COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Colorado Community Health Alliance (Region 6)

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

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Introduction and Background

The Colorado Department of Health Care Policy & Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011 as a central part of its plan for Medicaid reform. The ACC Program was designed to improve the member and family experience, improve access to care, and transform incentives and the healthcare delivery process to a system that rewards accountability for health outcomes. Central goals for the program are (1) improvement in health outcomes through a coordinated, member-centered system of care; and (2) cost control by reducing avoidable, duplicative, variable, and inappropriate use of healthcare resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. **Colorado Community Health Alliance** (**CCHA**) began operations as a RCCO in October 2011. The RCCOs provide medical management for medically and behaviorally complex members, care coordination among providers, and provider support such as assistance with care coordination and practice transformation for performance of medical home functions. An additional feature of the ACC Program is collaboration—between providers and community partners, between RCCOs, and between the RCCOs and the Department—to accomplish the goals of the ACC Program.

The Affordable Care Act of 2010 allowed for Medicaid expansion and eligibility based on 133 percent of the federal poverty level. Affected populations included parents of Medicaid-eligible children and adults without dependent children. The Department estimated that, as a result of Medicaid expansion, 160,000 additional members would be integrated into the RCCOs in phases. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program demonstration project provided for integration of 32,000 new dually eligible Medicare-Medicaid members into the RCCOs, beginning September 2014. Effective July 2014, the RCCO contract was amended primarily to specify additional requirements and objectives related to the integration of ACC Medicare-Medicaid Program (MMP) enrollees.

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 organizational successes and challenges in implementing key components of the ACC Program. This report documents results of the fiscal year (FY) 2014–2015 site review activities, which included delegation of care coordination, RCCO coordination with other agencies and provider organizations, and performance of individual member care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2014–2015 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2014–2015 care coordination record reviews. Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2014–2015 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the

care coordination record reviews. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

Summary of Results

The care coordination record reviews focused on two select populations: children with special needs and adults with complex needs. HSAG assigned each requirement in the record review tools a score *of Met, Partially Met, Not Met, or Not Applicable*. HSAG also identified opportunities for improvement with associated recommendations for each record. Table 1-1 presents the scores for **CCHA**'s care coordination record reviews for each special population reviewed. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-1—Summary of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# Partially *Met*	# Not *Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Children With Special Needs	45	28	19	6	3	17	68%
Adults With Complex Needs	35	29	22	7	0	6	76%
TOTAL	80	57	41	13	3	23	72%

* The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. (*Partially Met* and *Not Met* scores received a point value of 0.0)

Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Although most contract requirements remained the same for the two review periods, scores may have changed due to reformatting and clarifications in the record review tool.

Table 1-2—Comparison of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Care Coordination 2013–2014	168	131	91	24	16	37	69%
Care Coordination 2014–2015	80	57	41	13	3	23	72%

* The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. (*Partially Met* and *Not Met* scores received a point value of 0.0)

The Data Collection Tool (Appendix A) was used to capture the results of the pre-on-site document review and on-site discussions related to Delegation of Care Coordination and RCCO Coordination With Other Agencies/Provider Organizations. Following is a summary of results for each content area of the 2014–2015 review.

Summary of Findings and Recommendations by Focus Area

Delegation of Care Coordination

Activities and Progress

CCHA has delegated care coordination activities to five primary care medical providers (PCMPs)—Clinica Family Health Centers, Metro Community Provider Network, Salud Family Health Centers, Denver Health, and Kaiser Permanente Colorado (Kaiser). The five delegated PCMPs represent 35 percent of the members attributed to Region 6, and **CCHA** retains the responsibility for complex care coordination for the remaining 65 percent. **CCHA** staff members stated that **CCHA** is not pursuing delegation with additional PCMPs and that many of the PCMPs in the region are too small to have the financial resources needed to implement complex care coordination; however, **CCHA** is considering implementing partial delegation of care coordination functions with some of the more robust practices.

CCHA has a formal delegation agreement with each entity that delineates the care coordination requirements outlined in the **CCHA** contract with the Department, reporting requirements to the RCCO, payment terms, and other accountabilities of each delegate. **CCHA** outlined the care coordination requirements in broadly-defined terms. **CCHA** stated it was not being prescriptive with the methodologies or systems used by each delegate to perform care coordination, due to cross-RCCO affiliations of the PCMPs and varying systems of care coordination pre-existing within each PCMP. **CCHA** suggested that the Department consider the feasibility of attributing members to a RCCO region based on the location of the PCMP facility chosen by the member, which would eliminate the need for PCMPs to affiliate with more than one RCCO Region.

