outline reporting responsibilities, and address **Colorado Access** oversight processes. **Colorado Access** organized staff resources to support existing delegated entities with training and consultation to help delegates "grow into" meeting contract expectations. **Colorado Access** conducts annual on-site review and case audits of each delegate to provide feedback and consultation to individual delegates. Delegates are engaged in quality improvement processes and meet regularly in all regions to share best practices. In addition, **Colorado Access** identified areas in which the RCCO could best support gaps in delegate processes by improving

data sharing and information to delegates and by providing guidance and navigation through the system for individual members with complex needs.

At the time of on-site review, both internal **Colorado Access** staff and structures and delegate participation had been enhanced to meet the commitments and expectations regarding complex care coordination to members. Staff reported that significant improvements have been made by delegates and that **Colorado Access** is supporting delegates with connections to other non-medical resources.

Internal Care Coordination

Colorado Access has internal care coordination staff which provide care coordination for approximately 60 percent of RCCO members in its three regions. In addition to the RCCOs, **Colorado Access** has multiple lines of business which also require some form of care management—including CHP+, BHOs, and SEP. At the inception of the RCCO contracts, **Colorado Access** determined that delegating care management to its FQHC and large practice providers was a better alternative than hiring a large centralized staff to support care coordination throughout the regions and therefore maintained a small team of RCCO-dedicated care coordinators. Midway through the RCCO contract period, **Colorado Access** gained both an additional contract for BHO services in Region 2 and the SEP contract for the Denver metropolitan area. As Medicaid enrollment expanded, **Colorado Access**' geographic scope expanded, and the comprehensive nature of RCCO care coordination expectations were better understood, the care management staffing requirements across all lines of business grew exponentially. Similar to the delegates, **Colorado Access** experienced difficulties in the early years of RCCO operations related to effective data-driven stratification methodologies to identify members requiring care management—SDAC data was not timely; and clinical risk groups (CRGs)—based on a physical health/behavioral health diagnosis model—proved inadequate for directing members to the appropriate care coordination team. In addition, admit, discharge, and transfer data were not available from all hospitals. **Colorado Access** progressively explored several data manipulation methodologies and data system enhancements to ultimately define effective predictive modeling capabilities. Care management documentation systems were also initially inadequate to support the comprehensive care coordination requirements for RCCO members. All of these infrastructure challenges resulted in several phases of reorganization of **Colorado Access**' internal care coordination structure as follows:

- Phase One (early years of the contract)—**Colorado Access** care management was provided primarily by generalist care coordinators performing only telephonic interventions, with no identified focus on specific populations. This was a "one size fits all" approach with no delineation of interventions, limited person-centered care planning and goal setting, and minimal ability to connect care management interventions to outcomes.
- Phase Two—The care management model changed 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. **Colorado Access** implemented a transitions of care team assigned to work with select hospitals and follow up

regarding members' discharge planning needs. While this transition phase allowed for a more data-driven approach to risk stratification and targeted outreach, it also resulted in member confusion and operational inefficiencies due to multiple care management staff assigned to the same member across programs.

- Phase Three—In 2015, **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, assign integrated care teams to members according to their level of need, and implement interventions based on individual member-focused needs and goals. Implementation of this model requires extensive cross training of care management staff; therefore, transformation has been introduced in an iterative manner, with each step being thoughtfully planned and monitored. Staff stated that the "maturity model" allows for flexibility in implementation decisions and will be progressively evaluated and adjusted as necessary. At the time of on-site review, **Colorado Access** described the status of implementation as follows: development and rollout of training modules for care management staff; implementation of a RCCO/SEP team for MMP members, and progressing to organization of a BHO/SEP team; cross training of telephonic-based coordination teams that assist in lower-level interventions; adaptation of the transitions of care model to include a hospital visit, home visit, and PCMP visit within 30 days of discharge; collaboration with **Colorado Access**' population health department; partnering with external vendors for targeted outreach to members for population health initiatives, education for proper emergency department utilization, and attribution to primary care providers; and implementation of mechanisms for care management monitoring and quality improvement.

