RAE Care Coordination Overview

4/16/2021

What type of referrals do RAEs accept?	All RAEs will take care coordination referrals by phone, email, or fax.
What does the referral process look like?	Each RAE has a system that utilizes a central call number or email address for referrals. Referrals are triaged, from there, to the proper team. See below for the contact information of each RAE: Rocky Mountain Health Plans, Region 1: 888-282-8801 customer_service@rmhp.org Northeast Health Partners, Region 2: 888-502-4190 https://www.northeasthealthpartners.org/members/care-coordination/ Colorado Access, Regions 3 & 5: 866-833-5717 resource&referral@coaccess.com Health Colorado, Region 4: 888-502-4186 https://www.healthcoloradorae.com/members/care-coordination/ Colorado Community Health Alliance, Regions 6 & 7: 855-627-4685 https://www.cchacares.com/about-ccha/contact-us/
How long will it take to get a response about a referral request?	Each RAE strives to respond as quickly as possible to any request, but all RAEs will respond within two business days.
Are there standard care coordination processes among all the RAEs? What can members expect?	Each RAE varies slightly in their approach to care coordination, but their foundational approaches are very similar, including: • Care coordination (CC) is available to all members • CC requests are assessed for the proper level of intervention • RAE CC teams have staff with increasing levels of skill to meet increasing levels of member need • Each RAE has CC processes directed at facilitating smooth and appropriate transitions of care • Each RAE includes physical, behavioral, and social needs in the CC assessments

RAE Care Coordination Overview

4/16/2021

What can be expected of care coordination for transitions of care (TOC)?	RAEs receive daily admit, discharge, and transfer (ADT) lists identifying members who have been admitted to a hospital and those who are set to discharge. RAEs begin TOC processes upon notification of an inpatient admission; and for discharging members, all RAEs have procedures in place to initiate contact, clarify discharge orders, and coordinate among various systems of care and social needs. Each RAE's TOC process includes stratifying for members of higher risk and identifying members who are engaged long-term behavioral health services. Throughout the process, every RAE works to ensure proper and timely physical and behavioral health follow-up.
When do RAEs initiate contact with DHS?	RAEs will not initiate contact with DHS about a member unless notification has come via other means that the member is connected to welfare services or that DHS is the member's legal guardian. Notification may come from DHS, HCPF, or a provider; but is not included in the ADT lists. Upon notification, RAEs will contact the DHS caseworker and work to secure the necessary releases of information in order to allow communication across multiple and disparate groups regarding the member's situation and health care needs.
How are members assigned to a care coordinator?	Members are assigned in a variety of ways, including direct referrals from a provider or other member representative, being identified through the ADT list, and appearing on a high-risk member list distributed to the RAEs by HCPF. All RAEs have methods in place to assess member physical and behavioral health needs and to assign appropriate care coordination support. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Heath Colorado, Region 4 CCHA, Regions 6 & 7

RAE Care Coordination Overview

4/16/2021

How are high needs members identified; and how does this inform the development of a care plan?	High needs members are identified in a variety of ways, but each RAE reviews hospital utilization data, communicates consistently with behavioral health and physical health providers, conducts assessments upon referral, and coordinates information from other sources, such as behavioral health inpatient census and utilization management data to best identify those members who need enhanced care coordination and care management services. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
How are a member's care coordination needs determined; and will a member be connected to services if a request is not made by a custodian, provider, or by the member?	RAEs use assessment processes that include screening tools; collaboration and communication with member families, providers, and guardians; and input from service professionals who are connected to a member's case. All RAEs work closely with members, families, guardians, and providers to determine the appropriate services a member may need and to locate providers best suited to deliver those services. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7

RAE Care Coordination Overview

4/16/2021

Are care coordinators expected to outreach providers to ensure openings and service fit, before suggesting them to the member for follow-up?	All RAEs are committed to offering a range of provider options to members, to the extent that such options are available; however, members or their guardians are expected to make the final decision regarding providers. Certain dynamics, such as rural location or specialty service type, may limit available options. RAEs can help secure an appointment, once a provider is selected, but will not offer medical advice. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
How do RAEs measure successful care coordination efforts for high needs children?	RAEs coordinate across multiple sources to help ensure that high needs children have care plans that connect them with appropriate physical and behavioral health services, clearly articulate goals for improved health, identify wrap-around services and supports, and facilitate consistent channels of communication among all parties. Success is defined as meeting these aims and those outlined in the care plans. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7

RAE Care Coordination Overview

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What efforts are made by RAE care coordinators to engage with members?	All RAEs have efforts consistently and constantly underway to engage with members; and those may vary in scope, depending on how the member came to the attention of the RAE and the member's situation. RAEs work through various communications platforms to inform members of their benefits and the supports that RAEs can offer them in accessing services. Each RAE has specific programs in place for priority populations, including foster youth. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
Do care coordinators receive specific training regarding care coordination needs for potentially high-needs & complex demographics they serve?	RAE care coordinators receive specialized training to support needs across a wide spectrum of member situations. Each RAE has programs and training aimed at best meeting the needs for a variety of identified populations, including foster care, members engaged with the Department of Corrections, members engaged in Long Term Services and Supports (LTSS) programming, pregnant members, to name a few. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7

RAE Care Coordination Overview

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If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE have to recruit and contract with a provider to meet that need?	Each RAE is responsible for ensuring that its network is sufficient to meet the access to care needs for every one of its members—in short, for ensuring timely access to appropriate care for all medically necessary services. RAEs work to develop a full range of service options within their network, and actively pursue Single Case Agreements with non-contracted providers when necessary for the care of member. An in-state behavioral health provider can contract with any RAE, regardless of where they are located; and RAEs are able to contract with out of state providers to meet member needs in special cases. It is important to note that RAEs can only contract with a provider who has completed validation as a Colorado Medicaid provider and RAEs are prohibited for paying for services that are not covered by Medicaid. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
What are RAEs doing to recruit providers?	RAEs work consistently to enhance the availability of services within their networks and to recruit quality providers to deliver those services. Each RAE evaluates network needs within their own region and develops strategies accordingly. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7

