



Care Coordination

Care coordination is a cornerstone of the Accountable Care Collaborative. The contract language regarding care coordination from the current RCCO contracts is attached. The Department asks members of the PIAC to read this contract language and, while also considering common themes from the Request for Information (RFI) responses, give the Department feedback regarding:

- Whether or not there should be special care coordination requirements for specific populations (and initial thoughts on what these special requirements might be),
- Appropriate level of specificity in future contracts,
- Responsibilities and duties currently missing in the scope of work that should be included in future requirements, and
- How to successfully measure care coordination.

The Department seeks PIAC and stakeholder feedback regarding care coordination requirements for the contracts for the single administrative entities that will undertake care coordination for both physical and behavioral health.

RFI Responses

- 56% of respondents said **care coordination is best done at the point of care** and the basic cost for providing is between \$5-\$8 PMPM.
- Diverse recommendations regarding evaluating care coordination outcomes. The most common theme (noted by 14% of respondents) was total cost of care.
- RCCOs should have **a larger role in addressing the social determinants of health.**
- There should be **specific requirements for special populations.**
- Different expectations for **episodic vs. ongoing care coordination.**
- However, a recurring theme was “regulation vs. flexibility” and the desire to **focus on outcomes rather than processes.**



From the current Regional Care Collaborative Organization Contracts:

- The Contractor shall provide care coordination for its Members, necessary for the Members to achieve their desired health outcomes in an efficient and responsible manner. The Contractor may allow the PCMPs other Subcontractors or other sources to perform some or all of the care coordination activities, but the Contractor shall be responsible for the ultimate delivery of care coordination services.
 - In the event that the Contractor allows a PCMP or other Subcontractor to perform any care coordination activities, the agreement with that PCMP or other Subcontractor shall comply with all requirements of the Contract.
- Regardless of its relationships or contracts with PCMPs or Subcontractors, the Contractor shall:
 - Assess current care coordination services provided of its Members to determine if the providers involved in each Member’s care are providing necessary care coordination services and which care coordination services are insufficient or are not provided.
 - Provide all care coordination services that are not provided by another source.
 - Work with providers who are responsible for the Member’s care to develop a plan for regular communication with the person(s) who are responsible for the Member’s care coordination.
 - Reasonably ensure that all care coordination services, including those provided by other individuals or entities, meet the needs of the Member.
- The Contractor shall develop a formal system of care coordination for its Members. This formal system shall have the following characteristics:
 - Comprehensive Care Coordination characteristics include:
 - Assessing the Member’s health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed.
 - The care plan shall include a behavioral health component for those clients in need of behavioral health services.
 - The ability to link Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports. This ability to link may range from being able to provide Members with the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.
 - Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and



- document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.
- Providing solutions to problems encountered by providers or Members in the provision or receipt of care.
 - The Contractor shall document all problems presented by providers and Members in the provision or receipt of care and the solutions given to the provider or the Member. The Department may review any of the documented solutions and, should the Department determine the solution to be insufficient or otherwise unacceptable, may direct the Contractor to find a different solution or follow a specific course of action.
 - Informing the Members of the Department’s Medicaid ombudsman to assist the Member in resolving health care issues and filing grievances.
 - Following up with Members to assess whether the Member has received needed services and if the Member is on track to reach their desired health outcomes.
 - Client/Family Centered characteristics include:
 - Ensuring that Members, and their families if applicable, are active participants in the Member’s care, to the extent that they are able and willing.
 - Providing care and care coordination activities that are linguistically appropriate to the Member and are consistent with the Member’s cultural beliefs and values
 - The Contractor shall provide cultural competency training to all of its new clinical staff members within three months of that staff member’s hiring. The Contractor shall provide updated training to all staff members on an annual basis or as needed to address issues that arise in relation to cultural competency as requested by the Department.
 - Providing care coordination that is responsive to the needs of special populations, including, but not limited to:
 - The physically or developmentally disabled.
 - Children and foster children.
 - Adults and the aged.
 - Non-English speakers.
 - All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act.
 - Members in need of assistance with medical transitions.
 - Members with complex behavioral or physical health needs.
 - Members with HIV: In order to serve this population, the Contractor shall coordinate with the STD/HIV section of the Colorado Department



of Public Health and Environment, which administers the Ryan White-funded program.

- Providing care coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible. The Contractor shall ensure that all care coordination activities comply with the Supreme Court decision in *Olmstead v. L. C.* (527 U.S. 581 (1999)).
- 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.
 - Providing services that are not duplicative of other services and that are mutually reinforcing.
 - Implementing strategies to integrate member care such as:
 - Developing a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.
 - Becoming familiar with the Department's initiatives and programs.
 - Knowing the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.
 - Identifying and addressing barriers to health in the in the Contractor's region, such as member transportation issues or medication management challenges.
- The Contractor shall document its formal system of care coordination and deliver this documentation to the Department within sixty (60) days of the Contract's Effective Date.
 - DELIVERABLE: Documented formal system of care coordination.
 - DUE: Sixty (60) days from the Contract's Effective Date.
- The Contractor shall provide the Department with an updated documentation of its formal system of care coordination whenever it makes any significant change to its system, when a series of minor changes have combined into a significant change from the prior system or upon the Department's request. The Contractor shall deliver this documentation to the Department within sixty (60) days of the change has occurred or from any request by the Department for updated documentation.
 - DELIVERABLE: Updated documentation of formal system of care coordination.
 - DUE: Sixty (60) days from the change or from the Department's request.
- The Department may review the Contractor's formal system of care coordination at any time. The Department may direct changes in the Contractor's system of care coordination in the event that it determines any aspect of the system to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any changes



directed by the Department and update its documentation of its formal system of care coordination accordingly.

- The Contractor shall provide, and document in its formal system of care coordination, all of the following:
 - Individuals to act as emergency department diversion outreach specialists, located in local hospitals, to assist Members who present at the emergency department in explaining the medical home concept and scheduling follow-up appointments with their PCMP.
 - Individuals to act as patient navigators to address the medical, social and socio-economic needs of the Members in the Contractor’s Region.
 - The patient navigators shall provide education to Members regarding available services that include, but are not limited to, public assistance, housing, nutrition and child care. This education shall also include the offer of additional supports for possibly unrecognized needs and assistance in accessing any additional services.
 - Individuals to act as service coordinators for Members, the Member’s PCMP and other providers and the Member’s family. These service coordinators shall interact with their assigned Members and providers, over the telephone, to provide information about Contractor and its provider network, provide Member assistance with PCMP selection, provide timely Member access to non-PCMP services and community resources, collect and enter additional data not contained in Medicaid claims data, and support all providers.
 - The Contractor shall ensure coordination between behavioral health and physical health providers.
 - A care team for each Member to assist the Member in access to care issues and in navigating systems, such as, medical, referral, public assistance, social services and patient accounts. This care team shall consist of, at a minimum, all of the following:
 - The Member’s PCMP.
 - A behavioral health provider, if needed.
 - A dental provider, if needed.
 - Case management staff.
 - A referral specialist.
 - An emergency department diversion specialist.
 - A patient navigator.

