Colorado
Accountable Care Collaborative

FY 2015–2016 Site Review Report

for

Colorado Access (Regions 2, 3, and 5)

June 2016

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

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1. Executive Summary

for **Colorado Access (Regions 2, 3, and 5)**

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 to (1) improve member health; (2) improve member and provider experience; and (3) contain costs 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 Access** began operations as a RCCO for Region 2 in May 2011, for Region 3 in June 2011, and for Region 5 in July 2011. The RCCOs develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization, and outcomes for their populations of members. 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. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program (MMP) demonstration project provided for integration of new dually eligible Medicare-Medicaid members into the RCCOs beginning September 2014. The RCCO contract was amended in July 2014 primarily to specify additional requirements and objectives related to the integration of ACC 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 successes and challenges in implementing key components of the ACC program. This report documents results of the fiscal year (FY) 2015–2016 site review activities, which included evaluation of the RCCO's efforts regarding integration with specialist providers, integration with behavioral health services and behavioral health organizations (BHOs), and performance of individual MMP member care coordination. In addition, the Department requested a follow-up discussion of select focus projects implemented by each RCCO. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2015–2016 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 through Table 1-3contains the results of the 2015–2016 MMP care coordination record reviews. Table 1-4 through Table 1-6 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2015–2016 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 a sample of the MMP population who had a completed service coordination plan. HSAG assigned each question in the record review tools a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable*. HSAG also included, as necessary, comments for each element scoring *No*, *Partially*, or *Unable to Determine* and included any other pertinent reviewer observations. Table 1-1, Table 1-2, and Table 1-3 present the scores for **Colorado Access**' care coordination record reviews in each region. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-1—Summary of Care Coordination Record Review Scores for Region 2

Description of Record Review	# of Elements	# of Applicable Elements	# *Yes*	# *No*	# *Partial*	# Unable to Determine	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	142	142	0	0	0	68	100%

Table 1-2—Summary of Care Coordination Record Review Scores for Region 3

Description of Record Review	# of Elements	# of Applicable Elements	# *Yes*	# *No*	# *Partial*	# Unable to Determine	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	127	122	1	4	4	79	96%

Table 1-3—Summary of Care Coordination Record Review Scores for Region 5

Description of Record Review	# of Elements	# of Applicable Elements	# *Yes*	# *No*	# *Partial*	# Unable to Determine	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	139	129	3	7	0	71	93%

* The overall percentages were obtained by adding the number of elements that received a score of *Yes*, then dividing this total by the total number of applicable elements. (*No* and *Partially* scores received a point value of 0.0; *Unable to Determine* was included with *Not Applicable*.)

Table 1-4, Table 1-5, and Table 1-6 provide a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Although most care coordination requirements of the RCCO contract and MMP contract were similar, some 2015–2016 scores may have varied from previous years' reviews due to specific service coordination plan requirements for the MMP population.

Table 1-4—Comparison of Care Coordination Record Review Scores for Region 2

Description of Record Review	# of Elements	# of Applicable Elements	# Met (or Yes)	# Not Met (or No)	# Partially Met (or Partially)	# Not Applicable (or Unable to Determine)	Score* (% of Met/Yes Elements)
Care Coordination 2013–2014	72	64	41	14	9	8	64%
Care Coordination 2014–2015	71	57	45	4	8	14	79%
Care Coordination 2015–2016	210	142	142	0	0	68	100%

Table 1-5—Comparison of Care Coordination Record Review Scores for Region 3

Description of Record Review	# of Elements	# of Applicable Elements	# Met (or Yes)	# Not Met (or No)	# Partially Met (or Partially)	# Not Applicable (or Unable to Determine)	Score* (% of Met/Yes Elements)
Care Coordination 2013–2014	144	115	49	34	32	29	43%
Care Coordination 2014–2015	82	65	59	0	6	17	91%
Care Coordination 2015–2016	210	127	122	1	4	83	96%

Table 1-6—Comparison of Care Coordination Record Review Scores for Region 5

Description of Record Review	# of Elements	# of Applicable Elements	# Met (or Yes)	# Not Met (or No)	# Partially Met (or Partially)	# Not Applicable (or Unable to Determine)	Score* (% of Met/Yes Elements)
Care Coordination 2013–2014	132	111	66	18	27	21	59%
Care Coordination 2014–2015	80	54	33	5	16	26	61%
Care Coordination 2015–2016	210	139	129	3	7	71	93%

* The overall percentages were obtained by adding the number of elements that received a score of *Met/Yes*, then dividing this total by the total number of applicable elements. (*Partially Met/Partial* and *Not Met/No* 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 the focus content areas: Integration with Specialist Providers, Follow-up of Region-specific Special Projects, and Integration with Behavioral Health Services/BHOs. Following is a summary of results for each content area of the 2015–2016 review.

Summary of Findings and Recommendations by Focus Area

HSAG conducted staff interviews applicable to **Colorado Access** RCCO regions 2, 3, and 5 simultaneously. Regions 3 and 5 combined comprise the majority of the Denver metropolitan area. Region 2 covers the northeast quadrant of the state and, with the exception of Weld County, is primarily rural. Unless otherwise noted in the narrative, the information gathered is applicable to all three **Colorado Access** regions.

Integration With Specialist Providers

Activities and Progress

The concentration of specialists in the metropolitan area, and where most RCCO 3 and RCCO 5 members receive specialist care, is centered near the tertiary care hospitals. In addition, UCHealth and Children's Hospital Colorado (Children's) specialists are the primary source of "super sub-specialties." The majority of members in Region 2 access diverse specialists associated with Banner Health in Weld County and, to a lesser degree, UCHealth in Fort Collins. Children's is most frequently accessed for pediatric specialty care. While specialist practices are either owned by or closely affiliated with these hospitals, most specialists retain significant autonomy in determining acceptance of referrals. Within Region 3 and Region 5, Denver Health (DH) specialists are primarily available to empaneled staff providers, with members outside the DH system experiencing extensive wait times. Likewise, Kaiser clinics and specialists are only open to Kaiser-enrolled members. Within Region 2, both Banner Health and UCHealth have extended specialist care to the rural areas by transporting rotating specialists to various communities within the region.

Staff members stated that Colorado experiences a general shortage of specialists for the entire population, and access to specialty providers is a common concern of all payors. Due to the overall competition for access to specialists, providers do not have to accept Medicaid members; and the Medicaid fee structure is a key issue for providers, presenting a barrier to access. Existing personal and professional relationships among providers are the primary drivers of access to specialist care. **Colorado Access** has not formally adopted or implemented referral protocols with providers, but has used protocols developed in 2014 as education and guidance for primary care medical providers (PCMPs) to prepare members for effective specialist visits. Within Region 2, several large PCMPs have adopted referral compacts—formal agreements for bidirectional communication of information—with their various specialist providers. Within Region 3 and Region 5, **Colorado Access** has instituted with PCMPs practice transformation programs that enhance practice operations applicable to all patients irrespective of payor source—which may encourage more widespread adoption of specialist referral protocols.

Recognizing that access to specialists is a complex problem applicable to more than just Medicaid members, **Colorado Access** has engaged in several strategies to improve access to specialists.

Region 3 and Region 5

- **Colorado Access** leadership has been an active participant in community alliances focused on specialty care, specifically the Specialty Care Access Working Group *Mile High Health Alliance* (MHHA) and the Access to Specialty Care (ASC) Task Force *Aurora Health Access*. Staff members stated that the Mile High Health Alliance has made the most implementable progress of the two organizations by defining a program that includes a "hub" for managing Medicaid and uninsured referrals among MHHA providers. The program is intended to improve efficiencies in specialist practices and quality of specialist consults. Doctors Care PCMP has developed an individual practice initiative to implement a care management hub concept with PCMPs and several specialist practices in Douglas County.
- **Colorado Access** tracked Medicaid specialist referrals and conducted outreach to high volume specialist practices to gather information that profiles the practice regarding access for Medicaid members. These profiles are used by care managers, medical directors, or RCCO contract managers, all of which intervene as necessary to assist individual members or providers with access to needed specialists.
- **Colorado Access** informally considers PCMP capabilities to exercise successful specialist referrals as a criterion for delegation and provides an increased per-member-per-month (PMPM) reimbursement to delegates.
- **Colorado Access**' tele-behavioral health program provides behavioral health specialist expertise to primary care practices through patient-focused eConsults and education of primary care providers regarding primary care behavioral health interventions. Tele-behavioral health offers the primary care provider the opportunity to consult with a psychiatrist about any patient, and the psychiatrist is available for scheduled appointments for Medicaid patients. While currently limited to behavioral health, **Colorado Access** was exploring extension of telehealth into other specialty areas. Telehealth was considered especially advantageous for providers in Region 2.

Region 2

- Staff members stated that partnering with Banner Health system offers the most promising solutions for addressing the shortage of specialist availability for Medicaid members. RCCO leadership is continuously working with Banner Health to identify partnership initiatives that address Banner Health's needs—e.g., exploring mechanisms to recruit more specialists to the Banner Health system and/or implementing mechanisms that make it "easier" for specialists to provide services to Medicaid members.
- Due to the vast geographic distances in this largely rural region, staff members stated that transportation issues are the greatest barrier for members' accessing specialist services. RCCO leadership participates in community initiatives to respond to the various challenges of establishing locally-based medical transportation services.
- The RCCO participated in numerous other partnership initiatives intended to extend specialty services into local communities throughout the region, including implementation of co-located behavioral health providers and tele-behavioral health in several PCMP clinics, implementation

of a clinic-based clinical pharmacy program whereby clinical pharmacists and residency students work with primary care providers (PCPs) to assist with medication therapy for members with chronic conditions, and facilitation of a program to coordinate care and provide telehealth services to support specialized care for foster care children and families in two rural communities.