RAE Care Coordination Overview

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How do providers in one RAE establish a connection or contract with another RAE for continuity of services?	RAEs have established relationships among each other to help facilitate the transfer of services when a member switches RAEs or to help provider navigate the administrative differences between RAEs. RAEs are committed to using the new RAE to RAE transfer form for consistency. It is important to note that each RAE establishes its own processes for contracting and credentialing providers. Providers should contact each RAE for information on their processes.
Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?	There are multiple factors that dictate the need for Releases of Information (ROIs) in different cases. For example, certain county agencies may be a HIPAA covered entity, while others are not. Each RAE works within context of a complex regulatory framework to identify when ROIs are necessary to begin care coordination work and share information. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
How long do RAE care coordinators remain involved in a case?	All RAEs continue care coordination services for as long as a member requires or requests these services. There is no set time frame, and involvement stems around member/family preferences, goal assessment and attainment, and health care or SDOH need (as long as the member or family continues to consent to care coordination services).

RAE Care Coordination Overview

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What services can RAE care coordinators assist with?	RAE care coordinators can support members across a large range of needs including (but not limited to) accessing physical and behavioral health care services, connecting to non-medical resources and public assistance programs, care planning, health system navigation, understanding Medicaid benefits and programs, and transitioning among RAEs. For more details, click below on the link for a specific RAE: RMHP, Region 1 NHP, Region 2 Colorado Access, Regions 3 & 5 Health Colorado, Region 4 CCHA, Regions 6 & 7
How can RAEs and counties best work together, regardless of custody status?	Care coordination services are available for members regardless of custody status, and RAEs will deliver the same level of support for all members. However, it is important that RAEs learn, as early as possible, a member's custody status and be connected to the legal guardian. This connection allows for ROIs to be completed, decision points to be clarified and acted upon, care plans to be developed, and for RAEs to act on behalf of the member when coordinating services and offering supports. The more information RAEs have early in the process, the more effective care coordination services can be. RAEs are always amenable to learning more about the custody process and discussing ways to bring early clarity to each member's case.

Do care coordinators get assigned members or a specific care coordination need for a member, where resolution of the need or progress for the member is expected and tracked by the RAE or ASO? If so, how is progress for the member or towards a resolution tracked?

Members are assigned to RMHP care coordinators through multiple pathways such as: referrals, clinical events (i.e. hospitalization) or risk stratification methodology. Once a member is identified they are contacted by RMHP care coordination staff and an assessment is completed to identify their specific needs.

SMART goals, barriers and interventions are defined based on results of the needs assessment and follow-up care coordination activity is defined and tracked using the care coordination platform's daily queue that generates notifications for the care coordinator when it is time to follow-up.

Specialized care coordinators are available to address members with complex needs (i.e. high-risk pregnancy, behavioral health or SUD, medication concerns etc.).

A care plan remains open until goals are met.

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R1

How are high-needs (behavioral & mental health) members identified, and what does that identification mean, in practical terms, to the RAE and the member? Do care coordinators devise 'care plans' in a proactive manner such that they are outreaching members, providers, and other stakeholders with plans for care designed to address and mitigate these high needs?

RMHP has a team of behavioral health professionals and care coordination staff who provide care coordination and utilization management for RAE members and comprehensively identify needs to direct members towards the most appropriate level of care.

Hospital ADT data is reviewed to identify behavioral health and SUD diagnoses and campaigns are created and delivered to RMHP care coordination staff or local CMHCs for outreach. Additionally, any member with a 12-month claims history of behavioral health or SUD diagnosis is flagged; and if these members have an admission or

R1

ED visit for any reason they are placed in a follow-up campaign for immediate outreach, assessment and care planning. Outreach and car coordination occurs after hospitalization by the RMHP and/or CMHC teams to ensure adequate follow-up occurs.

Care coordinators proactively create and follow-up with care plans as members are identified and engage.

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R1

How are a member's care coordination needs determined? How is a member paired with a specific service or provider if a request isn't made by the custodian, member, the PCMP, or current provider?

RMHP uses multiple assessment tools to understand the unique needs of members who are identified or referred into care coordination.

RMHP assessments include screening questions related to social determinants of health, physical or behavioral health and are structured with questions that determine when escalation to a higher level of care is indicated.

Behavioral health professionals are available to receive *warm-handoffs* or respond to referrals within 24 hours.

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R1

Is it part of a care coordination's expected duties that they'd outreach a provider to ensure openings and that they are a good fit to meet the need prior to suggesting them to a custodian of a member for follow-up?

RMHP is committed to ensuring adequate levels of access prior to connecting members to providers or community resources. RMHP staff often facilitate three-way discussions between the provider, member and care coordinator to set up the appointment.

When urgent needs are identified, RMHP staff often connect the Member with a telehealth provider to promote immediate access and connect the member with a local provider for follow-up.

Members are reminded of appointments and when necessary NEMT is coordinated to ensure access.

R1

When a member needs to access specialty care that is not available in rural or frontier areas, RMHP works with the member to confirm appointments where available and secure long-distance transportation, lodging and funds for food as necessary.

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R1

What does successful care coordination for high needs children and struggling families "look like" from the RAE perspective? How are positive outcomes of care coordination measured for this population?

RMHP participates in care conferences that bring all involved agencies together with the family to ensure successful coordination of care and services for high needs children and families. These care conferences ensure all aspects of care are addressed. RMHP serves as the facilitator of care conferences and monitors follow-up activities and gaps.

Positive outcomes are measured through documentation in the care management platform, when barriers are removed or goals are complete, care plans are closed.

Success is defined by the member and care team.

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R1

Are efforts made by the RAE or care coordinators to engage members? Are there members who are tracked and regularly contacted/outreached by care coordinators to ensure that the care that's been coordinated is effective?

RMHP proactively outreaches on several situations, including:

- Foster children, with release. RMHP outreaches to foster families
- Children who have repeatedly been hospitalized for S/I, H/I and substance abuse
- Any member with an ED or hospitalization receives follow up after discharge - assessment and care planning occur
- Children/families with housing instability (placement instability)
- Children/families with repeat crisis episodes as indicated by crisis team contact w/ CMHC, hospitalizations, & enrollment in intensive services.

