AGGREGATE RCCO REPORT

HEALTH SERVICES ADVISORY GROUP (HSAG)
Kathy Bartilotta, Senior Project Manager
August 16, 2017
HSAG Site Review Process

• Annual Site Review of each RCCO every year since inception of RCCO.

• Not required by CMS—flexible

• Different focus topics each year based on key components of contract.
HSAG Site Review Process

- Semi-structured qualitative interview methodology to explore each topic with RCCO staff members.
- Care Coordination Record Reviews each year.
- Individual RCCO reports
- Statewide Aggregate Report
Aggregate Report

• Aggregate Report—
  ➢ Summarized Findings for each Region
  ➢ Analyzed statewide trends-- common experiences or concerns across regions
  ➢ HSAG Conclusions
  ➢ HSAG Recommendations

➢ Full Report can be found at
https://www.colorado.gov/pacific/hcpf/site-reviews
HSAG Site Review Process

• This year—theme was lessons learned over first 6 years of program

• Five Topic areas—
  ➢ Coordination of Care
  ➢ Provider Network/Provider Participation
  ➢ Member Engagement
  ➢ Community Partnerships/Collaboration
  ➢ Balance Between Department–driven and Regional/Community–driven Priorities
This Presentation

HSAG’s high level conclusions and recommendations.

Discuss Next Steps
Overall Conclusions

• As intended in the ACC design, RCCOs have embraced learning experiences and challenges and have responded with many region-specific program innovations.

• State-wide program in many ways exceeds original expectations of the ACC model.

• Rather dramatic differences between the Colorado ACC model and traditional managed care plans nation-wide.
Overall Conclusions—Differentiating Characteristics

• ACC uses regional non-competitive organizational model which respects need for local flexibility in implementing goals of the program.

• Community-based healthcare solutions have been developed throughout the state.

• Ongoing collaborative efforts between RCCOs and the Department have been significant and are somewhat unique to Colorado.
Overall Conclusions—Differentiating Characteristics

- Care coordination has evolved to a significantly more “social needs” model than traditional medical management model.

- ACC has become a major source for previously inaccessible data needed by providers and other community partners.

- Collaborations among community organizations, agencies, and providers will serve as a solid foundation for continuing reform.

- Multiple grant opportunities implemented through the RCCOs have resulted in improvements in healthcare delivery that will be sustained.
Care Coordination

Conclusions
Care Coordination

Good news –

• Care coordination is solidly established and effective component of the ACC.

• Commitment to innovative approaches that work for members and communities in regions.

• ACC focus on *comprehensive* care coordination
  - Evolved into significantly sophisticated programs
  - Integrated with community organizations and providers.
RCCOs invested significant energy into improving care coordination programs—

• Sometimes multiple operational redesigns.

• Programs have significantly grown in size and scope since inception.

• Transitioned from a telephone outreach model to a largely one on one interpersonal approach.

  (Even in geographically dispersed regions)
Care Coordination

• Care coordinators demonstrate a high level of expertise and commitment.

• RCCOs effectively –
  ➢ Perform as convener or facilitator among multiple care manager resources.
  ➢ Often assume the lead coordinator role.
  ➢ Support agencies or providers, filling gaps as necessary.
Care Coordination

• Most RCCOs increasingly embedding coordinators in PCMP sites and community-based partner locations
  ➢ Effective in building trust with members.

• As technology allows, many will develop community—based integrated care coordination plans.
Care Coordination

• Social determinants of health often play a major role in members with complex needs.

• Care coordination teams commonly used for member with complex needs.
Care Coordination

• Members with complex needs require services that far surpass what the Primary Care Medical Home (PCMH) model originally envisioned as the hub of care coordination for members.
  - social determinants of health.
  - “coordinating the coordinators” among external agencies and organizations.
  - PCMHs typically unprepared and under-resourced.
Care Coordination

• Appears unlikely—and perhaps even inappropriate to expect-- that PCMPs will emerge as the sole or primary source of care coordination for members with highly complex needs.
Care Coordination--Delegates

Delegates –

• Regions that from inception delegated PCMPs to independently perform care coordination–
  ➢ Have developed more formalized mechanisms for holding delegates accountable.
  ➢ are expending significant resources to do so
  ➢ need continued progress.
  ➢ RCCO care coordinator support is a factor.
Care Coordination--Challenges

- Challenges that repeatedly complicate care coordination—
  - lack of housing resources.
  - lack of SUD resources.
  - lack of or inadequate NEMT resources.
  - lack of adequate pain management resources.
Care Coordination--Challenges

• Despite BAAs to share care coordination information, coordination with mental health providers and SUD providers remains a challenge.