Within Regions 3 and 5, **Colorado Access** has also embedded care coordinators in strategic clinical and non-clinical provider sites, including Denver Health, University of Colorado Hospital, Fort Logan, and the Denver Housing Authority. The Region 2 Northeast care management team is configured to address medical, behavioral, and social determinants of health through a five-member team that includes RCCO and BHO care managers and is assigned to members based on geographic considerations. The rural nature of the region has enabled personal relationships with SEP care managers throughout the region for integrated care management as necessary. Similarly, the NCHA team, supporting Weld County PCMPs is readily integrated with the Weld County SEP due to shared office space and long-term working relationships.

All regions identified that the homeless population, members with substance use disorders or both physical health and mental health needs, and members with low engagement or motivation levels present especially difficult challenges for care coordinators. Staff stated that comprehensive screening and further understanding of the social determinants of health have assisted care management staff in engaging and developing trust with these member populations.

Staff members stated that the Department has exhibited patience and responsiveness to **Colorado Access**' questions as the health plan has continued to improve care coordination through several iterations of restructuring internal processes. Staff members also commended the Department for having the foresight to develop the SDAC database, which has been essential for understanding the fee-for-service population; however, the historical data characteristics of SDAC presented many challenges for

identifying members appropriate for care coordination. The Department's assistance in gaining access to CORHIO data was essential to enabling **Colorado Access**' implementation of an effective transition of care program for members. Staff 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.

Observations and Recommendations

HSAG observed, through **Colorado Access**' on-site presentation of 15 care coordination cases, the following trends:

- Profile of member types: 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 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 ED.
- All cases included arranging referrals, 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.
- 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 member.

Over the RCCO contract period, **Colorado Access** has experienced several infrastructure challenges with care coordination for RCCO members, primarily as a result of initial assumptions regarding the capability of PCMPs to perform delegated care coordination and **Colorado Access**' desire to effectively and efficiently organize staff resources across **Colorado Access**' multiple lines of business. In response to multiple lessons learned, **Colorado Access** has progressively evolved through several models of care coordination within the organization, particularly in relation to Regions 3 and 5. While the current phase of organizational transformation has been in process for nearly two years, **Colorado Access** has methodically progressed toward its goals. In order to minimize disruption to operations and maintain varying care management requirements of its numerous lines of business, **Colorado Access** is

evaluating each implementation step ongoing, and will adjust its implementation strategy accordingly. Meanwhile, the expansive geographic and rural characteristics of Region 2 presented challenges that required it to uniquely configure resources to respond to that region's needs. As in most rural regions, the general scarcity of resources requires that care coordinators collaborate with other agencies and community providers to innovate solutions for individual member needs. In response to the need to nurture the delegated entities toward successful execution of the complex care coordination requirements of the Department's contacts with the RCCOs, **Colorado Access** organized internal staff resources and developed more structured processes and contracts to support delegates. Staff reported that delegates have made significant improvements in care coordination for members with complex needs. **Colorado Access** also has made significant progress in data-driven supports for 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.

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

Lessons Learned—Successes and Challenges

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** described examples of Department-initiated programs in which it has participated, which included (but are not limited to): The Colorado Opportunity Project (COP), State Innovation Model (SIM), Comprehensive Primary Care (CPC) multi-payer initiative, Colorado Department of Public Health and Environment (CDPHE) cancer prevention initiative, Community Health Works (health disparities), Medicare-Medicaid Program (MMP), Extension for Community Healthcare Outcomes (ECHO) e-consult program, enhanced PCMP factors, Healthcare Equality Index (HEI) assessment, and Client Over-Utilization Program (COUP). **Colorado Access** assigned a RCCO team dedicated to assessing each proposed program and its applicability as it related to priorities of the RCCOs. Changing priorities are managed through this team in order to have a clear and consistently defined unit of accountability. **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**. If considered an asset, the project is referred to an implementation team. Over time, **Colorado Access** developed a shared resource matrix model to identify the administrative and practitioner resources and support required for each program as well as existing overlap among programs. Staff stated that most Department initiatives have been conceptually—although not always functionally—easy to integrate with RCCO strategies. **Colorado Access** has learned over time that consideration of the way an "opportunity" is structured—i.e., reporting responsibilities may deter provider participation unless the RCCO can alleviate the burden for providers, how special program services can be billed or otherwise reimbursed by Medicaid—is another important factor in decision-making.