Observations/Recommendations

Overall, **Colorado Access** has developed a multifaceted strategy in each of the regions to address short-term and long-term solutions to improve access to specialist care for Medicaid members. Access to specialists is an all-payor concern; therefore, competition for Medicaid member access to specialists remains a complex issue that requires innovative solutions beyond formal referral protocols. **Colorado Access** has developed tele-health technology and thoughtful program implementation which, with expansion to increased PCMP practices and specialty areas, promises to be an effective interim and long-term solution to access to specialty services for Medicaid members.

Follow-up of Region-specific Special Projects

Activities and Progress

Relationship with the Health Information Exchange (HIE)

In 2014, **Colorado Access** established an agreement with the Colorado Regional Health Information Organization (CORHIO) to receive daily admit, discharge, and transfer (ADT) data and laboratory data from hospitals participating in the HIE. **Colorado Access** staff members developed the capability for direct data transfer from CORHIO into the **Colorado Access** database. **Colorado Access** does not use the data feed provided through the Department's agreement with CORHIO. Staff members stated that gaps or inadequacies with the data received included missing diagnosis codes in the ADT data (a hospital input issue) and lack of standardization in the laboratory data. **Colorado Access** was working with CORHIO and the Colorado Hospital Association to determine a solution for hospitals to consistently provide diagnosis codes in ADT data, but was not using the laboratory data because non-standardized data are not meaningful. ADT data are being used to provide internal reports to care managers and the transition of care team of real-time hospital admissions and discharges. Although **Colorado Access** provides daily ADT data for RCCO members to the delegate practices, half of the 16 delegated entities have a direct relationship with CORHIO to receive data feeds pertaining to their entire patient base. **Colorado Access**' practice transformation team was working with delegated practices to understand how to best use their CORHIO data to facilitate transition of care activities. Staff members described several challenges associated with integration and use of the CORHIO data. In general, however, having access to real-time ADT data was considered a success for support of care management activities. **Colorado Access** staff also integrated ADT information into population health reports used to analyze special populations. In the upcoming year, **Colorado Access** intends to capitalize on its relationship with CORHIO to further expand the innovative uses of both ADT and laboratory data to support population-based programming and evaluation or other clinical applications.

Transition of care—transfer to delegates

Colorado Access has defined and successfully implemented a very robust Transition of Care (TOC) program, and has developed scripts and tools to guide each type of care management encounter with the member. Staff members stated that member activation to participate in care management was a significant indicator of success in engaging members and had incorporated a patient activation measure into assessment processes. **Colorado Access** staff presented the TOC program to the delegate workgroup, which responded with interest in implementing the program within their PCMP practices. The RCCO practice transformation team was responding to requests from several practices to assist in implementing the TOC processes in their practices, which would be applicable to patients of all pay sources.

Integrating RCCO members into DH

The State Medicaid Management Information System (MMIS) discontinued passive enrollment into Denver Health Managed Care (DHMC) of some categories of newly eligible Medicaid members, including members already attributed to RCCO providers. **Colorado Access** reported that some unconfirmed problems may still exist with the passive enrollment process. However, 38,000 RCCO members have chosen DH as their PCMP. Staff members stated that RCCO member access to DH primary care clinics did not appear to be a concern, as RCCO members have equal access to the DH clinics; however, the refugee clinic was reportedly not returning phone calls made by refugee members due to language barriers. Continuing challenges with access to DH services included: access to DH specialists is prioritized for patients of DH staff physicians, and members of RCCO providers experience delayed access; RCCO providers complain about difficulties with the DH authorization systems; and many RCCO members have the mistaken understanding that they must live in the city of Denver to have access to DH specialty clinics such as the HIV or homeless clinics or to non-medical services such as WIC. RCCO managers continue to build relationships within the DH system to pursue solutions to member and provider issues and have initiated regular meetings with Denver Health to help identify the appropriate staff to help champion initiatives and make decisions within the DH system.

ER-based care coordinators in University Hospital

UCHealth data documented 15,200 ER visits in a three-month period, many of whom were Medicaid members. Data also indicated that the age group most commonly accessing the ER involved those in the 20-to-29-year-old range. In February 2016, **Colorado Access** initiated a two-year pilot project with University of Colorado (UC) Health to place two RN care coordinators in the UC hospital *Fast Track* emergency room (ER) to divert RCCO members to more appropriate services when indicated. The mutual goal of **Colorado Access** and UCHealth was to reduce the number of ER visits by intervening with Medicaid members entering the *Fast Rack* ER who did not need diagnostic interventions or inpatient services. Care coordinators funded by **Colorado Access** but employed by UCHealth were expected to complete a health needs assessment and care plan with the member, assist the member with PCMP attribution, and organize specialty and community resource referrals as needed. **Colorado Access** outlined detailed work flow and training tools for the project. Care coordinators documented in both the hospital electronic medical record system and the Altruista care management system. At the time of HSAG review, only one of two care coordinators had been hired and data indicated an average of 67 encounters monthly with **Colorado Access**

members. UCHealth was pursuing a second care coordinator to work the evening/night shift. **Colorado Access** reported that it will evaluate the effectiveness of the program prior to expanding it to other member groups, and will follow these members long term to determine whether ER utilization patterns have been altered.

Improving delegate compliance with comprehensive care coordination requirements

Colorado Access had developed an extensive delegate training plan and a comprehensive *Pre-delegation Care Management Audit Tool*, which was applied to two new delegate practices added in 2015. In addition, **Colorado Access** had performed audits of care management records in thirteen existing delegate practices and was working with eight delegates on corrective action plans resulting from the audits. **Colorado Access** staff conducted regular mandatory group meetings with delegate care managers to discuss issues and solutions for improving care management performance. Staff members reported that delegates were openly sharing RCCO-related processes and procedures, and **Colorado Access** encouraged peer-to-peer consultation to promote care management best practices. The delegate work group was working on defining more meaningful care management outcome measures to be reported to **Colorado Access**. Staff members stated that most delegates had responded very favorably to **Colorado Access**' expanded emphasis on meeting RCCO comprehensive care management requirements. While **Colorado Access** retains the right to rescind delegate agreements based on nonperformance, staff members were confident about the potential for all delegated PCMPs to ultimately perform according to RCCO care management standards.

Observations/Recommendations

Although **Colorado Access**' relationship with CORHIO provides for timely access to ADT information, **Colorado Access** continues to describe that the amount of data received is overwhelming, includes some gaps and inadequacies, and is difficult to effectively integrate into care coordination and other processes. **Colorado Access** was pursuing solutions to these issues through relationships with CORHIO and other external stakeholders to determine ways that the CORHIO data may be improved upon at a systems level. **Colorado Access** was also intending to intensify its internal organizational focus and its relationship with CORHIO to maximize the benefit of receiving and using information that is currently or may in the future be available through the HIE. HSAG encourages **Colorado Access** to continue to seek solutions for both effective and innovative applications of ADT and laboratory data.

RCCO contract managers appear to be satisfied that RCCO members have appropriate access to DH primary care services and that attribution of RCCO members to non-DH PCMPs is no longer a significant issue for RCCO members. However, **Colorado Access** must continue to address with DH the prioritization of access to DH specialists for RCCO members and other access issues as they arise. HSAG appreciates the challenges presented in working with a large and established public health provider such as DH and recognizes **Colorado Access**' continued efforts to work with DH to troubleshoot RCCO member and provider issues as well as improve communications or expedite decision making within the DH system.

While it appears premature to make valid observations about the UCHealth ER *Fast Track* diversion project, preliminary data appeared to indicate a disproportionately low number of care coordination encounters relative to the total number of ER visits.

Colorado Access has significantly intensified its monitoring activities and interactions with delegates to ensure compliance with comprehensive care management contract requirements. Staff members also reported that most delegates had responded positively to the RCCO's efforts to assist with improving performance. With continuous ongoing efforts to communicate expectations, involve delegates in determining solutions, and encourage sharing of best practice techniques among delegates, it appears that the delegates' impact on **Colorado Access**' overall performance of comprehensive care coordination may significantly improve. Similarly, the RCCO's presentation of TOC processes to delegates appears to have been well received, and has stimulated an opportunity for RCCO processes to be applied to all patients within a PCMP practice through practice transformation initiatives.

Integration With Behavioral Health Services/BHOs

Activities and Progress

Region 5, in its entirety, is geographically aligned with Access Behavioral Care-Denver (ABC-D); Region 3, in its entirety, is geographically aligned with Behavioral Health Inc. (BHI); and Region 2, in its entirety, is aligned with Access Behavioral Care-Northeast (ABC-NE). Many of the BHO network providers are contracted with both BHI and ABC. Due to the extensive geographic and functional overlap of the RCCO and BHO regions, **Colorado Access** has integrated management committees and program activities for its Medicaid lines of business in Region 2 and Region 5 and works with BHI to execute integrated programming in Region 3. Care management activities of the RCCO and BHO are highly integrated in all regions.

Colorado Access' goal in all three RCCO regions is to ensure that 80 percent of members have access to integrated behavioral health (BH) providers within the next five years. **Colorado Access** has employed a variety of integration models and reimbursement methods to encourage and support this transition, including:

- Community mental health center (CMHC)-employed practitioners may be co-located in a primary care practice and reimbursed through the BHO.
- A PCMP or federally qualified health center (FQHC) may independently employ behavioral health providers, and the BHOs contract with these practitioners to reimburse the practice for behavioral health services provided to Medicaid members. **Colorado Access** was also experimenting with reimbursing FQHCs for behavioral health services billed at the FQHC rate.
- Tele-behavioral health offered by **Colorado Access** may be implemented in PCMCs to integrate behavioral health consultative services into primary care sites.