R1

RMHP is working closely with Crisis Services to identify members on a real time basis that have frequent crisis episodes.

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R1

Can or do care coordinators receive specific training re: care coordination needs for potentially high-needs & complex demographics they serve, such as:

- Children in foster care,
- Children in kinship care,
- Children who have experienced complex trauma,
- Children who should also be served and supported by the CCB but have not/are not (we've been told that the RAE do the care coordination until the child is formally served by the CCB and a waiver)

RMHP staff receive training to work with these populations mentioned above.

RMHP stratifies members in these categories into campaigns and they receive regular outreach, assessments, care planning and follow-up until their needs are met.

Continuous follow-up is important especially in rural and frontier counties where services are not always available.

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R1

If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE and/or care coordinator have to recruit and contract with a provider to meet that need? Is that responsibility spelled out in the contract the RAE has w/ HCPF?

RMHP continuously pursues high standards of network adequacy and if a specific provider is not available, we will actively recruit providers in the region or identify alternative solutions for members in need of access.

We work with any/all community partners to find solutions for the needs of our members. Care conferences are critical to bring all parties together to problem solve on difficult cases.

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R1

What are the RAE's doing to recruit more providers?

RMHP works closely with the PAR and internal UM team for RAE and Prime members. RMHP care coordinators continuously work with members to find the most appropriate level of provider and coordinate activities required to establish a preauthorization and case rate as needed. Transportation and follow-up services are also offered by RMHP care coordination staff.

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R1

Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?

RMHP also shares minimum necessary information without an ROI with Covered Entities and has BA agreements with all community partners. When working with foster children RMHP is required to receive the ROI from the county prior to discussing a child needs with the family.

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R1

What services can RAE care coordinators assist with?

RMHP provides whole person care coordination, and our assessment evaluates 11 domains to identify needs.

Examples of things we assist with are: behavioral health, physical health, getting doctor's appointments, finding food and housing, signing members up for SNAP and other available services, going to appointments with members.

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R1

Do care coordinators get assigned members or a specific care coordination need for a member, where resolution of the need or progress for the member is expected and tracked by the RAE or ASO? If so, how is progress for the member or towards a resolution tracked?

NHP assigns members to care coordinators through a variety of methods. NHP care coordinators are part of teams and have specialized training/additional understanding regarding the population(s) they are serving to ensure they are following best practices and the members needs are met. NHP care coordinators use a care coordination tool to assess, create care plans and progress notes to ensure they are tracking the process of members assigned to them. Additionally, care coordinators have access to regional data to ensure they have up to date information on members they are coordinating care for.

NHP ensures closed-loop processes between providers within the member's care team using the *Care Coordination Agreement Form* for all team decision meetings to level-set involvement/expectations for each entity involved in a member's care. This form also acts as a tracking mechanism, indicating progress and resolution of issues.

Cases are generally closed once the members goals are met or the member indicates they are no longer interested in receiving services.

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R2

How are high-needs (behavioral & mental health) members identified, and what does that identification mean, in practical terms, to the RAE and the member? Do care coordinators devise 'care plans' in a proactive manner such that they are outreaching members, providers, and other stakeholders with plans for care designed to address and mitigate these high needs?

Behavioral Health/High-Needs members are identified by having mental health conditions, limited functional status, and/or higher psychosocial needs.

NHP receives referrals for behavioral health/high-need members through hospital admissions (UM authorizations) and discharges/transitions of care; community partners, the state, and by members/family requesting help.

R2

Behavioral Health/High-Needs members are also flagged for outreach when they come to our attention due to utilization/institutionalization, for example:

- Members with frequent ED and hospital admissions (ADT lists);
- Members with higher levels of psychiatric hospitalizations (daily census);
- Members transitioning out of DOC;

NHPs general approach to care management of these individuals includes stratification/screening, assessment, care planning, and management/monitoring of both treatment and outcomes. Currently, members with behavioral health/high needs in Region 2 are outreached for services within 24 hours of receiving the referral.

Members targeted for clinical outreach receive a comprehensive clinical assessment that further stratifies using responses to assessment questions. This helps to determine intensity and frequency of outreach and ongoing interventions. The assessments examine a broad range of domains and information to determine member needs, interventions available to members, and how interventions are targeted to members.

During the initial assessment process, members are encouraged to establish a condition-centered goal to achieve while participating in the program. The Care Coordinator ensures the goal is attainable based on the member's condition and progress to goal attainment can be measured at subsequent contacts with the member. Member centered goals are continually reviewed and adjusted as barriers are identified.

Care Coordinators attempt to assess both the member's understanding of their own conditions as well as their individual readiness to change as it pertains to the plan of care set forth by their healthcare provider. Through individualized planning, education, and goal setting, Care Coordinators help fill knowledge deficits and assist members in increasing their perceived level of importance and confidence regarding health goals pertaining to the prescribed plan of care.

Members are informed that is it not the intention of the Care Coordinator to provide specific medical advice but rather to provide additional information and resources necessary to improve the member's understanding of the disease process and possible interventions that are intended to or may improve health.

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NHP, Region 2

How are a member's care coordination needs determined? How is a member paired with a specific service or provider if a request isn't made by the custodian, member, the PCMP, or current provider?

Care Coordination needs are determined through assessment(s), screening(s), member interviews, discussions with the family, discussion with the PCP/treatment team and other providers involved in the members care. The assessments examine a broad range of domains and information to determine member needs, interventions available to members, and how interventions are targeted to members.

If/when care coordination is requested through a systematic process (hospital discharge, DHS referral, HCPF request), an initial 'triage' or 'screening' occurs where the care coordinator asks a list of questions to have a better idea of what the members needs might be. During this period, the care coordinator may also have additional conversations with the referral source (if possible) and other providers involved in the members care. The subsequent process involves completion of the care coordination assessment/screenings/interviews to determine needs and begin linking members to resources/providers.