  (Perhaps resolved the RAE structures?)
Care Coordination--Challenges

• Complexity of the structure of the Medicaid health care and social support systems
  ➢ Members lack of familiarity with system.
  ➢ Highly unlikely that member’s with complex needs could independently navigate the health system.

• Member engagement is a significant factor in successful care coordination outcomes
Care Coordination--Challenges

• Members with complex needs—
  ➢ Consume large amounts of healthcare resources.
  ➢ Require extensive time, energy and commitment of the care coordination team.

• Dynamic tension between limited care coordination resources and desire to achieve success with individual members.
  ➢ Each RCCO will need to evaluate the question of “when is enough, enough?”
Recommendations—Care Coordination

- Evaluate limited care coordination resources vs. huge resource consumption for some members—“when is enough, enough?”. (RCCOs/RAEs only)
- Ensure all members have access to care coordination when requested.
- Examine mechanisms to improve direct care coordination with LTSS providers—SNFs, home care agencies, DME.
Recommendations—Care Coordination

• Continue emphasis on improving independent delegate performance—

➢ Pair RCCO coordinators with delegate PCMPs when members require extensive interagency coordination or social support resources.

➢ Align KPIs/provider incentives with care coordination requirements.
Recommendations—Care Coordination

• Department should continue to facilitate relationships with state agencies or major provider systems—
  ➢ Break down systems-level data-sharing or functional barriers among care coordinators.
  ➢ Streamline interagency paperwork/multiple applications.
  ➢ LTSS providers.
  ➢ Mental health providers.
  ➢ DOC.
Recommendations—Care Coordination

• Initiate policy-level discussions—Department, RCCOs, providers, community partners-- to address frequent challenges in meeting member needs—
  ➢ Low-income housing.
  ➢ NEMT.
  ➢ SUD services.
  ➢ Pain management resources.
Provider Participation

Conclusions
Provider Participation

- All RCCO’s provider networks that have been relatively stable over the past several years—
  
  - Include a mix of FQHCs, large provider systems, and smaller independent providers.
  
  - Most willing providers have been recruited.
Provider Participation

• Integrating behavioral health into primary care practices—
  ➢ Embraced by all RCCOs.
  ➢ Improves services for members and improves provider practice satisfaction.
  ➢ Requires innovation and flexibility based on variations in practice styles and community needs and resources.
  ➢ Provider reimbursement barriers need to be addressed.
RCCO’s focus—

• Increasing capacity for Medicaid members within existing practices.

• Building depth of relationships with the provider community.
Provider Participation

• Primary concern of providers—both primary care and specialists—is level of Medicaid reimbursement.

• Providers are most responsive to RCCO initiatives oriented to increasing reimbursement—
  - KPIs.
  - Provider financial incentives.
  - PMPM.
  - Delegation.

• Highly sensitive to any actions that may negatively impact provider payments or costs.
Provider Participation

• RCCOs continuously attempt to demonstrate the “value” of participating in the ACC—
  ➢ Assist individual practices with attribution issues.
  ➢ Review practice KPI performance.
  ➢ Flexibly respond to individual practice-defined needs.
Practice Transformation

• Most RCCOs have invested in robust practice transformation efforts—
  - Data support, practice coaching, care coordination, and addressing individual practice concerns.
  - Increasing operational efficiencies and provider satisfaction.
• Practice Transformation Challenges—

➢ Practices unable or unwilling to change operational functions for a segment of total patient population.

➢ Some practices inundated by multiple practice coaches.

➢ Providers exceedingly busy just caring for medical needs of patients.
Provider Participation

• Challenges that frustrate the provider experience—
  ➢ Continuing attribution issues.
  ➢ Changing KPI measures.
  ➢ Multitude of reporting requirements for ACC programs.
Provider Participation

• RCCOs have established a positive working relationship with the majority of providers in the network.

• Remains to be seen whether RCCOs’ considerable investments in practice transformation activities result in:
  ➢ actually transforming overall practice operations.
  ➢ building additional capacity for Medicaid members.
Recommendations--Providers

• Resolve attribution issues expediently OR consider an alternative mechanism for increasing provider reimbursements for serving Medicaid population.

(One of the most long-standing and resource-consumptive issues facing RCCOs--for 6 years)
Recommendations--Providers

Regarding provider reimbursement opportunities ---

• Increase regionally-defined provider financial incentive programs.

• Streamline provider KPIs and other financial incentives.

• Maintain consistency in measures and processes that impact provider payments.