Colorado Access used an Integrated Practice Assessment Tool (IPAT) to assess the level of integration in practices across the three RCCO regions and to identify the best behavioral health (BH) integrated practice options for each practice.

Tele-behavioral health services have been developed and implemented by **Colorado Access** in a number of PCMP practices in each region. Tele-behavioral health provides behavioral health eConsults and education to PCMPs. Tele-behavioral health services are provided through scheduled eConsults with PCPs or co-located behavioral health practitioners or through psychiatrist

consultations directly with members, enabling PCMPs to manage individual members' behavioral health needs within the primary care environment.

Colorado Access participated in several community coalitions and learning collaboratives intended to enhance PCMPs' integration skills or to advance implementation of integrated behavioral health/physical health (BH/PH) care in practices.

At the time of HSAG on-site review, staff members estimated that more than 50 percent of members in Region 3 and Region 5 combined and that 60 to 65 percent of members in Region 2 had access to co-located behavioral and physical health services, as follows:

Region 5

- Mental Health Centers of Denver (MHCD) has collaborated with six primary care practices in Region 5 to implement a pre-defined model for placing co-located behavioral health (BH) therapists in the PCMP practice. MHCD's focus in 2015 was high-Medicaid population pediatric practices, but intended to expand to adult services in five to six additional sites by the end of 2016. Additionally, the BHO contracted with BH providers already employed by four major PCMPs, including Kaiser and DH, to reimburse the practitioners for BH services provided to Medicaid members. Tele-behavioral health was implemented in two PCMPs.

Region 3

- Three PMHPs partnered with various local CMHCs to co-locate BH therapists in the PCMPs. Four PMHPs had employed or contracted on-site BH providers. Telehealth had been implemented in two PCMPs. BHI was engaged in planning and inventorying integration efforts in the region and was working with Aurora Mental Health Center (AMHC) to assess barriers to BH referrals with five targeted PMHCs.

Region 2

- Two CMHCs partnered with the Sunrise Community Health FQHC in Weld and Larimer counties to co-locate BH therapists in two FQHC clinic locations as well as to co-locate primary care practitioners in the CMHCs. Banner Health and Salud FQHC had employed behavioral health therapists co-located in numerous primary care clinic locations. A private BH counseling company has co-located 25 BH therapists in primary care and school-based sites in Weld and Larimer counties.
- **Colorado Access** telehealth had been implemented in two PCMPs and was pending implementation at three additional sites.

Colorado Access was also actively engaged in many and varied pilot programs or special projects in each region to test innovative models of BH/PH integrated care. Some projects were successful and sustained, and others were suspended due to funding complexities or other circumstances. **Colorado Access** staff members discussed that revision in payment mechanisms to enhance the payment rate for costs of the more comprehensive service models is needed to sustain integrated BH/PH services beyond grant funding and in anticipation of the Regional Accountable Entities (RAEs) of the ACC 2.0 contract.

The designated crisis support centers included the major BHO CMHCs in each of **Colorado Access**' RCCO regions. Although some BHO functions for Medicaid members were related to the crisis center services, staff members explained that the relationship between the crisis support centers and the RCCOs/BHOs is somewhat remote. **Colorado Access** had educated its staff members and providers on the availability and use of crisis support services for members, and had provided written materials and tools to enhance PCMP referrals to the Crisis Services system. Staff members stated that anecdotal feedback indicated that the crisis support centers and services were well-utilized in all locations.

Observations/Recommendations

Colorado Access has actively pursued integration of BH and PH through a variety of models intended to provide BH/PH for the member at the point of service. CMHCs and FQHCs in all regions were actively collaborating on co-located integrated care models. The geographic overlap of the **Colorado Access** BHOs in Region 2 and Region 5 has facilitated execution of reimbursement models to sustain these efforts, although Behavioral Healthcare, Inc. (BHI) was preparing to work on similar strategies with Region 3 during 2016. **Colorado Access**' tele-behavioral health program was an important asset to fill gaps in behavioral health services for primary care practices, particularly in the rural areas of Region 2. At the time of HSAG review, staff estimated that the majority of RCCO members had access to co-located BH/PH services, and the extent of collaborative efforts in process indicated that **Colorado Access**' goals for integrating BH/PH in practices could likely be achieved. **Colorado Access** may need to increase focus on innovative payment reform initiatives to sustain integrated care in anticipation of the ACC 2.0 contracts.

Care Coordination Record Reviews

Findings

HSAG conducted Medicare Medicaid Program (MMP) member record reviews that focused on understanding the role of the Service Coordination Plan (SCP) in documenting and performing care coordination. All records reviewed were part of the original sample selected by the Department—10 records for each of the three RCCO Regions—a total of 30 records for **Colorado Access**. Eight of the 30 SCPs were completed by delegates, one delegate in each region—with the remainder completed by **Colorado Access** care coordination staff. All records completed by **Colorado Access** coordinators were documented in the **Colorado Access** web-based SCP tool, which was designed to include all elements of the SCP, was easy to follow, and consolidated all pertinent care coordination information into one easy-to-follow document. Delegates documented the SCP elements in their internal electronic health record (EHR) systems or in the Altruista care management system. **Colorado Access** scored 96 percent overall compliance with the care coordination requirements—100 percent in Region 2, 96 percent in Region 3, and 93 percent in Region 5. Twenty-four of 30 records (80 percent) demonstrated that the member had no or limited unmet needs and/or that the member's needs were entirely being met through other entities—single entry point (SEP), community centered board (CCB), long-term care facility, or primary care medical provider (PCMP). When the member was already linked with an external care coordinator, well established with services, and unable to identify any unmet needs or goals, the RCCO care coordinator appropriately deferred to the external case manager as the lead coordinator. SCPs were generally

completed through face-to-face interviews with the member; although, if the member was unavailable or had difficulty communicating, information in the SCP may have been derived from input by family, other care managers involved with the member, or records obtained from other agencies such as the **Colorado Access** SEP.

Observations/Recommendations

Based on the sample of cases reviewed on-site, it appears that many MMP members have limited care coordination needs or have needs already being adequately addressed through other agencies, providers, or family members. In these cases, completion of the SCP appeared to be duplicative of other agencies' involvement with the member; and involvement of the RCCO care manager in completing an SCP with the member resulted in little or no added value for the member. **Colorado Access** may consider collaborating with the Department and other RCCOs to streamline the SCP requirements for those members who demonstrate few unmet needs or goals.

Based on several records reviewed and on-site discussions, HSAG noted that care coordinators were sometimes unaware of a member's hospitalization or ER visits until the six-month update of the SCP was conducted. Staff members stated that the real-time ADT data received (daily from 35 hospitals) provided an overwhelming amount of information to process and that **Colorado Access** staff members were experimenting with different methods to sort the data—i.e., combining with state data analytics contractor (SDAC) data—to prioritize high-risk cases for the transition of care team and care coordinators. Record reviews indicated that mechanisms currently in use were not consistently successful in timely identification of MMP members needing transition of care follow-up. HSAG recommends that **Colorado Access** focus on how to more effectively use available ADT data to address members' transition of care needs.

Based on several records reviewed and on-site discussions, HSAG noted an opportunity for improvement in the designation of a "lead" coordinator in the following circumstances:

- When the member was previously established with an SEP care manager for some services, the RCCO care manager tended to defer to the SEP as the "lead," even when assessment indicated that the member had additional needs for non-SEP services. In these cases, the RCCO care manager might more appropriately document that care coordination was shared between the SEP and the RCCO. HSAG also noted that in several cases information from the SEP care manager was obtained through review of information in the **Colorado Access** SEP database rather than through interpersonal communication with the SEP care manager. HSAG cautions that the role of the SEP tends to be limited to addressing the member's needs for select services and that processes are not necessarily aligned with the comprehensive care coordination requirements of the RCCOs. In order to ensure that the member's needs are fully addressed and that follow-up with the member is appropriately completed, HSAG recommends that RCCO care managers more directly communicate with SEP care managers to coordinate services for individual members and establish which care manager will serve as the lead coordinator with the member.
- The DH care coordination model uses a health team approach of clinic-based care managers, all performing designated functions for the member. DH did not designate a lead coordinator among the "team," and documentation in the EHR was unclear as to role of each team member in completing care coordination with the member. Additionally, HSAG reviewers noted that DH

procedures included telephonic outreach to the member to complete the SCP rather than face-to-face interview with the member. During on-site discussions, RCCO staff acknowledged that one of **Colorado Access**' challenges included aligning the DH clinic-based care management model with RCCO contract expectations. Given that DH has the second largest number of attributed Medicaid members in the RCCO, HSAG recommends that **Colorado Access** enhance its work with this delegate to ensure that MMP care coordination requirements are met.

Based on record reviews, it appeared that **Colorado Access** was applying the six-month SCP update time frame requirement as the target date for beginning to schedule follow-up care coordinator appointments with the member. In many cases, the inability to reach the member and/or lack of response from the member and/or RCCO care coordinator availability delayed completion of the updated SCP by several months. Additionally, in several cases—particularly when member's unmet needs were not complex—the care coordinator provided resources to the member, but did not follow up with the member until the scheduled six-month SCP update was due. HSAG recommends that **Colorado Access** use discretion when applying the six-month SCP update time frame, determining which members need follow-up prior to the six-month update and, for other members, that staff members begin scheduling six-month updates further in advance of the required due dates.

While not formally evaluated in the SCP record reviews, HSAG reviewers observed that the assessment of the member's cultural needs often documented only the member's language and/or religion. This documentation may indicate that care coordinators need further understanding of broader cultural considerations and how to observe or explore those with members.