CCHA provided evidence of predelegation assessment of the infrastructure and systems capabilities within each PCMP to meet the requirements of the delegated care coordination agreement. **CCHA** staff described that it intends to perform an annual audit of each PCMP, including care coordination record reviews, to ensure compliance with care coordination requirements. However, **CCHA** reported being dissatisfied with the design of the audit process and is revising its approach. **CCHA** has audited each PCMP once since inception of the program and plans a second audit in 2015. **CCHA** meets monthly with delegates to share best practices, review outcome data (e.g., key performance indicators [KPI's]), and provide information about any anticipated ACC program developments.

Each delegated PCMP provided **CCHA** the data included in the semiannual care coordination report to the Department as part of the delegate agreement reporting requirements. Metrics included statistics for staffing levels, stratification levels of members in care coordination, and the care coordination metrics originally defined by the cross-RCCO leadership group (categorized by member eligibility category). In addition to submitting the report to the Department, **CCHA** management used the report for internal tracking and trending of each delegate's care coordination activities. Staff stated that the processes for stratification and targeting of members for referral to care coordination varied by delegate and that **CCHA** is working with its delegate partners to determine the best methods for identifying the categories of members to which care coordination resources may be most effectively applied.

The delegate PCMPs are responsible for 10 to 15 percent of Region 6's Medicare-Medicaid Program (MMP) members. Completion of the service coordination plan (SCP) is one of the expectations of the agreement with all delegates except Kaiser. **CCHA** completes the SCP for all nondelegated PCMPs and Kaiser. Staff stated that, effective April 1, 2015, **CCHA** would be receiving from 28 regional hospitals daily admission, discharge, and transfer (ADT) information that it will share with the PCMPs to facilitate timely follow-up with MMP members after discharge. Staff stated that completion of the SCPs is very time-consuming for care coordination staff and needs to be integrated into the Essette care management software in the future.

Observations/Recommendations

CCHA appeared to have a positive relationship with its delegate PCMPs (particularly the FQHCs) related to program development activities and ongoing discussions of care coordination and outcome data. **CCHA** recognizes that some of its larger, independent practices may have the potential for partial delegation of care coordination functions in the future. Although they are resource intensive, **CCHA** remains committed to conducting home-based assessments as an effective mechanism for engaging members in comprehensive care coordination. Co-location of **CCHA** care coordinators in high-volume Medicaid practices also appears to be an effective strategy for engaging members.

The performance expectations of delegates related to RCCO care coordination requirements are broadly documented in the delegation agreement and monitored at a high-level. Staff acknowledged that the RCCO is inhibited in its ability to be prescriptive with the requirements for PCMPs or to take corrective action, due to both the political implications of working with the major network PCMPs and the cross-RCCO affiliations of the PCMPs. Audit mechanisms that evaluate the delegates' performance related to the requirements of the current **CCHA** contract with the Department are not yet effectively in place. HSAG recommends that **CCHA** consider:

- Updating or amending the Delegation Agreement and annual audit tools to more closely align with the comprehensive care coordination requirements outlined in Amendment 7, Exhibit A6, of **CCHA**'s contract with the Department.
- Engaging the cooperation of the delegated PCMPs and other area RCCOs to collaboratively pursue a uniform set of delegate expectations and mechanisms to ensure meeting the care coordination requirements within the RCCO contract.

RCCO Coordination With Other Agencies/Provider Organizations

Activities and Progress

CCHA listed 17 agencies or community organizations with which it has established formal relationships and 33 agencies or community organizations with which it has established informal working relationships. In addition, **CCHA** listed numerous agencies with which it is pursuing relationship, primarily related to serving the MMP population. The care coordinators are a primary source for identifying the high-priority organization and agency relationships in the region. The Department has also identified key agencies related to special populations. Fundamental to all relationships are mutual referral of clients and shared care coordination, where applicable. When necessary for sharing of client data, **CCHA** has implemented business associate agreements

(BAAs). Most relationships are initially established through face-to-face communications and mutual education about the roles and responsibilities of each organization. **CCHA**'s care managers, community liaison, and leadership staff are its primary contacts for developing relationships with either community organizations or agencies. Due to the more formal and complex structures of agencies, **CCHA** assigns a member of its leadership team as the primary contact with each agency. These more formal relationships include routine meetings, written agreements, and policy level interactions. Common activities with agencies include shared grant applications and programs, co-branding of programs and educational resources, and provision of materials for PCMPs and members. Staff described numerous examples of collaborative activities with community organizations and agencies.

Barriers to a successful relationship may occur when there is inconsistency in the populations served by the RCCO and the organization or when an organization is large and diverse, lacks a single point of contact, or continues to perceive the RCCO as a threat. The lead time required to establish relationships with agencies is longer than with community organizations, and frequent staff turnover at agencies poses an ongoing challenge. Staff stated that educating organizations on the role of the RCCO is a long-term process.