• Streamline and minimize provider reporting requirements for participation in multiple ACC projects.
Recommendations--Providers

• Continue integrating behavioral health (BH) services into primary care environments.
  ➢ Address BH reimbursement issues that have been encountered in integrated practices.
  ➢ Develop professional training channels--behavioral health therapists and primary care practitioners— for working effectively in an integrated environment.
MEMBER ENGAGEMENT

Conclusions
Member Engagement

• Most regions similarly defined member engagement—

  ➢ “members participating in their own health”.
  and/or
  ➢ “meeting members where they are”.
Member Engagement

RCCOs commonly implemented through—

• Care coordination with individual members.

• Traditional outreach communications and materials.

• Member advisory groups.

  ➢ Moving advisory meetings to dispersed locations throughout region.
Member Engagement

• “Push” strategies to communicate RCCO-defined messages or attain RCCO-defined objectives may not equate to member engagement—

(Examples)
  o Member attribution—is not member access.
  o Member outreach communications--largely one-way messages.
  o Population health programs—don’t ensure member response.
  o Member Advisory groups--RCCO-defined subjects; number of participants limited.
Member Engagement

• RCCOs increasingly employing technology—text messaging, video, social media, or mobile phone applications—in member communication strategies.

• *Interactive* technology could have significant potential in future member engagement.
Member Engagement

• One region expressed a more forward-thinking definition of member engagement—
  ➢ “Understanding” the member experience
  ➢ Moving beyond member communications
  ➢ Moving beyond competent to becoming “conversant” with diverse member populations.

• Had initiated processes to explore--
  ➢ Members’ perceptions and experiences with the Medicaid program.
  ➢ “Enlightening” findings—*Voices of Medicaid* report.
Member Engagement

• Most common challenge—

Inability to contact members due to lack of accurate contact information.
Member Engagement

• Effective engagement with members must be executed at the local level—
  ➢ Diverse cultural and community-based environments and perspectives.

• Department’s most useful role in member engagement—
  ➢ Distributing state-wide mass communications to members.
  ➢ Improving Department internal customer service functions for inbound member inquiries.
Member Engagement

• Member engagement is in its infancy as a component of the ACC program.

• Many opportunities to modify traditional and historical assumptions regarding—
  - Members’ relationships with the health care system
  - Members’ real needs and interests
  - What might be involved in “improving the member experience”
Member Engagement

- Traditional outreach communications or messages driven by RCCO objectives fall short of true member engagement.

- Member advocate quote—
  “The system does not need to engage members to meet RCCO objectives, rather the RCCO needs to understand how to meet members’ objectives.”
Recommendations—Member Engagement

• Conceptually separate outreach member communications from true member engagement.

• Consider mechanisms which exceed obtaining member responsiveness to RCCO objectives.
Recommendations—
Member Engagement

• Advance meaningful and forward-thinking assumptions regarding member engagement beyond conventional member engagement strategies.
  ➢ Embrace and promote concept of understanding Medicaid members’ perceptions, interests, and experiences before outlining engagement strategies or measuring member engagement.
  ➢ Review Region 1 Voices of Medicaid report
  ➢ Encourage each RCCO to replicate similar primary research with members in each region to gain statewide perspective.
Recommendations—Member Engagement

• Implement more widely disseminated opportunities for engaging individual members throughout the regions.

• Maintain Department role in member communications—
  ➢ Distribution of centralized program materials
  ➢ Department call center communications
  ➢ Improve quality of Department call-center operations.

• Increasingly employ use of technology in member communications; move toward applications that enable interactive communications.
COLLABORATION WITH COMMUNITY PARTNERS

Conclusions
Community Partnerships

- RCCOs successfully established relationships with SEPs, CCBs, county public health departments, and Departments of Human Services.

- RCCOs also had multiple locally-driven community partnerships.

- Coordination of care is most prevalent theme driving partnerships.
Community Partnerships

• Partner organizations’ initial lack of familiarity with ACC required extensive educational and negotiation efforts.

• RCCOs tend to assume a supportive position in collaborative initiatives in order to foster positive working relationships.
  ➢ Bidirectional interagency cooperation has increased and progressed.
Community Partnerships

• Some regions have extensive community partner relationships--beyond care coordination.

➢ Flexibility of the RCCOs is critical component of successful partnerships.

➢ Strong foundation of support from diverse community organizations.

➢ Expedites response to future RCCO/RAE objectives and meeting the needs of local communities.
Community Partnerships

• Rural/urban dichotomy in community and agency relationships—

**Rural**
- Lack resources to meet needs of Medicaid populations.
- Readily form collaborative partnerships--creatively use limited resources.
- Committed to meeting local population needs.

**Urban**
- Have lots of resources.
- Challenged by the complexity and size of organizations--slows implementation.
- Relationships tend to be organizationally/functionally focused.
Community Partnerships

• Some RCCOs generously extended RCCO funds to partners to facilitate development of needed services and programs; while others provided RCCO support—staff, data—but limited funding.