During on-site discussions, staff members described that the **Colorado Access** internal care management transformation project was designed to integrate care management teams across product lines using functionally defined roles within the care teams—i.e., basic care coordination outreach, Care Manager 1 designation for routine care management, and Care Manager 2 designation for transitions of care and special populations. At the time of HSAG review, staff members estimated that the transformation process was 25 percent completed and that Phase 1 would be complete by the end of August 2016. Phase II will incorporate the behavioral health team and the lower-risk member population. Recognizing that the transformation involves many dynamics including staff re-alignment, training processes, and system changes, HSAG recommends—similar to the prior year's on-site review—that **Colorado Access** expedite the completion of the entire care management transformation processes.

Overview of Site Review Activities

The FY 2015–2016 site review represented the fifth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **Colorado Access** as the RCCO for Regions 2, 3, and 5. During the initial five years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to continual collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2015–2016 site visits focused on evaluating RCCO activities related to integration with specialist providers, integration with behavioral health services, and Medicare-Medicaid Program (MMP) member care coordination activities. In addition, HSAG gathered follow-up information on select special projects that had been implemented by each RCCO within the past two to three years. Through review of member records, HSAG evaluated the effectiveness of individual MMP member care coordination, including the implementation of the Service Coordination Plan (SCP). The Department asked HSAG to identify initiatives and methodologies implemented by the RCCOs in response to key contract objectives and to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the record review tool and the data collection tool, which provided the parameters for the on-site interviews. The purpose of the site review was to document compliance with select care coordination contract requirements, evaluate **Colorado Access**'s mechanisms for integrating with the BHO in the region and integrating behavioral healthcare for members, identify activities related to the involvement of specialists in the care of RCCO members, obtain updates of the progress in select special projects implemented by each RCCO, and explore challenges and opportunities for improvement related to each focused content area. Site review activities included a desk review of documents submitted by **Colorado Access** prior to the site visit. These documents consisted of program plans, written procedures, tracking documents, and any formal agreements related to each of the focus areas. During the on-site portion of the review, HSAG interviewed key **Colorado Access** personnel using a semi-structured qualitative interview methodology to elicit information concerning mechanisms for implementing the objectives and requirements outlined in the ACC contract. The qualitative interview process encourages interviewees to describe their experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. The assessment of RCCO activities related to integration with behavioral health services was conducted through a joint interview of RCCO and BHO staff.

To continue the annual evaluation of care coordination processes, on-site review activities included care coordination record reviews. The Department determined that FY 2015–2016 care coordination

record reviews would focus on the MMP population. HSAG developed a care coordination record review tool based on contract requirements and the instructions for completing the required individual member SCP.

HSAG reviewed a sample of 10 care coordination records (selected by the Department's MMP program staff from the MMP report) of members with a SCP completed during the 2015 review period. The Department forwarded the sample lists of 10 records plus 10 oversample records to **Colorado Access** and HSAG prior to the on-site visit. HSAG completed an individual record review tool for 10 MMP members during the on-site visit. Although completion of the SCP document was not the focus of the record review, HSAG used SCP information, as available, when assessing the member's overall care coordination. HSAG assigned each question in the review tool a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable* and entered reviewer comments, as necessary, related to each evaluation element within the tool.

The completed data collection tool includes narrative information and recommendations related to on-site discussion of the RCCO's integration with specialty care, integration with behavioral health services/BHOs, and progress on two special projects. The special project topics were selected by the Department from projects identified by the RCCO during previous years' on-site reviews. These topics were different for each RCCO. Summary results and recommendations resulting from the on-site interviews as well as the care coordination record reviews are also included in the Executive Summary.

Appendix A. Data Collection Tool for Colorado Access (Regions 2, 3, and 5)

The completed data collection tool follows this cover page.

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
Group 1: The Contractor shall reasonably ensure that Members in the Contractor's Region have access to specialists promptly and without compromising the Member's quality of care or health. RCCO and MMP Contracts—4.2.5 The Contractor shall ensure that all PCMPs refer members to specialty care as appropriate and ensure that clinical referrals are completed between PCMPs and specialists/referred providers. RCCO and MMP Contracts—6.1.1 The Contractor shall develop and maintain a written protocol for clinical referrals to facilitate care coordination and sharing of relevant member information. RCCO and MMP Contracts—6.1.1.1 The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid, including those not associated with the Contractor or another RCCO. RCCO and MMP Contracts—6.1.2	◆ Incentives to stimulate specialist involvement ◆ Initiatives to address shortages ◆ Expanding accessibility of specialist care ▪ Telemedicine ▪ Downstreaming services into PCMPs ▪ Transporting specialists to rural or remote areas ▪ Relationships with hospital systems ▪ Other ◆ Successes and challenges in integrating with specialists and/or maintaining capacity for Medicaid members ◆ Mechanisms for monitoring specialist involvement/responsiveness, if any ◆ Referral protocols ▪ What are they? ▪ How have they been implemented? ▪ What is degree of success of using protocols (including feedback from specialists/PCMPs)? ◆ Plans, strategies, or solutions moving forward

Discussion and Observations:

Regions 3 and 5 (Metropolitan Denver)

The concentration of specialists in the metropolitan area (where most RCCO members receive specialist care) is centered around the tertiary care hospitals of University of Colorado Health (UCHealth), The Children's Hospital Colorado (Children's), Denver Health, Swedish Medical Center, and Sisters of Charity Leavenworth (SCL) Health. The extension of HealthONE hospitals into Douglas County resulted in more Medicaid specialty provider availability in the south metropolitan area. Specialist practices are either owned by or closely affiliated with these hospitals. However,

Section I—Integration with Specialist Providers	
Contract References	**Possible Discussion Topics**
RCCO staff stated that the specialists retain significant autonomy in running their practices and determining acceptance of referrals. Staff members cited that more specialists are leaving Colorado than moving to it, resulting in a general shortage of specialists, particularly in dermatology, neurology, and rheumatology. Access to behavioral health (BH) providers is a common concern across all payors. Denver Health specialists are primarily available to empaneled staff providers, with members outside the Denver Health system experiencing extensive wait times. Likewise, Kaiser clinics and specialists are only available to Kaiser Permanente (Kaiser) enrolled members. University Physicians, Inc. (UPI)—UCHealth—specialists and Children's specialists are academically driven and the primary source of "super sub-specialties." Access to specialists is not limited to Medicaid members. Medicaid expansion increased the demand for specialist care due to new members (that had not previously had access to healthcare) entering the system. Due to the overall competition for access to specialists, providers do not have to accept Medicaid members. Reimbursement levels are a key issue with specialists; therefore, the Medicaid fee structure presents a barrier to access. Dermatologists increasingly have trended away from contracts with any payors, making patients financially responsible for services. Staff members stated that non-profit health systems tend to be more open to Medicaid referrals as a demonstration of their community benefit responsibility. Existing personal and professional relationships among providers are the primary drivers of access to specialist care. Although most clinics have referral coordinators, physician-to-physician communications generally result in more expedient access to care and/or consultations. In 2014, Colorado Access piloted a program of referral protocols between PCMPs and specialists, but has since determined that access to specialists is a more complex problem and is applicable to more than just Medicaid members. Therefore, Colorado Access chose not to adopted or implement referral protocols with providers, but used the protocols as education and guidance for PCMPs to prepare a member for an effective specialist visit. PCMPs have not consistently used the protocols because practices deal with many payors; and procedures applicable to a select payor group (e.g., Medicaid) are difficult to integrate into practice operations. However, Colorado Access instituted practice transformation programs with PCMPs that enhance practice operations applicable to all patients—irrespective of payor source—and may encourage more widespread adoption of specialist referral protocols. At the RCCO health plan level, Colorado Access has engaged in several strategies to improve access to specialists: ◆ Care managers track Medicaid specialist referrals and outreach high-volume specialist practices to gather information regarding geographic location, availability to Medicaid members, hours of operation, and preferred referral processes. Care managers also target specialist practices according to primary care providers' input of priority areas of concern. Colorado Access' care managers, medical directors, and RCCO contract managers use the information collected to intervene, when necessary, and to assist individual members or providers with access to needed specialists. Colorado Access also encourages PCMPs to consult directly with the specialist concerning member needs. ◆ Colorado Access generally considers that PCMP practices delegated to provide care coordination for members (delegates) are capable of exercising successful specialist referrals. While not a component of the formal evaluation of potential delegate partners, partnership	

Section I—Integration with Specialist Providers	
Contract References	**Possible Discussion Topics**

eligibility encompasses consideration of the delegate's access to specialists (e.g., Denver Health and Kaiser). Delegates receive an increased per-member-per-month (PMPM) reimbursement from Colorado Access.

- Colorado Access leadership has been an active participant in community alliances focused on specialty care, specifically the Colorado Coalition for the Medically Underserved (CCMU) *Mile High Health Alliance (MHHA)*, and Aurora Health Access' *Access to Specialty Care Task Force (ASC).*
  - Staff stated that the MHHA has made the most implementable progress of the two organizations by defining a program that includes a "hub" for managing referrals of Medicaid and uninsured members among MHHA providers. The program includes referral protocols to ensure that all member clinical information is available for the specialist, and includes an eConsult between the specialist and PCP prior to the specialist's face-to-face consultation with the patient. In addition, the hub will ensure that the patient shows up for the specialist appointment, including making transportation arrangements. The program is intended to improve efficiencies in specialist practice and quality of the specialist consult. The MHHA set an aggressive 12-month timeline for implementation and must obtain commitment from participating providers. Colorado Access staff stated that Doctors Care PCMP developed an individual practice initiative to implement a care management hub concept for managing appointment preparation and follow-up of specialist recommendations with multiple PCMPs. The project has potential for expansion to additional PCMPs and specialist practices in Douglas County.
  - Aurora Health Access is a multifaceted group of provider and community organizations dedicated to education and advocacy related to healthcare access. Staff stated that the organization has avoided defining programmatic approaches and that the work group's energies rise and fall over time. To date, Colorado Access has recognized the opportunity to develop relationships for potential partnerships with participating organizations as the primary asset of Aurora Health Access.
- Access Care is Colorado Access' tele-behavioral health program for providing behavioral health specialist expertise to primary care practices. Colorado Access developed the technology platform and employed and contracted behavioral health providers (including psychiatrists) to provide scheduled consults with PCPs or behavioral health practitioners co-located in PCMP practices or to provide scheduled psychiatrist consults directly with members. The primary objective of either approach is to educate the PCP regarding primary care behavioral health interventions. While currently limited to behavioral health, Colorado Access is exploring technology to enable extension of telehealth into other specialty areas.