Colorado Access uses data to track results of all project activities, including return on investment (ROI) of each program. Results are analyzed through regular reporting to the **Colorado Access** leadership team. Data analysis of results are used to assess sustainability of programs to be supported through the RCCO once the grant funding or term of the project expires. However, staff acknowledged that some results are easier to track and measure than others and that some evaluation considerations are strategic. For example, staff stated that the MMP program has instigated immersion of staff into the long-term services and supports (LTSS) environment, which will be beneficial to future activities. The SIM program propelled the integration of physical and behavioral health and the development of telepsychiatry to improve member outcomes. The COP program allows the RCCOs the opportunity to explore how Medicaid dollars may be used in non-traditional ways to support the costs of social determinants of health. Many of the concepts and processes realized through special programs will be retained within the RCCOs regardless of continuation of funding.

Staff members cited MMP as the first program which 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. However, staff stated that the Department's MMP staff members were very responsive and transparent concerning identified issues and demonstrated the Department's commitment to "make things work." They also noted that field trips to the regions by Department staff were instrumental in stimulating stakeholder involvement. Conversely, the SIM program, which supported integration of behavioral health into primary care, was not at all prescriptive and left **Colorado Access** questioning the expected role of the RCCOs in the program. (Going forward, **Colorado Access** will assist with practice transformation to accommodate altered work flows within an integrated practice. The RCCOs also anticipate potentially aligning substance abuse treatment with primary care.) Staff members noted that other challenges with managing multiple projects include managing the reimbursement methodologies—e.g., paying for outcomes, but measuring processes; defining billable services (e.g., no billing codes to directly bill for behavioral health interventions in primary care practices, and on-site clinical pharmacy services not being reimbursable); and RCCOs seeing opportunities to do things differently to achieve outcomes, but possibly encountering contractual and regulatory barriers.

Despite these challenges, **Colorado Access** credited the Department with having "a greater vision" to identify projects necessary to push RCCOs forward. Staff also stated that, within Region 2 and Region 3, having the Department's endorsement of projects elevated the importance and priority level of the program. Within Region 2, the Department's approach of outlining goals while allowing innovation and creativity at the community level was considered critical. Staff members offered the Department the following recommendations concerning the balance between Department-driven and regional RCCO priorities:

- The Department should continue to dedicate staff resources to assist the RCCOs through special project implementation and ongoing questions or concerns.
- Gaining a better understanding of the Department's vision concerning participation in select programs and initiatives will assist the RCCOs in establishing priorities.

- Broader participation of RCCOs in initiatives that involve the multi-payer environment may enhance successful implementation and outcomes, including clarification of which entity is the payer (i.e., the Department, the BHO, or the Regional Accountable Entity (RAE).
- Program services and requirements should not be "bucketed" by pay source.
- The Department should determine whether or not it is going to be "prescriptive" in methodologies and requirements, then remain consistent in its approach.
- Measures for evaluation and monitoring should not evolve over time. Decisions regarding measures should be made up front so that data can be gathered from the inception of a project.

Observations and Recommendations

Colorado Access has participated in most initiatives and programs that have been presented to the RCCOs by the Department. **Colorado Access** has established 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. Staff acknowledged that even when **Colorado Access** initially questioned the applicability of a specific program to RCCO objectives—e.g., MMP, COP—the knowledge gained and results of participation proved beneficial and sustainable. **Colorado Access** also credited the Department with having a "greater vision" regarding selection of Department-driven initiatives to complement the goals of the ACC. **Colorado Access** identified that managing varying reimbursement methodologies, reporting requirements, and evaluation measures were some of the challenges of integrating multiple initiatives through the RCCOs. Staff also warned of risk of provider and staff "innovation fatigue" (see "Provider Network/Provider Participation" section). **Colorado Access** had several suggestions for the Department to improve the balance between Department-driven and RCCO priorities, including broader participation of the RCCOs in Department strategic and structural decisions regarding special programs and initiatives.