➢ Funding high-priority needs of communities has very positive impact on engaging community partners.

➢ RCCOs that have not typically extended funding experience slower implementation of community partnerships and services.
Community Partnerships

- Pilot projects to test initiatives most effective way for RCCOs to readily implement or respond to regional priorities—
  - Evaluate feasibility and sustainability of projects.
  - Modify engagement as necessary.

- Sharing RCCO data with partners has emerged as a significant and valued role of the RCCOs.
Community Partnerships

- Most frequently defined unresolved collaborative priorities—
  - Transportation needs
  - Housing issues
  - Improved coordination with criminal justice involved (CJI) members and agencies.
Community Partnerships

• RCCOs valued the role of the Department in—
  ➢ Facilitating relationships among State agencies.
  ➢ Assisting RCCOs in trouble-shooting regional issues.

• ACC 2.0 era may well be the era of major Department strategic planning efforts—
Community Partnerships

• Develop statewide complement to regional accomplishments achieved in initial ACC era.
  ➢ Elevate to the Department level a process to develop collaborative relationships among multiple agencies and other community organizations.

• Address issues unable to be resolved at a regional level during the initial ACC contract period.
Recommendations—Community Partnerships

• Department should seriously consider a State-level strategic planning initiative with other State agencies to de-silo agency:
   Objectives
   Funding
   Financial incentives
   Systems
   Functions
Recommendations—Community Partnerships

To address social determinants of health—

• Designate a flexible pool of funds to be shared among collaborative participants.

• Align measures and financial incentives across multiple community organizations.
BALANCING DEPARTMENT-DRIVEN AND REGIONAL/COMMUNITY PRIORITIES

Conclusions
Balancing Department and Regional Priorities

• RCCOs consistently participated in all major program initiatives presented through the Department.
  ➢ Department driven programs largely supportive of regional priorities.
  ➢ Relative ease of balancing State and regional projects.

• Value of participating in any initiative determined by applicability to regional strategies, providers, and partners.
Balancing Department and Regional Priorities

• Implementation design of programs varied by region.
  ➢ Flexibility for implementation was essential.

• Pilot programs were commonly employed—
  ➢ prior to region-wide implementation
  ➢ to evaluate feasibility of community-based initiatives.

• In most cases, programs sustainable beyond the expiration of special funding sources.
Balancing Department and Regional Priorities

• Credited Department with having a “greater vision” to identify grant and program opportunities.

• Additional funding resources enabled implementation of services for members or enhancements to the delivery system that may not otherwise have been achievable.
Balancing Department and Regional Priorities

Operational challenges/barriers—

• Required extensive implementation resources from RCCO staff and partners.

• Reimbursement mechanisms for behavioral health in PCMP.

• Regulatory constraints for innovative regional solutions.

• Multiple external practice coaches associated with programs.

• Inadequate data and personnel resources-- CJI integration.
Balancing Department and Regional Priorities

• Regions beginning to experience “innovation fatigue” resulting from cumulative effects of multiple special projects.
  - Monitoring, reporting, and outcome measure requirements present burden for both providers and RCCOs.
  - Some RCCOs considering a global review of relative value of initiatives within the region.

• Suggested a joint strategic planning process with the Department to guide future initiatives (both Department and regional).
Recommendations—Balancing Department and Regional Initiatives

• Collaborating with RAES, develop a state-wide master plan--shared vision, anticipated priorities, and targeting pursuit of funding resources.
  ➢ To sustain changes in strategic direction of delivery system
  ➢ To provide guidance to Department and regions regarding special program initiatives/programs

• Define consistent program measures and align measures across multiple programs.
Recommendations—Department

• Allocate and deploy Department personnel with increasing frequency to individual regions—
  - Department “carries weight” with providers, agencies, and community organizations.
  - Demonstrates support for providers, community partnerships, and special program initiatives.
  - Increases awareness of the Department regarding the diversity of the state-wide healthcare environment and issues.
Recommendations--Department

To prevent extensive duplicative education efforts within each region—

• Prior to implementation of the RAEds, dispatch Department staff to conduct regionally-based education—
  - ACC 2.0 goals/role of the RAEds.
  - Changes that impact members, providers, or potential relationships with other organizations.
Recommendations--Department Data

• Pursue solutions to expediently correct inaccurate member contact information in State data systems.

• Facilitate increased data-sharing across State agencies and data bases.

• Develop a shared data resource, accessing data from all State databases.
Next Steps
Next Steps

• PIAC discussion/input

• Provide direction to Department—how to move forward
  ➢ Priorities—short-term; longer-term?
  ➢ Possible structure for further input/actions?
  ➢ Oversight role of PIAC?