<u>Region 2 (Northeast Colorado)</u>
Region 2 is a largely rural region, with the majority of members accessing diverse specialists associated with Banner Health in Weld County and, to a lesser degree, UCHealth in Fort Collins. UCHealth also established a rural specialist clinic which provides a rotating schedule of UCHealth specialists to the Sterling area. Children's in Denver was used most frequently for pediatric specialty care. Colorado Plains Medical Center's associated specialty clinic in Fort Morgan was an additional concentrated source of select specialists for members in the region. Banner Health

Section I—Integration with Specialist Providers	
Contract References	**Possible Discussion Topics**

provides air transport of specialists to various locations throughout the region; the type of specialists transported to the remote regions varies according to availability of individual specialists. Staff members reported that Centura Health is entering the region with telehealth specialist services. Existing relationships between PCMPs and select specialist providers remained the primary force driving specialist referral patterns. Several large PCMPs adopted referral compacts (formal agreements for bidirectional communication) with their various specialist providers. These PCMPs include Sunrise Community Health (eight locations), Banner Health Clinics (24 locations), Family Physicians of Greeley (four locations), and The Children's Health Place. Due to the vast geographic distances in the rural areas of the region, staff members stated that the greatest barrier to accessing specialist care is transportation issues. The RCCO leadership participates in community initiatives to establish locally-based medical transportation services. In addition, Total Transit non-emergency medical transportation (NEMT) services in Weld County has a poor reputation for performance, resulting in Weld County's consideration of assuming control of NEMT services. Staff stated that when medical transportation exists, the door-to-door criteria for transportation to specialist appointments does not allow for necessary adjunct stops such as obtaining specialist prescriptions that are not available in some rural areas. RCCO leadership stated that transportation challenges are the key issue in improving access to specialist services in the region.

Staff stated that partnerships with Banner Health system offer the most promising solutions for addressing the shortage of specialist availability for Medicaid members in Region 2. Colorado Access and Banner Health leadership continually looked for opportunities to address specialty needs. Examples include recruiting more specialists to the area and implementing mechanisms that make it "easier" for specialists to provide services to Medicaid members (i.e., using care managers to reduce no-shows for appointments, ensuring that the member is prepared for the visit, and ensuring that the referring PCMP provides adequate clinical information). Colorado Access engaged in numerous other program initiatives to extend specialty services into local communities throughout the region. Examples included:

- The Home Health Roundtable, facilitated by the RCCO, identifies initiatives to enable home health providers to better serve members with special healthcare needs in the home, thereby relieving the demand on specialists.
- The Colorado Access telehealth program has been implemented to extend behavioral health consultations to primary care providers and members in select PCMPs (i.e., The Children's Health Place, Salud Family Health Center [Salud] clinics in Fort Morgan and Sterling, UCHealth clinic in Sterling) and attempting implementation in Yuma County Hospital District clinics.
- RCCO facilitated co-location of behavioral providers into Sunrise Community Health's Greeley and Loveland clinics. Salud had agreed to integrate behavioral health providers in six clinics located throughout the region but was delayed by loss of grant funding to support the initiative. Numerous other PCMP locations also instituted on-site behavioral health provider services.
- Colorado Access, in partnership with the Department of Human Services (DHS) and Salud's Fort Morgan and Sterling clinics, was implementing a program directed at children in foster care. The program will provide telehealth services and navigators to coordinate care to support specialized services for foster care children and families in those communities.

Section I—Integration with Specialist Providers	
Contract References	**Possible Discussion Topics**
◆ Salud partnered with UCHealth's School of Pharmacy to implement a program whereby clinical pharmacists and pharmacy students assist physicians with medication therapy, patient education, shared medical appointments, and hospital transitions for members with chronic conditions. Salud will consider this model for potential expansion to other clinics in Region 2. ◆ RCCO leadership had been working with Yuma County Hospital District to identify programs to improve access to specialist services in the local area. However, staff stated that extensive turnover of hospital leadership in rural areas, including Yuma, has been a barrier to implementation. Overall, Colorado Access recognized the challenges presented by the general shortage of specialists serving Colorado's population and developed multifaceted short-term and long-term solutions to improve Medicaid members' access to specialist care in each of its three regions.	

Section II—Follow-up of Region-specific Special Projects	
Contract References	**Possible Discussion Topics**
NONE	Relationship of RCCO with the health information exchange—Colorado Regional Health Information Organization (CORHIO) or Quality Health Network (QHN) ◆ Describe the RCCO's relationship with the health information exchange (HIE) ▪ How the relationship was developed ◆ Agreement between the RCCO and the HIE ▪ HIE "user/participant"? ▪ Receive information/contribute information? ▪ Functional relationship--How information is received from the HIE (e.g., direct interface, web portal, member list/inquiry) ◆ Type of data received from the HIE ▪ How RCCO is using/applying the information ▪ Has access to information replaced previous mechanisms of provider notifications/alerts? ▪ Any data or components of the delivery system that are missing/incomplete/gaps? ◆ Successes and challenges of relationship with HIE: ▪ Is exchange working smoothly? ▪ Describe value(s) of the relationship ▪ Difficulties experienced (potential solutions) ◆ Do you envision an expanded/evolving role of the HIE in meeting the future needs of the RCCO? ▪ Status of any planned/anticipated data exchange functions

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics

Discussion and Observations:

In 2014, Colorado Access established an agreement with the Colorado Regional Health Information Organization (CORHIO) to receive daily admit, discharge, and transfer (ADT) data and laboratory data from hospitals participating in the health information exchange (HIE). Colorado Access is a CORHIO system user that contributes no information to the HIE database. Colorado Access provides a full-eligibility file—with daily changes, additions, and deletions—to CORHIO; and CORHIO matches the RCCO member file against the HIE files from 35 participating hospitals. Colorado Access' information technology (IT) staff programmed the capability for direct data transfer from CORHIO into the Colorado Access database of real-time messaging of laboratory and ADT activities. Denver Health and several hospitals in Region 2 are not yet participating in CORHIO. Colorado Access does not use the data feed provided through the Department's agreement with CORHIO.

Staff members stated that gaps or inadequacies with the data received included missing diagnosis codes in the ADT data (a hospital input issue) and lack of standardized laboratory data. At the time of the site review, Colorado Access was not using the laboratory data because, given the non-standardized input, the data are not meaningful. Colorado Access used ADT data to provide its care managers and transitions of care (TOC) team with real-time hospital admissions and discharges. Colorado Access provided its delegate practices daily ADT data for RCCO members using the delegate's file transfer protocol (FTP) folder. Colorado Access integrated ADT information into population health reports used to analyze special populations, including pediatrics, foster children, refugees, members who are homeless, members who have HIV, and members with complex chronic conditions. Colorado Access also used monthly reports of ED visit history and hospitalizations for member outreach and follow-up. These applications may be compromised by the lack of diagnosis codes in the hospital data. Colorado Access was working with CORHIO and the Colorado Hospital Association to ensure that hospitals consistently provide diagnosis codes in ADT data. Staff members stated that Colorado Access will continue to expand upon the internal processes for intake and use of ADT data for timely care coordination support. In general, Colorado Access considered having access to real-time ADT data a success for support of care management activities.

Staff members stated that challenges in using the data included developing technological mechanisms to accept a new dataset and formats of information into the Colorado Access database, multiple diagnosis codes on any one record that lack standardized formatting, and lack of standardized data requiring multiple workaround solutions. Colorado Access was working with delegates to determine what information is of value to be shared with delegates. Half of the 16 delegated entities have direct relationships with CORHIO to receive data feeds of their patient bases, and Colorado Access staff members stated they prefer that all delegates ultimately have their own data feeds. Staff members stated that in the upcoming year Colorado Access will seek to capitalize on its relationship with CORHIO to further expand the innovative uses of both ADT and laboratory data—e.g., population-based programming and evaluation, use of laboratory data to support key performance indicators (KPIs), or population-based clinical projects or member registries.

Section II—Follow-up of Region-specific Special Projects	
Contract References	**Possible Discussion Topics**
NONE	**TOPIC #1**: Transition of Care team—developing mechanisms transferable to delegate care coordination teams **TOPIC #2:** Status of integrating RCCO members into Denver Health delivery system: ▪ Access to Denver Health providers/services (primary and specialty) for RCCO members? ▪ Resolving Denver Health MCO auto-enrollment and RCCO attribution issues? Get an update on each project as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of program on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ And Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:

Transition of care—transfer to delegates

The RCCO's TOC procedures included face-to-face meetings with high-risk members and Medicare-Medicaid Program (MMP) members prior to discharge, within seven days post-discharge for hospitalizations, and within seven days of emergency room (ER) visits. The visits include medication reconciliation, health needs assessment and care planning, and patient activation assessment. Colorado Access developed scripts and tools to guide each type of care management encounter with the member. During 2015, Colorado Access completed 80 percent of encounters with members face to face. The robust program was based on Eric Coleman's TOC methodology. RCCO staff supplemented daily ADT data with SDAC data in order to identify high-risk members for referral to the TOC care managers—e.g., complex chronic diagnoses, high utilizers, MMP members, or other defined special populations. Staff members stated that member activation to participate in care management is a significant indicator of success in engaging members, and Colorado Access was tracking the level of activation of members involved in the program.