NHP follows evidenced-based clinical practice guidelines, collaborate with the member's primary healthcare practitioner and other members of the healthcare team to support relationships between members and their practitioners and providers.

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R2

Is it part of a care coordination's expected duties that they'd outreach a provider to ensure openings and that they are a good fit to meet the need prior to suggesting them to a custodian of a member for follow-up?

Care coordinators provide referral options for INN providers/specialists and can research provider information with the member. They can also discuss transportation options and assist with securing if needed. In addition, care coordinators will outreach providers to discuss availability of appointments and ensure services needed are offered by the provider.

Members are informed that is it not the intention of the Care Coordinator to provide specific medical advice but rather to provide additional information and resources necessary to improve the member's understanding of the disease process and possible interventions that are intended to or may improve health. Care coordinators allow

R2

the member and/or guardian to make the determination regarding the best fit. Additionally, the provider treating the member may also be consulted regarding fit/recommendations.

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R2

What does successful care coordination for high needs children and struggling families "look like" from the RAE perspective? How are positive outcomes of care coordination measured for this population?

NHP views success as:

- Helping the member/family set clear goals that are feasible to achieve within the identified timeframe.
- Ongoing engagement with the PCP and other providers involved in the members care/treatment team.
- Ongoing contact between the care coordinator and member/family/treatment team.
- Information sharing among the group, putting the member/family at the center of care.

When care coordinators are engaged with the member/family and care team, it is much more feasible to reach the goal(s) and meet the member's needs. Ongoing success is identified as helping the member get to a point where they feel confident navigating future systems of care independently.

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R2

Are efforts made by the RAE or care coordinators to engage members? Are there members who are tracked and regularly contacted/outreached by care coordinators to ensure that the care that's been coordinated is effective?

NHP has ongoing efforts to engage a wide variety of Medicaid members, to inform them of their benefits, to offer services and to link them with providers/resources.

Foster Children: For all children in foster care, especially those with complex needs, we recognize that timely information sharing between child-serving organizations is critical to preventing the child or adolescent from falling through the cracks of a complex system.

- NHP has established a pilot program involving foster children in the region.
- The foster child pilot was developed to create a best practice for assisting members entering the foster care system (or returning) and to reach various KPI for both the RAE and DHS simultaneously. The current process includes first receiving a referral from a foster care worker with DHS. This referral includes ROI

R2

for North Range and the referral sheet. NCHA care manager will then outreach the foster family, completes an initial home visit, establishes a plan of care, and completes Releases of Information. From there, the care coordinator assists in scheduling an appointment for Monfort Children's Clinic to include well child check, behavioral health screening, and a dental check. The dental check is with a hygienist and will include a fluoride treatment. If further needs are found during the visit, the care manager will assist in finding resources. Throughout the process, the care coordinator is in constant communication with the caseworker at DHS, they attend provider appointments, update caseworkers weekly, and attend Family Team Meetings and Team Decision Making Meetings.

- Additionally, NHP participates on the Human Services Advisory Commission (HSAC). This group has oversight of CCB programs and allows for regional collaboration regarding care coordination needs for members, including members who fall into the Foster Care category.

Children with ongoing psychiatric needs/hospitalizations: As described earlier, care coordinators receive the daily census alerting them to all members recently placed in higher levels of psychiatric/behavioral health care. In addition to receiving these alerts, NHP care coordinators are integrated with the regional CMHCs, working alongside clinical staff to share information timely and offer ongoing care coordination services to members/families with higher needs.

- NHP tracks member hospitalizations (ongoing readmissions/rapid readmissions) and has a targeted approach for these members to evaluate and discern ongoing issues that might be contributing to this pattern and offering more intensive care coordination services with a goal to reduce unnecessary hospitalizations.

Housing instability: NHP does not receive specific alerts notifying the RAE of members experiencing housing insecurity; however, once it is identified we can direct them to our *Housing Navigation Center*. This program is strategically located in a large complex that houses Sunrise Community Health's largest primary care clinic and a specialized team of NCHA's community care management team assigned to the center. These housing care managers are fully embedded with NHPs CC team and are located across the hall from the navigation center specifically to engage members on a daily basis to address housing instability and Social Determinants of Health (SDoH) needs and gaps.

Members in ongoing crisis: similar to the response given previously regarding members with ongoing psychiatric hospitalization(s) and crisis interventions, care coordinators are embedded in service delivery alongside CMHCs

colleagues. Specific/targeted care coordination approaches are developed to ensure the member/family needs are met, the member is in a safe environment and is utilizing services needed.

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R2

Can or do care coordinators receive specific training re: care coordination needs for potentially high-needs & complex demographics they serve, such as:

- Children in foster care,
- Children in kinship care,
- Children who have experienced complex trauma,
- Children who should also be served and supported by the CCB but have not/are not (we've been told that the RAE do the care coordination until the child is formally served by the CCB and a waiver)

The NHP Care Coordination team comprises health care professionals with extensive training, continued education in the target diseases, and specialized training in nursing, mental health, community health, and physical health. The team is organized by geographic zones and disease specificity and includes a liaison between medical staff and families as well as a presence in community sites to meet the needs of families more effectively.

- Care Coordinators assist members with the development of care plans and assessments to assist with the improvement of member self-monitoring and symptom identification. These individualized plans are designed to be member-focused and goal-oriented to drive tangible results. Also, the assessments analyze, and log information related to mental and socially related health conditions.
- Additional Care Management education:
    - One Step (Secondhand Smoke effects on children),
    - Home Care Agencies, Hospice and Palliative care
    - Food, Nutrition, and Disease (diabetes, etc.)
    - Mental Health First Aid,
    - Refugee Center Panel Discussion,
    - CPS training,
    - Human Trafficking,
    - HIV 101,
    - Positive Problem Solving
    - Suicide awareness and intervention training

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- SPBRT, drug and alcohol awareness, assessment, and referral
- Housing Navigation
- Maslow's Hierarchy of Needs
- Motivational Interviewing and Motivating Members Self-Management
- Growth and Development Review
- Bridges Out of Poverty
- Cultural Awareness and Competency – Exploration of Personal Views and Values
- Navigating Hospital or other facility Transitions
- How to help your members/ children navigate the school systems
- Long-Term Benefit Waivers
- Foster Care and Child Protection Basics

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R2

If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE and/or care coordinator have to recruit and contract with a provider to meet that need? Is that responsibility spelled out in the contract the RAE has w/ HCPF?