Overview of Site Review Activities

The FY 2016–2017 site review represented the sixth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **Colorado Access** as the RCCO for Regions 2, 3, and 5. During the initial six years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2016–2017 site visits focused on evaluating RCCO experiences and lessons learned related to diverse ACC stakeholders and regional characteristics—including community partnerships, provider participation, member engagement, and integration of multiple Statewide and regional priorities. In addition, HSAG gathered follow-up information on care coordination activities and strategies implemented by each RCCO. Through review of member care coordination cases, HSAG documented examples of RCCO-selected "best" cases of comprehensive care coordination. The Department also asked HSAG to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the Focus Topic Interview Guide and coordination of care case summary tool. The purpose of the site review was to explore with each RCCO the "lessons learned" since the inception of the ACC program regarding each focus topic—including changes over time, influence of recognized challenges and successes on RCCO operations, and the role of the Department in influencing RCCO operations. Site review activities included a desk review of documents related to each focus topic that were submitted by **Colorado Access** prior to the site visit. During the on-site portion of the review, HSAG conducted group interviews of key **Colorado Access** 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 system issues and associated outcomes.

To continue the annual assessment of care coordination activities, on-site review included care coordination case presentations by RCCO staff members. The Department determined that FY 2016–2017 care coordination reviews would focus on demonstrating the best examples of RCCO care coordination activities and outcomes for members with complex needs. HSAG reviewed a sample of 15 care coordination cases--five cases for each region--selected and presented by the RCCO. HSAG completed an individual care coordination summary for each case. The Department determined that the care coordination record reviews would not be scored. HSAG considered results of care coordination presentations in documentation of findings related to the Care Coordination focus topic area.

Summary results and recommendations resulting from on-site interviews and care coordination case presentations are included in the Summary of On-Site Discussions.

Appendix A. Focus Topic Interview Guide

This appendix includes the HSAG Focus Topic Interview Guide used to facilitate the on-site discussions.

Focus Topic 1: Community Partnerships/Collaboration

- How are relationships with these community entities progressing:
  - County agencies?
  - SEPs/CCBs?
  - Other community organizations?
  - Do you feel like you could benefit from additional key relationships? (Specify)
- How did you build these relationships over the past five years? Such as:
  - Methods of contact/communications
  - Techniques used to sustain
  - What has been the evolutionary process?
- How responsive are organizations to RCCO interests or priorities?
- What are some of the major areas of success?
  - How have those successes influenced operations, programs, and/or relationships?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe)
- How is "coordinating the coordinators" among agencies and organizations working for you?
  - Do you feel like you're successful in this? If not, what are the barriers?
- What has been most helpful from the Department to facilitate or influence your relationships with community partners?
- What could the Department have done differently to improve/facilitate the process or outcomes?
- What programs other than those associated with Department initiatives have you developed with community partners?
- Other lessons learned regarding community partnerships since RCCO implementation?

Focus Topic 2: Provider Network/Provider Participation

- How has your provider network evolved over time?
- How are providers functionally involved with your RCCO? What is the current role of providers in your RCCO?
- How active are providers in RCCO initiatives?
- How receptive (or not) have providers been to the ACC?
  - In what areas?
- How has provider participation changed since inception of the RCCO?
- What have been some of the major areas of success with providers?
  - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or positively influence provider participation in the RCCO?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
  - What could the Department have done differently to improve/facilitate the process or outcomes?
- What could be done to improve the provider network or provider experience?
  - By the RCCO?
  - By the Department?

Focus Topic 3: Member Engagement

- What is your RCCO's perspective/view of "member engagement?"
  - How do you define it?
  - What do you consider to be "member engagement"?
- In what areas does member engagement occur?
- What mechanisms do you use to engage members (including tools—e.g., Patient Activation Measures)?
- What have been some of the major areas of success in member engagement?
  - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or influence member engagement?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe)
- Is member engagement more appropriate at the State level or is it more effective at a local level?
- How has member engagement changed or evolved since inception of the RCCO? Why?
- What could the Department have done differently to improve/facilitate the process or outcomes of member engagement:
  - From the beginning?
  - Support needed going forward?

Focus Topic 4: Care Coordination

- Please describe your model for delegation and care coordination.
  - How has it changed over time?
  - What do you consider the more successful features of your model?
    - How have those successes influenced operations, programs, and/or relationships?
  - What have been some of the less successful or challenging features?
    - What solutions were considered or implemented as a result?
- How much success have you had in holding your delegates accountable? (describe)
- Are there differences in care coordination successes or challenges related to specific member populations? (If yes—describe.)
- Describe other significant lessons learned since inception of RCCO (such as staffing, structure, communications, systems support).
- What has been most helpful from the Department to facilitate or influence your care coordination efforts?
- What could the Department have done differently to improve/facilitate the process or outcomes?