Section II—Follow-up of Region-specific Special Projects	
Contract References	**Possible Discussion Topics**

Colorado Access staff presented the TOC program to the delegate work group, which responded with interest in implementing the program within their PCMP practices—6 of 14 delegates spontaneously contacted the RCCO practice transformation team to request assistance in implementing the TOC processes in their practices. (The practice transformation team works with individual practices to integrate a variety of improved operational processes into practices.) Challenges in transferring the TOC care management process into delegate practices relate to the need for practices to implement processes applicable to all payors, not just RCCO members. In addition, individual practices vary in their use of CORHIO data in practice operations. Colorado Access was working with the delegates to define the best mechanisms for using CORHIO data to support the TOC program in delegate practices.

Integrating RCCO members into Denver Health

Effective June 2015, the State's Medicaid Management Information System (MMIS) discontinued passive enrollment into Denver Health Managed Care (DHMC) of newly eligible Medicaid members in the following categories: foster care children, refugee populations listing volunteer agencies as their residential address, and clients with existing attribution to a non-DHMC primary provider. Despite these exemptions from passive enrollment, staff members stated that anecdotal feedback indicated that some foster children were still being passively enrolled and that some PCMPs believed that their RCCO-attributed members were also still being passively enrolled in the Denver Health system. However, staff members stated that no evidence had been presented to confirm these suspicions. Staff members stated that RCCO member access to Denver Health primary care clinics did not appear to be a concern as all RCCO members have equal access to the Denver Health clinics; however, due to language barriers, the DH Lowry clinic was reportedly not returning phone calls made by refugee members. Staff members stated that 38,000 RCCO members chose Denver Health as their PCMP. Staff members also reported that an ongoing challenge with Denver Health included access to specialists. Denver Health specialists grant priority access to patients of Denver Health staff physicians. RCCO members attributed to other PCMPs experience extensive delays. Many RCCO providers are "disgruntled" by the inability of timely access to Denver Health specialists and complain about the Denver Health authorization process. Additionally, many RCCO members believe that they must live in the city of Denver in order to have access to Denver Health specialty clinics (e.g., HIV or homeless clinics) or non-medical services (e.g., WIC) located on the DH campus. RCCO managers continue to build relationships within the Denver Health system to pursue solutions to these issues. In order to overcome the challenges of communicating with numerous departments and decision makers within the structure of Denver Health, Colorado Access staff members have initiated regular meetings with Denver Health to help identify the appropriate staff to help champion initiatives and make decisions within the DH system. Colorado Access also continues to pursue partnership programs with Denver Health, particularly related to behavioral healthcare (see Section III).

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	**TOPIC #3:** Co-funding of ER-based care coordinators in University Hospital ER to assess RCCO member needs and link members to PCMPs **TOPIC #4:** Delegate PCMP responsiveness to improving compliance with comprehensive care coordination requirements (i.e., member identification, coordinating the coordinators, documentation systems) Get an update on each project as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of project on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:

ER-based care coordinators in University of Colorado Hospital

In February 2016, Colorado Access initiated a two-year pilot project with UCHealth to place two registered nurse (RN) care coordinators in the UC Hospital *Fast Track* ER in hopes of diverting RCCO members to more appropriate services when indicated. Colorado Access funds the care coordinators, but they are employees of UCHealth. Colorado Access proposed the project after UCHealth data documented 15,200 emergency visits in a three-month period, many of which involved Medicaid members. The largest group of emergency room users were 20-to-29-year-olds, and the most frequent hours of access fell between the hours of noon to 6 p.m. and 8 p.m. to 6 a.m., respectively. The mutual goal of Colorado Access and UCHealth was to reduce the number of ER visits by intervening with those Medicaid members entering the *Fast Track* ER who did not need diagnostic interventions or inpatient services. Care coordinator expectations included completing a health needs assessment and care plan with the member, assisting the member with PCMP attribution, and organizing specialty and community resource referrals, as needed, within 48 hours of the ER visit. The on-site care coordinator also intervened with Access Behavioral Care (ABC) members and then referred those members

Section II—Follow-up of Region-specific Special Projects	
Contract References	**Possible Discussion Topics**
to Colorado Access' behavioral health care managers. Colorado Access outlined detailed work flow and training tools that included orientation to the RCCO care management process, attribution processes, the Altruista care management system (Altruista), and use of SDAC and CORHIO information. Care coordinators had access to and documented in both the hospital electronic medical record system and Altruista. At the time of HSAG review, UCHealth had hired only one care coordinator, whose work hours were from 8 a.m. to 5 p.m. UCHealth was pursuing hiring a second care coordinator to work the evening/night shift. Initial data demonstrate that the coordinator encountered an average of 67 Colorado Access members per month, 90 percent of whom were RCCO members. Colorado Access reported that it will evaluate the effectiveness of the program prior to expanding it to other member groups and will follow these members long term to determine whether they alter their ER utilization patterns. <u>Improving delegate compliance with comprehensive care coordination requirements</u> Colorado Access added two additional delegate PCMPs in 2015 for 16 practices delegated to perform comprehensive care coordination. Colorado Access had developed an extensive delegate training plan and a comprehensive *Pre-Delegation Care Management Audit Tool*, which included a detailed assessment of routine and intensive care management, TOC, and MMP processes and procedures as well as program alignment with Department-defined key performance indicators (KPIs). Staff members applied the audit tool in evaluating each of the two new delegate practices. Colorado Access staff also audited care management records at thirteen existing delegate practices and was working with eight delegates on corrective action plans resulting from the audits. Colorado Access leadership conducted regular mandatory group meetings with delegate care managers to discuss issues and solutions for improving care management performance. Delegates openly shared RCCO-related processes and procedures, and Colorado Access encouraged peer-to-peer consultation to promote care management best practices. Staff members reported that delegates applied comprehensive care management processes to all members regardless of payor. The delegate work group was also working on defining more meaningful care management outcome measures that could be collected and reported to Colorado Access. Colorado Access' practice transformation team, which has a customized program for PCMPs to integrate multiple RCCO processes, incorporated comprehensive care management requirements into its program. Staff members reported that most delegates responded favorably to the expanded focus on comprehensive care management processes. Colorado Access retained the right to impose financial penalties or discontinue the delegate's care management contract if necessary, although staff members were positive about the potential for all delegated PCMPs to ultimately perform according to RCCO care management standards.	

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Group 1: The Contractor shall create, document, and maintain a Communication Plan to communicate with all behavioral health managed care organizations (BHOs) with which it has relationships. RCCO and MMP Contracts—4.3.1 The PIAC includes members representing the behavioral health community. RCCO Contract—7.4.1.3.6 If the Member has an existing case manager through another program, such as behavioral health program, then the Contractor shall coordinate with that individual on how best to coordinate care through a single care coordinator. RCCO and MMP Contracts—6.4.3 The care plan shall include a behavioral health component for those clients in need of behavioral health services. RCCO and MMP Contracts—6.4.5.1.1.1 For members who have been released from the Department of Corrections (DOC) or county jail system, the Contractor shall coordinate with the members' BHO to ensure continuity of medical, behavioral, and pharmaceutical services. RCCO and MMP Contracts—6.4.5.2.6	General structure of RCCO/BHO/CMHC relationships ◆ How many BHOs does the RCCO work with? (How many RCCOs does the BHO(s) work with?) ◆ Is there formal organizational alignment? ▪ Ownership/partnership? ▪ Are there MOUs or contracts between the organizations? ▪ Is there a financial relationship? ◆ Do formally defined accountabilities/responsibilities exist between the organizations? ◆ How long have these relationships been in place? Functional relationships/operational interface ◆ Does the BHO participate in committees, boards, or joint planning related to RCCO strategic or operational decision making? (RCCO in BHO decision making?) ◆ Shared systems? ◆ Are there reporting responsibilities or data shared among the organizations? ◆ How extensive are the collaborative processes? ▪ Outline the functional areas of collaboration—how processes work ▪ How do these processes impact members (e.g., transparency, degree of coordination/overlaps, any feedback from members)? ▪ Care coordination—walk through the processes • Sharing information (verbal/documentation) • Designating a lead coordinator • Deciding how to share care coordination duties

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Integrated care coordination characteristics include: Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care. RCCO and MMP Contracts—6.4.5.3.1 The Contractor shall ensure coordination between behavioral health and physical health providers. RCCO and MMP Contracts—6.4.11	• Who generally identifies the member with complex behavioral and/or physical health needs? • Who initiates the care coordination process? ▪ Describe how these collaborative processes have evolved; what do you anticipate going forward? ▪ What are the opportunities/successes to date related to collaborative responsibilities? ▪ What are the challenges related to collaborative processes?