In addition to NHPs primary responsibilities for a contracted network of primary care and behavioral health providers, we also have the responsibility for ensuring timely and appropriate access to medically necessary services offered by the full range of Medicaid providers in the Health Neighborhood, including specialty, hospital, and home-based care. In particular, the regional organizations are responsible for developing infrastructure and processes to streamline referral processes, improve communications among providers, and increasing the number of specialty care providers enrolled in Medicaid and actively treating members.

Members and families can choose any NHP Provider who is licensed, credentialed, and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A Member may request that a provider be considered to join the relevant RAE. In cases of a Member already in treatment with a provider at the time the Member obtains NHP eligibility, for the purpose of continuity of care, the Member's provider may request a Single Case Agreement and treatment may be continued. In cases involving special needs, NHP may offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria.

R2

Under certain circumstances Members may request an out-of-network provider. These circumstances may include:

- The service or type of provider the Member needs are not available in our network.
- The network provider refuses to provide the treatment requested by the Member on moral or religious grounds.
- The Member's primary provider determines that going to a network provider would pose a risk to the Member.
- The Member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship.
- The State determines that other circumstances warrant out-of-network treatment.

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R2

What are the RAE's doing to recruit more providers?

It is easy to become a NHP provider and we are always looking for qualified candidates to join or network. We offer contracts to any willing provider who meets all requirements to service Medicaid Members as a Primary Care Provider and Medical Home in the ACC Program, this includes:

- Be enrolled as a provider in the Colorado Medicaid program:
  - Certified by the state as provider in the Medicaid and CHP+ Medical Homes for Children program
  - Individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, family medicine, pediatrics, geriatrics, or obstetrics and gynecology, or is a qualified CMHC or HIV/infectious disease practitioner or
  - A federally qualified Health Center (FQHC) or Rural Health Clinic (RHC)
  - Be licensed as a MD, DO or NP provider by the Colorado Medical Board of Nursing to practice in the state of Colorado;
  - Act as the dedicated source of primary care for members and be capable of delivering the majority of the Member's comprehensive primary, preventive and sick medical care; and
  - Demonstrate commitment to the following principles of the Medial Home model as amended by the state.

R2

NHP, Region 2

For Behavioral Health, NHP credentials individual practitioners and facilities. Groups must have a valid OBH license to be credentialed as a facility; otherwise, we will credential individual practitioners within your group.

We evaluate our behavioral health network adequacy based on state standards, which we meet at a 100% rate in almost all areas except in our very remote locations where we do not have multiple options, specifically for SUD providers.

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R2

Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?

NHP can share minimum necessary for care coordination with covered entities or related to Treatment, Payment, or operations. We had tried to address this issue via MOU/data sharing agreements which were halted by entities until AG weighed in with no additional follow up. We do not require court orders etc. to identify and establish a care coordination relationship as we are not releasing PHI.

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R2

What services can RAE care coordinators assist with?

NHP is amenable to offering a variety of care/services; however, more information is needed to discern what services are referred to as 'not in operation' as we can only link to services available.

Services are offered and driven by the members identified needs and goals- often starting with their identified top priority.

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R2

RAE Care Coordination Overview – Colorado Access, Regions 3 & 5

4/16/2021

Do care coordinators get assigned members or a specific care coordination need for a member, where resolution of the need or progress for the member is expected and tracked by the RAE or ASO? If so, how is progress for the member or towards a resolution tracked?

Members get assigned to a care manager through a variety of sources such as transitioning out of the hospital (behavioral health and physical health), a registry (state list of those with asthma/diabetes/etc.), through high cost utilization, through the email referral process, etc. Care Managers have specialized training in these areas in order to assist members to the best of their ability. Colorado Access has an EMR that care managers utilize to generate care plans, read UM notes, and track progress for goals. Resolution or progress is largely dictated by the member and if their needs have been met.

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R3 R5

How are high-needs (behavioral & mental health) members identified, and what does that identification mean, in practical terms, to the RAE and the member? Do care coordinators devise 'care plans' in a proactive manner such that they are outreaching members, providers, and other stakeholders with plans for care designed to address and mitigate these high needs?

Many high needs behavioral health members are identified by hospital utilization. When a member is hospitalized, the Utilization Management team notifies the care manager assigned to that hospital using our EMR. The care manager begins connecting with the providers, hospital, etc. to ensure there is appropriate discharge planning and care coordination.

If the member is not connected through hospitalization, they could be connected to a care manager through lists the state sends to the RAEs or referred through a community partner.

Most care plans are generated within the first call to the member. Colorado Access uses a person-centered approach and addresses needs identified by the member and their care team. However, there are some goals that a generated when a person is inpatient for a behavioral health need.

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R3 R5

COA, Regions 3 & 5

How are a member's care coordination needs determined? How is a member paired with a specific service or provider if a request isn't made by the custodian, member, the PCMP, or current provider?

Care coordination needs are often determined by the member, family, or provider recommendations. They could also be determined by how the referral was received (example:7 day follow up for hospital discharges).

Specific service provider is dependent on many factors and the services that are being put in place. For instance, if a hospital is recommending in-home services as a part of the discharge plan, they may make referrals and find a provider. If the service is Long Term Residential, the requestor of the service coordinates the provider. If someone is in an ED, the ED makes referrals and chooses which provider (after an authorization is made). Care Managers can assist families and providers with lists of in-network providers and which provider may be able to meet their needs.

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R3 R5

Is it part of a care coordination's expected duties that they'd outreach a provider to ensure openings and that they are a good fit to meet the need prior to suggesting them to a custodian of a member for follow-up?