Focus Topic 5: Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities

- Has your RCCO focus changed over time regarding State-driven priorities vs. local RCCO priorities? (If so, how?)
- How do you determine strategic priorities within the RCCO?
  - What factors do you consider?
  - What factors most influence your decisions?
- Explore the multitude of Department "projects" and programs implemented through the RCCOs (e.g., Colorado Opportunity Project, SIM).
  - How do you handle/integrate the multiple projects?
  - What influence have they had on RCCO operations?
  - Do you have data to determine whether initiatives are working?
  - How do you perceive sustainability of these programs?
- What are lessons learned over time about the influence of State-driven priorities on RCCO strategic processes or priorities?
- What has been most helpful from the Department to facilitate balance of State-driven priorities and programs with RCCO community-driven objectives and operations?
- What could the Department have done differently to facilitate the process of balancing state-driven and regionally-driven priorities? What is needed from the Department to improve this process?

Appendix B. Record Review Summaries

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Colorado Department of Health Care Policy & Financing's Quality Unit for more information.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **Colorado Access**.

Table C-1—HSAG Reviewers and Colorado Access and Department Participants

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
Colorado Access Participants	**Title**
Aaron Brotherson	Director, Provider Engagement and Strategy
Amie Levesque	Grants and Research, Colorado Access
Andrea Richter	Manager, Clinical Care Management
Anna Brown-Cohen	Health Programs Manager, Colorado Access
April Abrahamson	Vice President, Health Plan Operations
Aruta Bharadwaja	Community Health Care Manager, North Colorado Health Alliance
Brittany Rogers	Director, Community Engagement
Cassidy Smith	Deputy Director, Accountable Care; RCCO 3 Contract Manager
Chris Engleby	Grants and Research, Colorado Access
Claudine McDonald	Director, Member Engagement and Inclusion
Danielle Catallo	Care Manager 2, Colorado Access
David Rastatter	Director, Northeast Colorado Medicaid
Denise Iverson	Care Manager, Denver Health
Diane Botton	Care Manager, Denver Health
Eneria Gutierrez	Care Manager, Colorado Access
Erika A. Asumadu	Clinical Care Coordinator, MCPN
Felicia Pless	Care Manager
Gretchen McGinnis	Senior Vice President, Healthcare Systems and Accountable Care
Heather Logan	Director, Accountable Care, MCPN
Ivan Montes Carrera	Community Health Care Manager, North Colorado Health Alliance
Jamie Haney	Manager, Accountable Care, MCPN
Jamie Zajas	Care Manager, Colorado Access
Jenn Conrad	Denver Health Care Manager

Colorado Access Participants	Title
Jenny Nate	Deputy Director, Behavior Health and Contract Manager, Region 5
Joanna Martinson	Director of Care Coordination, North Colorado Health Alliance
Kathleen Homan	Medicare-Medicaid Policy & Outreach Specialist
Katie Suleta	Population Health, Colorado Access
Kay Sasser	Care Manager
Mandee Hartshorn	RN and Community Health Care Manager, North Colorado Health Alliance
Marty Janssen	Deputy Director, Northeast Colorado Medicaid; RCCO 2 Contract Manager
Maryann Waugh	Director, Grants and Research
Meredith Munoz	Care Manager Supervisor, North Colorado Health Alliance
Nicki Zaffino	Care Manager 1, Colorado Access
Patrick Gillies	Vice President, Accountable Care
Regina Fetterolf	Director, Care Management
Rene Gonzalez	Population Health, Colorado Access
Reneé Smail	Behavioral Health Care Coordinator, MCPN
Sheryl McGully	Care Manager—Transitions of Care
Sophie Thomas	Account Communications, HCPF
Stephanie Becker-Aro	Care Manager 2, Colorado Access
Stephanie Phibbs	Care Manager, Denver Health
Tim Webb	Population Health, Colorado Access
Tyler Washington	Medical Director, Region 3
Robert Bremer	Vice President of Integrated Care
Shelby Kiernan	Director of Integrated Care
Department Observers	**Title**
Andrea Denka	Managed Care Regulations Administrator
Emily Berry	Contract Manager, ACC
Matt Lanphier	Contract Manager, ACC
Russ Kennedy	Quality Compliance Specialist
Van Wilson	Medicare-Medicaid Program