Discussion and Observations:

Staff confirmed that Region 5 was wholly aligned with Access Behavioral Care-Denver's (ABC-D) service area, Region 3 was wholly aligned with Behavioral Health Inc.'s (BHI) service area, and Region 2 was entirely within the Access Behavioral Care-Northeast (ABC-NE) service area. (ABC-NE also served Elbert County in Region 7 and Larimer County in Region 1.) Additionally, Colorado Access is also the contracted provider of administrative support services for BHI and conducts care management for BHI's RCCO members. Due to the extensive geographic and functional overlap of the RCCO and BHO regions, Colorado Access has integrated program activities for its Medicaid lines of business in Region 2 and Region 5 and works with BHI to execute integrated programming in Region 3. Management committees of ABC and Regions 2 and 5 are fully integrated. Region 2 has a shared Executive Director for both the RCCO and ABC-NE, and Region 2 Performance Improvement Advisory Committee (PIAC) meetings are combined meetings of the RCCO and BHO. While BHI does not participate in Colorado Access management committees, BHI leadership participates in all functional integration meetings with Colorado Access. Colorado Access leadership participates on the BHI Board of Directors and PIAC. Many BHO network providers are contracted with both BHI and ABC, although BHI maintains responsibility for contract decisions, credentialing, payment models, and other activities with BHI providers.

Care Management Steering Committee meetings address integrated BHO/RCCO activities in all regions, although ABC maintains a behavioral health care management team for BHO members with intense behavioral health needs. BHI also maintained its own care management model for BHO members, which staff members stated presents some complications for Colorado Access' internal care management transformation processes. The RCCO and BHO care coordinators coordinate care management activities through shared data systems, verbal communications, and case conferences, and may refer members to each other as the "lead" coordinator depending on the priority needs of the member. Members may also be assigned to BHO or RCCO care managers based on claims data used to inform care managers regarding priority needs of the members. Within Colorado Access' care management transformation project, a "job responsibility team" has been designated to define care manager job competencies and responsibilities within the integrated RCCO/BHO care

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Contract References	Possible Discussion Topics
management teams. Staff members stated that care managers will have a diverse skill set to address comprehensive behavioral, physical, and social needs of members and that Colorado Access anticipated implementation of integrated care management teams by September 2016.	
Group 2: The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include members with complex behavioral or physical health needs RCCO and MMP Contracts—4.1.6.5 The Contractor shall distribute materials (provided by the Department) related to behavioral health and BHOs to all of the PCMPs in the Contractor's PCMP Network. RCCO and MMP Contracts—5.2.1 Enhanced Primary Care Standards include: ◆ The PCMP provides on-site access to behavioral health care providers. ◆ The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents. ◆ The practice has documented procedures to address positive screens and agreements with behavioral healthcare providers to accept referred patients. RCCO Contract—Exhibit F1 (4) and (5) Behavioral Health Integration Report: ◆ The Contractor shall submit to the Department a report that includes an environmental scan of current practices, challenges, and new strategies for integration of behavioral and physical healthcare for all covered populations. RCCO Contract—8.2.1.1	General level of behavioral health (BH) integration into medical practices or with other providers throughout network Special programs/initiatives: update of programs in Integrated Care Report R2: Telepsychiatry: ◆ The Children's Health Place ◆ Yuma District Hospital and Clinics ◆ Salud Family Health Centers integrated clinical pharmacy R3: ◆ Addressing barriers to BH referrals ◆ Telehealth at Rocky Mountain Youth Clinic ◆ Doctors Care integration advancement R5: ◆ Co-location of physical health into behavioral health settings ◆ BH co-location into South Federal Family Practice and Horizon Pediatrics ◆ Increased access to substance abuse services via community referral network: Bruner Family Medicine population ◆ Access to behavioral health for members attributed to Kaiser Get a brief update on each initiative above as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation

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Contract References	**Possible Discussion Topics**
	◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date ◆ Potential impact on members when program completed ▪ How many members? Degree of importance/significance in member care and services? ◆ Potential impact on practitioners/other service organizations ▪ If BH/PH practice integration: • Where do the resources come from? • To whom are these practitioners accountable? • How available are resources to members? • How do co-located practitioners interact in patient care or the dynamics of office operations? Crisis Support Services system: ◆ How does the RCCO/BHO coordinate with the Crisis Support Services network? ◆ How are members informed by RCCO/BHO? ◆ How does the referral system work between the RCCO/BHO and crisis centers? ◆ What are your challenges/successes in working with the center(s)? ◆ Do you have a sense of how effective the crisis network might be? (Do you know if members use the center(s)? Any feedback from members?) Overall successes/challenges in integrating BHOs/mental health providers with RCCO/physical health providers

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Contract References	Possible Discussion Topics
	Overall impact of integration efforts on members ◆ Any way to monitor/assess? (Any feedback from members?) Going forward—Strategies for integration of behavioral and physical healthcare for all covered populations

Discussion and Observations:

Colorado Access' goal in all three RCCO regions is to ensure that 80 percent of members have access to integrated behavioral health providers within the next five years. Models of integrated behavioral/physical health varied, including: the CMHC or BHO contracts with or employs behavioral health providers to be co-located in a PCMP site, and providers bill Medicaid member behavioral health services through the BHO; a PCMP or FQHC independently employs behavioral health providers, and the BHOs reimburse the practice for behavioral health providers integrated into their clinics; and tele-behavioral health offered by Colorado Access to PCMPs is implemented to integrate behavioral health consultative services into primary care sites. Staff members stated that an Integrated Practice Assessment Tool (IPAT) has been used to assess the level of behavioral health integration in 255 practices across the three RCCO regions and to identify the best options for each practice to integrate behavioral health services. Colorado Access works with individual practices to understand barriers to integrated care and develop customized solutions. At the time of HSAG on-site review, staff members estimated that more than 50 percent of members in Region 3 and Region 5 and 60 to 65 percent of members in Region 2 had access to co-located behavioral and physical health services.

Tele-behavioral health services have been developed and implemented by Colorado Access in a number of practices throughout the regions. Tele-behavioral health provides behavioral health consultation and education to PCMPs through Colorado Access' contracted behavioral health providers. Tele-behavioral health services are provided through scheduled consults with PCPs or co-located behavioral health practitioners as well as psychiatrist consults directly with members and often require practice transformation efforts to prepare for integration. Tele-behavioral health enables PCMPs to manage members' behavioral health needs within the practice, improves the PCPs efficiency for attending to other patients, improves provider satisfaction with the practice environment, and requires no on-site IT staff expertise for implementation. Colorado Access' telehealth initiative was supported through grant funds from the Colorado Health Foundation.

Colorado Access participated in several community coalitions and learning collaboratives intended to enhance PCMP's integration skills, including:

- The Colorado Behavioral Health Council contracted with Jefferson Center for Mental Health to develop the Integrated Care Training Institute to educate practitioners on the importance of integrated care and how to implement practice changes for integrated care.
- The Mile High Health Alliance established access to behavioral healthcare as one of its two primary goals. Members of the alliance had or would like to adopt integrated care practice models and were collectively identifying support systems (e.g., data and medical records systems, availability of grant funds) required to do so.

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Contract References	Possible Discussion Topics

- The Pediatric Practice Learning Collaborative—a work group of 13 practices, agencies, and practice transformation organizations—to advance integrated care in pediatric practices, was in the process of examining mechanisms such as workforce and professional capacity issues as well as billing and coding issues related to behavioral health in primary care practices.

Region 5

- Mental Health Centers of Denver (MHCD), the primary CMHC in Region 5, has collaborated with six primary care practices—South Federal Family Practice, Horizon Pediatrics, Rocky Mountain Youth Clinic Denver, Lowry Pediatrics, Sapphire Pediatrics, and Clinica Tepeyac—to co-locate MHCD practitioners into PCMPs. MHCD has a "plug and play" model and has engaged a transitions coordinator to assist practices with implementation. BH providers are fully integrated into practices, and on-site services are funded through BHO capitated reimbursement; BH practitioners may also refer members as needed to MHCD or other services and programs. MHCD's focus in 2015 was high-Medicaid population pediatric practices. MHCD will continue to be a source for co-located behavioral health practitioners and intended to expand to adult services in five to six additional sites by the end of 2016. MHCD also supports BH clinicians in school-based clinics.
- Several FQHCs or PCMPs—Kaiser, Denver Health, Colorado Coalition for the Homeless Stout Street Clinic, and Inner City Health—employed BH practitioners already integrated into their practices, and the BHO agreed to contract with these BH providers to enable reimbursement through the BHO.
- Denver Health provided primary care practitioners to MHCD delivery sites serving members with severe and persistent mental illness. Denver Health services included use of patient registries to track members with select chronic medical conditions and enabled access to Denver Health specialty clinics for MHCD members. The program was grant funded and ended in September 2015.
- Colorado Access initiated a program with Bruner Family Medicine to increase access to Substance Use Disorder (SUD) and mental health services for RCCO members attributed to Bruner Family Medicine. ABC-D contracted with the behavioral health and SUD providers to provide co-located care coordinated through web-based communications among providers. However, the SUD provider experienced some relationship issues with partner providers and lost their clinic to fire. Therefore, the project was suspended in April 2016.
- Tele-behavioral health was implemented to support behavioral health practitioners in the treatment of youth at Denver Indian Health and Family Services and Horizon Pediatrics.

Region 3

- During 2015, BHI provided limited BH professional resources for co-locating behavioral health in primary care practices. However, BHI had established a committee of practice champions for integrated care to inventory all community integration efforts and create a roadmap for moving forward. BHI was also focusing on provider outreach during 2016 to identify targets for chronic pain and substance abuse programs.