Staff described the major success factors in developing relationships with both community organizations and agencies as the ability to identify a mutual goal, establish a noncompetitive and mutually supportive environment, reduce perceptions that the RCCO is a threat to another organization's services, and simultaneously maintain successful functional level (i.e., care coordination) and management/policy/program level activities. **CCHA** has attempted to position itself as the facilitating resource for issues and questions from community agencies, providing a conduit for the flow of information to the Department. Staff stated that, as the visibility and understanding of the RCCO has increased in the community, the foundation has been established for continued development of collaborative processes with various organizations and agencies.

CCHA has established a formal relationship with the Boulder AIDS Project and a care coordination relationship with the Denver County AIDS Project, both Ryan White Program affiliates. Both AIDS project programs provide all care coordination for members with HIV. Due to the increased level of confidentiality required for this population, **CCHA** has not established data-sharing agreements with either agency. Staff described **CCHA**'s relationship with the Boulder AIDS Project as interactive and positive. **CCHA** provides support to the program through referrals, the infectious disease specialists, and the Advisory Committee.

The Department has been working with the Colorado Department of Corrections to develop a program to ensure that persons released from prison are enrolled in Medicaid immediately upon release. The Department anticipates that the details will be finalized and the plan implemented in 2015. Meanwhile, **CCHA** has met with the transitions and parole personnel in the State prison system to conduct cross-education and to discuss mechanisms for referral of criminal justice involved (CJI) individuals to the RCCO. **CCHA** has been meeting with staff from the Jefferson County Sheriff's Office, Jefferson County Jail, and Boulder County Jail to discuss methods of coordinating services for CJI members. Foothills Behavioral Health Partners (FBHP)—the behavioral health organization for Region 6—implemented a performance improvement project (PIP) with the county jails, and Jefferson County Mental Health (JCMH)—one of the community mental health centers in the Region—has developed a pre-release teleconference program with the

county jail. **CCHA** is tracking the progress of FBHP's PIP and Jefferson County Mental Health's program, and will collaborate with both agencies in coordinating care for CJI members.

CCHA's existing relationships with community organizations, its long-term partnership with the behavioral health organization (BHO), and Department-facilitated relationships with the community centered boards (CCBs) and single entry point (SEP) agencies have provided a solid foundation for building a network of services for MMP members. **CCHA**'s MMP population has a low proportion of elderly and a high proportion of members with disabilities. Staff stated that 70 percent of **CCHA**'s MMP members have disabilities and 50 percent are already receiving services through the regional BHO. **CCHA** has signed BAAs with the BHO, CCBs, and SEPs in its region. Care coordinators reach out to the CCBs for assistance with waiver programs and to SEPs and mental health centers to perform co-care coordination. Due to the Department's initiative with the Colorado Regional Health Information Organization (CORHIO), **CCHA** will now receive daily ADT information about **CCHA** members from 28 hospitals in the region, enabling care managers to identify MMP members for timely outreach after a hospital encounter. **CCHA** is pursuing a formal relationship with an additional 26 organizations, most of which are home health or long-term care (LTC) providers. **CCHA**'s community resource liaison has established many contacts with home health organizations, including the Professional Home Health Care Association of Colorado. However, **CCHA** expressed the need for some method of assessing the quality of the numerous home care organizations prior to formalizing initiatives with them. **CCHA** established informal relationships with hospice programs through the care coordination program although—due to the low volume of members needing those services—formal arrangements with hospice organizations are not the highest priority. **CCHA** has developed a formal relationship with Vivage Quality Health Partners, owner of nine skilled nursing facilities (SNFs) in the region, to partner on transitioning members back to the community. Staff characterized the relationship with Vivage as its most successful venture regarding care of MMP members and the completion of the SCPs as the most challenging aspect of the MMP demonstration program to date.

During on-site interviews, HSAG asked staff about **CCHA**'s progress in identifying Medicaid-eligible pregnant women for attribution to a PCMP and appropriate management of high-risk pregnancies. **CCHA** described the following initiatives for identification and management of Medicaid members who are pregnant.

- **CCHA** has a BAA relationship with the Healthy Communities programs in the region. **CCHA** receives a list from Jefferson County DHS of new Medicaid enrollees who are eligible because they are pregnant. **CCHA** shares this list with the Healthy Communities program so that their staff may perform early interventions, as appropriate. Similarly, Healthy Communities refers members or families in need of care coordination services to **CCHA** care coordinators. Of note, staff stated that although the Jefferson County Healthy Communities program previously shared information with the RCCO, in 2014 it determined a new BAA was required to continue this practice. At the time of the review, **CCHA** was finalizing a BAA with Jefferson County that will enable data sharing with all Jefferson County agencies.
- **CCHA** reviews ADT information from emergency rooms to identify Medicaid members who are pregnant and conducts follow-up to assist the member with attribution to a PCMP, as necessary, and to provide information about prenatal care programs and services.