Care managers and care coordinators provide referral options for members and providers who are wanting to make referrals. Care Managers will alert custodians to in-network options and allow the member or provider to recommend which provider may be the best fit. While many care managers do have knowledge about programming and availability, they may not have enough clinical information and likely have never met the member in order to evaluate fit. Fit and clinical recommendations are usually left to the provider who is treating the member.

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R3 R5

What does successful care coordination for high needs children and struggling families "look like" from the RAE perspective? How are positive outcomes of care coordination measured for this population?

Success is determined by the member being wrapped in services that meet their needs and mitigate risk. Ideally, there would be services to meet every need but the system has current limitations so we do our best to meet their needs, alert them to options, and ensure their questions are answered as they arise. Care managers assist

families and outside entities in navigating this complex system and sometimes that means navigating services inside of the RAEs and outside of the RAEs.

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R3 R5

Are efforts made by the RAE or care coordinators to engage members? Are there members who are tracked and regularly contacted/outreached by care coordinators to ensure that the care that's been coordinated is effective?

Foster Children: COA has a care manager assigned to this population but have often struggled to get custody orders/ROIs in order to coordinate care for them. If we have the needed information, we would like to coordinate care, track progress, and ensure effectiveness. COA received a list of high cost foster care children from the state but it does not include who guardian is and therefore, they are difficult to outreach but we would like to collaborate more on how to assist with this population.

For children who have been repeatedly hospitalized, COA ensures that the members are always connected to a care manager who will remain on their case despite multiple hospitalizations. At minimum, two outreach attempts will be made at every hospitalization.

COA does not have direct access to information regarding housing instability, but will support in finding resources when a member/family have been referred.

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R3 R5

Can or do care coordinators receive specific training re: care coordination needs for potentially high-needs & complex demographics they serve, such as:

- Children in foster care,
- Children in kinship care,
- Children who have experienced complex trauma,
- Children who should also be served and supported by the CCB but have not/are not (we've been told that the RAE do the care coordination until the child is formally served by the CCB and a waiver)

Colorado Access care managers receive training about these populations and how to serve them. Care managers workflow includes checking the BUS for current CCB involvement and if there is, an appropriate care manager

R3 R5

COA, Regions 3 & 5

will be assigned to engage with the member. Care Managers work with caregivers to determine if CCB waiver is appropriate to better meet the needs of the child. If so, Care Manager will make a referral to the appropriate CCB. COA employs licensed/ credentialed professionals such as RN, LAC, CAC, LCSW, LPC, LMFT, etc. who have advanced education, knowledge and training required to work with these specialty populations

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R3 R5

If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE and/or care coordinator have to recruit and contract with a provider to meet that need? Is that responsibility spelled out in the contract the RAE has w/ HCPF?

Colorado Access has teams dedicated to recruiting and contracting with appropriate providers. Care coordinators can communicate the need(s) of a member to the provider-facing teams, but care coordinators are not responsible for provider recruitment. Colorado Access has a large and robust provider network that meets the needs of most members; however, COA can and does execute Single Case Agreements (SCA) with providers when necessary to meet the needs of a member. These agreements can be completed quickly, but COA cannot execute a contract or SCA with a provider who has not completed validation with HCPF as Colorado Medicaid provider—and COA cannot vouch for the State's timeline during the validation process. COA is committed to connecting non-validated providers to the necessary resources for validation, but providers must carry their own action when validating.

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R3 R5

What are the RAE's doing to recruit more providers?

Colorado is always looking for qualified providers that would like to be part of our network. COA utilizes data, stakeholder input, and case referrals to help identify any potential gaps in our service network, and targets recruitment efforts accordingly. Also, COA communicates across different platforms, such as the Navigator Newsletter and provider forums to indicate our openness to new providers. Our efforts, lately, have focused on developing our SUD inpatient network, in response to the State's new SUD benefit roll-out, but COA is always willing to contract with qualified, quality providers.

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R3 R5

COA, Regions 3 & 5

Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?

Colorado Access requires a Release of Information (ROI) Authorization-Disclose-PHI.pdf (netdna-ssl.com) to be signed by the minor for ages 15 to 18 in order to collaborate with a guardian (including a parent or DHS) regarding Protected Health Information (PHI).

If a minor is under 15, Colorado Access requires Department of Human Services custody orders in order to exchange PHI with DHS. If the minor is not in DHS custody, Colorado Access requires the guardian to sign a ROI in order to exchange information with DHS.

ROIs are also needed to coordinate care with entities that are not Colorado Access providers. These entities include but are not limited to: school districts, GALs, and foster parents.

Due to 42 CFR Part 2, additional consent is needed to exchange substance abuse information with providers and external parties. Colorado Access requires the ROI to be completed with the "Drugs/alcohol diagnosis, treatment and referral information" box checked in order to exchange this information.

Colorado Access can receive information from DHS without an ROI and can outreach the member or family if they have custody. If DHS has custody, we do require custody orders to ensure we are following our compliance guidelines.

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R3 R5

What services can RAE care coordinators assist with?

Colorado Access care coordinators will assist members with a multitude of needs, and it varies greatly on a case by case basis. The goal of care coordination is to assist members with any services and supports they need to get healthy and remain that way. COA care coordinators have a wealth of knowledge about the supports and services that are available in the communities we serve and communicate with members to best assess their needs and what supports we can offer.

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R3 R5

RAE Care Coordination Overview – Health Colorado, Region 4

4/16/2021

Do care coordinators get assigned members or a specific care coordination need for a member, where resolution of the need or progress for the member is expected and tracked by the RAE or ASO? If so, how is progress for the member or towards a resolution tracked?

Members are assigned to care coordinators based on regional attribution. There is also a lead care coordinator to provide oversight and best practices to ensure members needs are met. HCI teams may include an RN, behavioral health case manager, and a peer support. HCI uses Essette as a care coordination tool to include a predictive analytics tool to assist care coordinators have data to meet member needs.

HCI stratifying member data for members that are at risk, high utilizers, and help members track their goals.