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- Doctors Care hired a staff psychologist to enhance referrals to Arapahoe Douglas Mental Health Center. Colorado Access was supporting efforts to identify alternative payment systems that would enable Doctors Care to employ additional on-site behavioral health counselors.
- Rocky Mountain Health Centers Pediatrics had an on-site behavioral health counselor through Children's Hospital. With a high Medicaid population, this practice considered on-site behavioral health a high value service for members with difficult-to-manage needs. When members require more intensive mental health services through Aurora Mental Health Center (AMHC), the practice personally contacts AMHC to arrange a warm hand-off of the member to AMHC.
- Additional Region 3 partnerships for co-locating behavioral health in primary care practices included Salud with the Community Outreach Center; Metro Care Physician Network (MCPN) with Aurora Mental Health Center and, in Englewood, with Arapahoe/ Douglas Mental Health Network; Clinica Family Health Care with Community Outreach Center; Peak Vista-Strasburg examining potential tele-behavioral health or co-locating a BH clinician; Parker Pediatrics having integrated behavioral health which preceded the RCCO; and Ardas Clinic, which specializes in serving the refugee population, providing behavioral health related to immigrant issues.
- A BHI/Aurora Mental Health Center project was targeting five practices—one pediatric, three family practice, and one internal medicine—to assess barriers to behavioral health referrals. The Region 3 contract manager had completed discussions with all practices regarding BH resources needed. Funding support for the project changed, and the project had not been implemented.
- Tele-behavioral health was implemented to support behavioral health practitioners in the treatment of youth at Sheridan Health Services and Rocky Mountain Youth Clinics at Thornton.
- Staff members stated that Colorado Access considered the ECHO pain management program an excellent potential resource for providers.

<u>Region 2</u>

- Staff members reported that relationships among the CMHCs, BHO, and other providers in the region have improved since the BHO contract was assigned to ABC and that the increase in number of non-CMHC BH providers in the network has improved diversity of services in the region.
- Region 2 has three basic models for co-located BH/PH services:
  - PCMPs may work with the CMHCs to obtain professional resources for a practice, with the CMHCs each having a turn-key operation and requiring only space within the practice. Examples included BH providers from North Range Behavioral Health Center (North Range) and SummitStone Health Partners (SummitStone) having been integrated into Sunrise Community Health (Sunrise) FQHC clinics and, conversely, Sunrise having placed primary care practitioners in North Range and SummitStone.
  - PCMPs may bring private BH resources into the practice, with BH practitioners contracted and reimbursed through the BHO. Examples included Banner Health having contracted with the BHO for BH practitioners located in Banner Health's primary care clinic locations and Salud having employed a resident psychologist and employing additional BH practitioners from the mental health centers for each of its six clinics in the region.

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Colorado Access arranged for the State to reimburse Salud for BH services at the FQHC rate.

- Heart-Centered Counseling has co-located 25 BH therapists in primary care and school-based provider settings in Weld and Larimer Counties and has developed a partnership with UCHealth to expand co-located behavioral health into 13 additional integrated care locations in the next one to two years.

- The objective is to move co-located services into more of the rural areas of the region where exist a shortage of professional and financial resources to sustain co-location of providers, requiring new and creative funding mechanisms. In addition, multiple dynamics within the rural hospital district communities, including turnover of leadership, have slowed development of integrated care initiatives within those areas.
- Tele-behavioral health is a viable option for PCMPs in the largely rural region. Tele-behavioral health was implemented to support behavioral health practitioners in the treatment of youth at both UCHealth primary care clinic at Sterling and the Children's Health Place and was pending implementation at Yuma County Hospital District facilities.
- A partnership of two Salud clinics and county DHSs in Fort Morgan County and Logan County would integrate BH care managers into the child welfare offices and implement tele-behavioral health in the Salud clinics to support care of foster children in the local communities. A Denver Health Foundation grant to support the project had been unsuccessful, but staff members stated that Colorado Access would continue to pursue implementation.
- Salud clinics have implemented an integrated clinical pharmacy program using clinical pharmacists and residency students from UCHealth School of Pharmacy to perform individual patient consultations, educate medical and embedded behavioral health providers, and build programs in the EHR system to identify adverse drug reactions. Behavioral health medications for serious mental health issues are an emphasis of the program. The program is extended to Salud's rural clinics through telehealth. Centennial Mental Health Center has also recognized that mental health patients can be more expediently transitioned back to their local PCMPs with improved competence of the PCMPs regarding behavioral health medications. Pharmacists were providing training to CMHC staff regarding drug interactions, treatment to improve stabilization of the members' conditions, and mechanisms for transitioning members back to the PCMPs.
- The RCCO and BHO participate in many additional functional areas of collaboration:
  - RCCO and BHO care managers are highly aligned, sharing training and care coordination activities. The North Colorado Health Alliance (NCHA) offices are physically adjacent to the BHO offices. BH care managers are integrated into the Salud and Banner Health clinics.
  - Colorado Access NCHA hosts the ABC and RCCO care managers' "hotspotter" meetings to discuss complex care management cases. Colorado Access also facilitates the Home Health Roundtable for NCHA care managers and home health leadership, which identified that BH issues often prevent members from remaining in their homes. The BHO encouraged BH providers to attend the meetings, and BH practitioners may conduct dual home visits with the home care manager.

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- The Northeast Colorado Health Department (NCHD) has offices established in remote counties of the region, with personnel having roles similar to those found within the RCCO. Colorado Access is considering partnering with NCHD to identify care navigators and develop a delegated care management agreement.
- The furthest eastern counties of the service area have regular meetings of DHS, the CMHC, public health departments, and the RCCO to discuss rural health issues and solutions. The Region 2 Executive Director represents both the RCCO and the BHO in these meetings.

Colorado Access staff discussed the revision in payment mechanisms needed to sustain integrated BH/PH services beyond grant funding. Some mechanism for obtaining an enhanced payment rate for services to cover costs of the more comprehensive services will be required. Staff members stated that they were focused on defining methodologies that could be sustained through the existing Medicaid reimbursement system and were experimenting with the FQHC payment model for co-located behavioral health services. Staff perceived that continuing partial BH capitation combined with some fee-for-service reimbursement in the Regional Accountable Entities (RAEs) might provide for necessary budgeting and reimbursement flexibility. Colorado Access was preparing to implement and test new payment models in select practices by the end of 2016.

Crisis Support Services:
The designated crisis support centers in the Colorado Access RCCO regions included the major BHO CMHCs—AMHC, MHCD, North Range, Centennial, and SummitStone—with multiple walk-in locations. Stabilization units and respite services were also available in the urban areas as well as in numerous mobile units within each region. The relationship between the crisis support centers and the BHOs or RCCOs—which deliver services only to Medicaid clients—is somewhat remote due to the variance in both the population served and payment source. Colorado Access had a pre-existing contract with Rocky Mountain Crisis Partners for the crisis and support line services for Colorado Access members and had developed a script for call center staff to determine whether referral of a member to a local crisis center or the crisis hotline was indicated. Colorado Access had educated its staff members regarding the crisis center services and informed PCMPs of crisis support services through newsletters. In May 2015, Colorado Access organized a webinar attended by 90 participants, which included presenters from the Office of Behavioral Health, AMHC, North Range Behavioral Health, and MHCD. Staff stated that several PCMPs preferred referring to the Crisis Services network over a referral to a specific CMHC, and RCCO staff have provided written materials and tools to enhance the PCMP referral process. In addition, any services to BHO members provided subsequent to walk-in crisis interventions may be processed through the utilization management (UM) department. Colorado Access had not arranged for any formal reporting of crisis center services provided to BHO or RCCO members; therefore, knowledge of crisis center utilization by members was incidental. Staff members stated that crisis walk-in services filled a void in behavioral health services in Adams County. Based on anecdotal feedback, staff members believed that the crisis support centers and services were well used in all locations and were supported by members of the community.

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

Appendix C. Site Review Participants for Colorado Access (Regions 2, 3, and 5)

Table C-1 lists the participants in the FY 2015–2016 site review of **Colorado Access**.

Table C-1—HSAG Reviewers and RCCO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	EQR Compliance Auditor
Colorado Access Participants	**Title**
Alexis Giese	Senior Vice President, Behavioral Health
Alison Sale	Internal Quality Assurance, North Colorado Health Alliance (NCHA)
Andrea Richter	Care Manager II
Ange Holm	Care Manager II
Beth Neuhalfen	Director, Physician Engagement/Practice Innovation
Cindy Dalton	Information Technology Operations Manager
Danielle Schroeder	Care Manager II
Dave Rastatter	Director, Northeast Colorado Medicaid
Erin Kormanik	Care Manager I
Gretchen McGinnis	Senior Vice President, Public Programs
Heather Logan	Care Manager, Metro Community Provider Network (MCPN)
Jamie Haney	Care Manager, MCPN
Jane Colvin	Care Manager, MCPN
Joanna Martinson	Director, NCHA
Jo English	Manager, Community Based Care Coordinator
John Kiekhaefer	Clinical Director, Access Behavioral Care
Jazz Garrison	Internal Quality Assurance, NCHA
Kerry Harger	Care Manager II
Kristi Toffoli	Care Manager II
Lynn Hellickson	Care Manager II
Michelle Tomsche	Operations Director, Behavioral Health and Lab Director, Behavioral Healthcare, Inc.
Molly Markert	Contract Manager, Colorado Access RCCO 3
Myra Bogedahl	Care Manager II
Patrick Gillies	Vice President, Accountable Care
Rachel Artz-Steinberg	Care Management Supervisor, NCHA
Regina Fetterolf	Director, RCCO Care Management
Rob Bremer	Vice President, Integrated Care
Sheeba Ibidunni	Contract Manager, Colorado Access Region 5
Shelby Kiernan	Director, Integrated Care
Stephanie Becker-Aro	Care Manager II
Terry Mayer	Chief of Operations, Access Care/Solution Architect

Department Observers	Title
Matt Lanphier	Policy Analyst, ACC
Russ Kennedy	Quality and Health Improvement Unit
Susan Mathieu	Program Manager, ACC
Van Wilson	Project Manager, Medicare-Medicaid Program