- Westside Women's Care delivers the majority of babies born to Medicaid enrollees in the region. **CCHA** initiated a special project with Westside Women's Care to encourage notifying the RCCO of Medicaid members who are pregnant.

Observations/Recommendations

CCHA actively pursues relationships ongoing with organizations and agencies that address the needs of its diverse populations. **CCHA** has formal and informal arrangements with numerous organizations and participates in data sharing; care coordination referrals; grant applications and collaborative programs; and co-branding and sponsorship, among other activities. **CCHA** has personnel engaged at both the operational and leadership levels to ensure ongoing successful relationships with these organizations. **CCHA** articulates an in-depth understanding of the challenges and success factors involved with establishing and maintaining positive relationships with agencies. The community resource liaison continually identifies and nurtures relationships with community organizations. It appeared that **CCHA** has secured relationships essential to the provision of care and services for Medicaid expansion special populations. HSAG agrees that **CCHA** has established a strong foundation for continued development and expansion of a network of functional affiliations to serve RCCO members.

Care Coordination Record Reviews

Findings

Care coordination record reviews achieved an overall score of 72 percent compliance with all of the criteria for comprehensive care coordination (the child records scored 68 percent compliance and the adult records scored 76 percent compliance). **CCHA** assigned an individual care coordinator to each case, and every record included a thorough assessment of needs. Most cases demonstrated that the coordinator actively linked the member to needed services, although only half of the cases addressed all assessed member needs. The major area of deficiency was care coordinator outreach to other care managers or providers involved in the member's care.

Several cases in the sample were omitted due to lack of complexity of needs. **CCHA** referred all member inquiries and requests for services to the care management department for follow-up, and these cases were documented and tracked through the care coordination software. Staff stated that the care coordination system did not have the capability to differentiate cases based on stratification of high-risk. Therefore, the selection list submitted to the Department included many cases that did not qualify as complex care coordination cases. Staff indicated that, in 2015, each care coordination record will include an acuity indicator that will enable **CCHA** to better delineate the complexity of a care coordination case.

CCHA implemented a new care coordination software system in December 2014 and added a health partner supervisory position to provide more consistent oversight of **CCHA** care coordination processes. The Essette care coordination system included enhanced features for documenting care coordination processes—including a comprehensive needs assessment, associated care plan goals and interventions, and reporting capabilities that will enable monitoring of care manager performance and outcomes. The system was implemented late in the review period;

therefore, the improvements offered in the new system had limited impact on the scores of the record reviews.

Observations/Recommendations

Despite the specific scoring results, care coordination record reviews demonstrated improvements in several areas compared to previous years' reviews. Coordinators documented comprehensive assessments of member needs, regularly followed up with the member, and demonstrated many referrals to needed services. HSAG observed that member needs frequently included financial resources, housing resources, and additional benefits.

HSAG also observed several trends that indicate opportunities for improvement. Care coordinators tended to close cases prematurely. (This issue was also noted in previous HSAG reviews.) HSAG observed several instances in which the case was closed prior to all needs of the member being met, when the member stated that he/she had no other immediate needs, or after limited phone outreach attempts with no response from the member. HSAG acknowledges that the decision to close a case must be balanced with the need to use limited care coordinator resources to assist other members. However, in each of these cases, the member appeared to have additional unmet short-term needs or the potential for additional, future needs due to the complexity of the situation. HSAG recommends that **CCHA** further evaluate its guidelines for determining when to close cases for members with many complex needs, and conduct training and/or monitor care coordinator decisions regarding circumstances for case closure.

In several cases, HSAG observed that the care coordinator appeared to be focused on maintaining direct communications with the member and providing referral information for member follow-up. In two cases, it was apparent that the member was overwhelmed and may have benefitted from direct intervention by the care coordinator to arrange the needed services. **CCHA** should consider actively rather than passively linking the member to needed services, when the member does not appear to follow-through with referrals.

Care coordinators were not consistently outreaching external case managers involved in the member's care and sometimes not making direct contact with the member's PCMP to communicate care coordination efforts related to the member's medical issues. In two cases, the member reported that another agency was assuming responsibility for care coordination for the member and the **CCHA** care coordinator closed the case before documenting attempts to communicate with the new care manager to provide needed information, offer co-coordination, and/or formally turn over the case to the new care manager. **CCHA** should conduct additional training and, as necessary, develop mechanisms to further the integration of **CCHA** care management with external agencies and providers.

While the newly implemented Essette care management software appears to offer many enhancements to improve documentation and tracking of member care coordination, HSAG recommends that **CCHA** periodically audit a sample of files to ensure that documentation aligns with RCCO comprehensive care coordination requirements and is substantive enough to represent coordination of services for members with complex needs.