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R4

How are high-needs (behavioral & mental health) members identified, and what does that identification mean, in practical terms, to the RAE and the member? Do care coordinators devise 'care plans' in a proactive manner such that they are outreaching members, providers, and other stakeholders with plans for care designed to address and mitigate these high needs?

Members with high behavioral health needs are identified through census data, ED utilization, and ADT lists; and stratifies members for high behavioral health needs and uses a daily census that is shared with our care coordination teams.

Through a person-centered approach, HCI ensures members care is aligned to help address the barriers to meeting those goals.

HCI has a dedicated care manager that helps members transitioning out of DOC.

HCI creates individuals care plans, medication assistance, and monitoring; and members with high BH needs are outreached within 24 hours of a referral.

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R4

HCI, Region 4

How are a member's care coordination needs determined? How is a member paired with a specific service or provider if a request isn't made by the custodian, member, the PCMP, or current provider?

Care coordination needs may be identified by family, primary care providers, or a member.

Upon hospital discharge a care coordinator will outreach a member to assess barriers, assist with any referrals, and coordinate in services as part of discharge planning. HCI staff coordinate with other healthcare providers for diagnostics, ambulatory care, and appointment follow up, and create a communication plan to help with ongoing needs.

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R4

Is it part of a care coordination's expected duties that they'd outreach a provider to ensure openings and that they are a good fit to meet the need prior to suggesting them to a custodian of a member for follow-up?

Members are provided with referral options to other PCMPs and specialty providers, and care coordinators help schedule appointments.

Care coordinators ensure that members have options to address member cultural and diversity needs.

HCI providers referral options both in the member communities or options outside of HCI should a specialty provider not be available in the area.

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R4

What does successful care coordination for high needs children and struggling families "look like" from the RAE perspective? How are positive outcomes of care coordination measured for this population?

HCI may assign an intensive case manager that creates a specialized team to support the member and family. This may include bringing in the child's other family members, school system, community agencies to assist the member and family with wraparound services to include setting goals, addressing risks, and provide options for the family for additional community resources.

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R4

Are efforts made by the RAE or care coordinators to engage members? Are there members who are tracked and regularly contacted/outreached by care coordinators to ensure that the care that's been coordinated is effective?

HCI works closely with DHS to ensure children in foster care have their needs address. We do struggle when children are removed from the RAE area. There are not many options for children in foster care in our rural communities.

Members with high needs will be assigned an intensive case manager who will schedule regular meetings with family, DHS, and other agencies.

Members with frequent hospitalizations are assigned a care team, members are outreached at a minimum twice, more if needed.

Housing Instability – our care coordinators will assist members with housing options.

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R4

Can or do care coordinators receive specific training re: care coordination needs for potentially high-needs & complex demographics they serve, such as:

- Children in foster care,
- Children in kinship care,
- Children who have experienced complex trauma,
- Children who should also be served and supported by the CCB but have not/are not (we've been told that the RAE do the care coordination until the child is formally served by the CCB and a waiver

HCI provides regular trainings and learning collaboratives for care coordinators to include motivational interviewing, Question Persuade, and Refer (QPR), suicide prevention, crisis services, diversity and inclusion, LGBTQ cultural competency, Youth Mental Health First Aid, Suicide awareness and intervention. Our care coordinators work closely with CCBs, coordinate care and support when a referrals are received. In collaboration with the CCBs we ensure that member needs through care coordination are met.

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R4

HCI, Region 4

If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE and/or care coordinator have to recruit and contract with a provider to meet that need? Is that responsibility spelled out in the contract the RAE has w/ HCPF?

HCI will assist members with options outside of the RAE and create Single Case Agreements, should a provider be out of network.

If a provider deems a member has a specialty need we will work with the provider to help identify options for the member to ensure members have a choice of providers.

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R4

What are the RAE's doing to recruit more providers?

HCI ensures we have network adequacy to meet the needs of our RAE.

Due to the rural aspects of HCI we often meet 100% of the state set standards. Some providers will have offices located in rural communities and staff will travel to offer coverage in those remote locations.

In the rural communities most PCMPs are in our network. We rely primarily in rural communities on safety net providers the FQHCS and CMHCs.

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R4

Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?

HCI does not require court orders for care coordination relationship as we are not releasing PHI. Not all counties are covered entities and if an ROI is necessary, we will require if PHI is to be shared.

We recognize the importance of legal guardian/decision maker when opening a case.

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R4

HCI, Region 4

What services can RAE care coordinators assist with?

HCI care coordinators provide many services from referrals, transportation, peer support, monthly meetings for members to address concerns and learn about their benefits. Needs are assessed on a case by case basis. If any needs are not being met, please reach out to HCI for further clarification and support.

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R4

RAE Care Coordination Overview – CCHA, Regions 6 & 7

4/16/2021

Do care coordinators get assigned members or a specific care coordination need for a member, where resolution of the need or progress for the member is expected and tracked by the RAE or ASO? If so, how is progress for the member or towards a resolution tracked?

There is always a primary/lead care coordinator on a case however there might be a physical health and a behavioral health care coordinator or a peer supporting based on the member's needs.

CCHA uses Essette and member directed goals to track progress for members- cases are typically closed when member goals have been met, they no longer want care coordination for some reason, or we are unable get a hold of them after multiple attempts.

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R6 R7

How are high-needs (behavioral & mental health) members identified, and what does that identification mean, in practical terms, to the RAE and the member? Do care coordinators devise 'care plans' in a proactive manner such that they are outreaching members, providers, and other stakeholders with plans for care designed to address and mitigate these high needs?

High needs behavioral health members are identified through ADT/Census reports, internal risk stratification, provider referral, and upon intake screening by CCHA. CCHA proactively outreaches high-need members who are identified through these processes.

Care coordinators create shared care plans with members and those involved in the member's care to address gaps in care and current needs with the intent to mitigate the member's high needs in the future. This often involves care conferences or staffings to bring all involved together to collaborate and includes the family. This approach helps ensure that all involved in the member's care are aligned and moving towards similar goals and can, together address the barriers to meeting those goals.

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R6 R7

CCHA, Regions 6 & 7

How are a member's care coordination needs determined? How is a member paired with a specific service or provider if a request isn't made by the custodian, member, the PCMP, or current provider?

Care coordination needs are determined through a thorough assessment process and collaboration with the family and those involved in the member's care.

Members are often referred to CCHA by community providers/partners although we do have internal risk stratification to identify those who may be at high risk as well and can then provide proactive outreach (this is harder for children who do not fit into specific populations as easily as adults do).

We need collaboration from a guardian or the member to connect a member to needed services as those services will often require consent on the part of the member or guardian to obtain the service and complete intakes when needed.

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R6 R7

Is it part of a care coordination's expected duties that they'd outreach a provider to ensure openings and that they are a good fit to meet the need prior to suggesting them to a custodian of a member for follow-up?

If there is a need for a specific provider type, we provide referral options for members based on individual requests and knowledge about provider specialties. If the service is more specialized or a higher level of care is needed, care coordinator will outreach provider and assess for best fit.

Additionally, many services offer or require an intake with the family to determine if that service is a good fit for both parties.

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R6 R7

What does successful care coordination for high needs children and struggling families "look like" from the RAE perspective? How are positive outcomes of care coordination measured for this population?

Care coordinators create shared care plans with members and those involved in the member's care to address gaps in care and current needs with the intent to mitigate the member's high needs in the future, which often

R6 R7

involves care conferences or staffings to bring all involved together to collaborate, including the member's family. This approach helps ensure that all involved in the member's care are aligned and moving towards similar goals and can, together address the barriers to meeting those goals.

Positive outcomes include:

- Goals being met or being revised as appropriate
- Member/family connected to needed services and resources
- Member/family aware of how to access services and resources available to them

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R6 R7

Are efforts made by the RAE or care coordinators to engage members? Are there members who are tracked and regularly contacted/outreached by care coordinators to ensure that the care that's been coordinated is effective?

Care coordination works with members/families toward their care plan goals and reassess goals regularly, especially if a provider or care team member determines there are additional needs.

Even once goals are met and/or the case is closed, an additional referral to care coordination can be made at any time.

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R6 R7

Can or do care coordinators receive specific training re: care coordination needs for potentially high-needs & complex demographics they serve, such as:

- Children in foster care,
- Children in kinship care,
- Children who have experienced complex trauma,
- Children who should also be served and supported by the CCB but have not/are not (we've been told that the RAE do the care coordination until the child is formally served by the CCB and a waiver

CCHA care coordinators are trained in working with these high-need populations.

R6 R7

CCHA works closely with the CCBs when care coordination needs are identified or a referral is received. We collaborate closely with the CCBs to ensure care coordination needs are met regardless of where the member is in the waiver determination process.

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R6 R7

If there are no providers contracted with the RAE to meet the specific needs of a member, what responsibility does the RAE and/or care coordinator have to recruit and contract with a provider to meet that need? Is that responsibility spelled out in the contract the RAE has w/ HCPF?

CCHA is committed to contracting with a robust network in order to meet the diverse needs of members and uses the strategies listed below to meet network adequacy. Per the RAE contract with HCPF the following is required: *The Contractor shall establish and maintain a statewide network of behavioral health providers that spans inpatient, outpatient, laboratory, and all other covered mental health and substance use disorder services. The Contractor shall develop and implement a strategy to recruit and retain qualified, diverse and culturally responsive Providers including, but not limited to, Providers who represent racial and ethnic communities, the deaf and hard of hearing community, the disability community and other culturally diverse communities who may be served. The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to: Serve all primary care and care coordination needs; Serve all behavioral health needs; and Allow for adequate Member freedom of choice amongst Providers.*

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R6 R7

What are the RAE's doing to recruit more providers?

In areas where gaps in coverage exist because providers are generally lacking, CCHA fosters collaborative relationships with local organizations and providers. Through formal and informal relationships with community partners, CCHA has better understanding of the community's unique needs, can leverage existing efforts to reduce gaps, and can prioritize efforts to improve member access to an appropriate range of services. In areas where gaps in coverage could be remediated by recruiting non-contracted providers, CCHA's provider solutions team utilizes available tools, including but not limited to, out of network authorization or single case agreement requests, non-contracted and enrolled provider lists provided by HCPF, stakeholder feedback, member requests received by member support services, care

R6 R7

coordination, and/or utilization management, and direct provider inquiries. Out of network providers that are identified as having a material number of single case agreements or out of network authorization requests, will be prioritized along with behavioral health providers requested by members. Regarding efforts to address gaps in coverage for behavioral health, CCHA aims to contract with all CMHCs, Federally Qualified Health Centers (FQHCs), and hospital systems to provide extensive member choice and facility access. CCHA also continues to welcome independent providers and any provider with a single case agreement to join the network. With that, CCHA continues to monitor ongoing issues surrounding the lack of providers and availability of substance use services in rural counties and continues to pursue innovating opportunities to ensure access.

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R6 R7

Why do some of the RAE's require ROI's and court orders prior to assigning a care coordinator?

Not all counties are covered entities and a ROI may be required in order to share PHI.

It is important to know who the legal guardian/decision maker is upon opening the case.

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R6 R7

What services can RAE care coordinators assist with?

CCHA supports members who need help navigating the health care system:

- Assessing member needs and goals
- Creating a proactive care plan
- Linking to health care and community resources
- Helping with transitions of care
- Supporting members' self-management goals
- Monitoring and follow-up after hospitalization
- Member education
- Convene and coordinate the care team, establish accountability

R6 R7

CCHA, Regions 6 & 7

CCHA can:

- Help connect members to the enrollment broker to change attribution
- Access the Benefits Utilization System (BUS), COHRIO, and other data systems accessible by the RAE
- Participate or facilitate staffings or home visits for complex clients
- Provide Monday through Friday call center support

Who is the integrated care coordination team?

- Physical and behavioral health care coordinators
- RN, LCSW, licensed behavioral health care coordinator
- Member Support Services team:
- CCHA Call Center
- Community health workers
- Peer support specialists
- Utilization care managers

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R6 R7