

Integrating Care for Medicare-Medicaid Eligible Clients:

A Guide to the Colorado Accountable Care Collaborative: Medicare-Medicaid Program

August 2014

Table of Contents

I.	PROGRAM INFORMATION.....	1
	Newsletter.....	2
	Fact Sheet.....	3
	Accountable Care Collaborative Fact Sheet.....	5
	Regional Care Collaborative Map.....	6
	Regional Care Collaborative Contacts for Customers.....	7
	Frequently Asked Questions	8
	Eligibility and Enrollment.....	9
II.	CLIENT INFORMATION.....	11
	Enrollment Letter.....	12
	Co-Pays.....	14
	Benefits.....	15
	Appeals & Grievances.....	16
	Important Phone Numbers	17
III.	CLIENT RESOURCES.....	19
	Behavioral Health Services	20
	Aging and Disability Resource Center.....	21
	State and Local Disability Resources	22
	Non-Emergency Transportation.....	23
IV.	PROVIDER RESOURCES	24
	Billing and Claims	25
	Service Coordination Plan.....	26
	How to use the Service Coordination Plan.....	34
	Provider Communication Agreements (Protocols).....	42
V.	GLOSSARY OF TERMS.....	74

Section I: Program Information

Newsletter



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

A new program to make Medicare-Medicaid benefits work better together

A new program to help Medicare-Medicaid enrollees has arrived in Colorado. The program will help Medicare and Medicaid work together making it easier for clients to get the services they need.

Clients will be enrolled in the Accountable Care Collaborative (ACC) and get to experience all the benefits of care coordination the program has to offer. **Clients will keep their doctors and keep all their Medicare and Medicaid benefits.** Plus they will also have access to other benefits and services. Nothing changes for enrollees except that all their services will now be coordinated in a way that works best for them.

Benefits to membership in the ACC include:

- Being a part of their health care team: care coordinators work directly with clients to determine the client's needs and personal goals.
- A service coordination plan: A personalized plan each client creates with their care coordinator to make sure they are receiving all the services they need and they are reaching their personal goals.
- Coordination of all the client's benefits, services and providers. The care coordinator works to improve communication between all of the client's providers.
- Care that is provided in a way that meets the needs of the client, is easily accessible and makes sense to the client.

Joining the ACC is simple: we will enroll all individuals who qualify. Clients can continue to see their doctors and have access to all the services they are currently using. If clients decide they don't like the ACC plan, they can also drop it at any time for any reason.

For more client information contact:

- Medicaid Customer Contact Center: 1-800-221-3943
- Medicare Customer Contact Center: 1-800-MEDICARE
- HealthColorado: 303-839-2120.

Program Contact: Van Wilson 303-866-6352

Media Contact: Rachel Reiter 303-866-3921

The Accountable Care Collaborative: Medicare-Medicaid Program

The Department of Health Care Policy and Financing (the Department) and the Centers for Medicare and Medicaid Services (CMS) have partnered to implement a new program to integrate care for Medicare-Medicaid clients. The demonstration is called “The Accountable Care Collaborative: Medicare-Medicaid Program (program)”. The program will integrate and coordinate physical, behavioral and social health needs for Medicare-Medicaid clients. Colorado is one of 12 states in the nation to implement this program.

Full benefit Medicare-Medicaid enrollees are individuals who are:

- Enrolled in Medicare Parts A and B and eligible for Part D,
- Receive full Medicaid State Plan benefits,
- Receive or are eligible for Medicaid waiver services, and
- Have no other comprehensive private or public health insurance.

It is estimated that 32,000 Coloradans are full benefit Medicare-Medicaid enrollees who do not currently participate in an integrated system of care. Clients who participate in this program keep all their Medicare and Medicaid benefits and services. They also have the right to keep the same doctors and other health care providers.

What makes Colorado’s plan innovative?

Colorado’s plan will advance the Department’s commitment to improving the care and health outcomes for full benefit Medicare-Medicaid enrollees. It builds on the infrastructure and resources of the Accountable Care Collaborative (ACC), a central part of Colorado’s Medicaid health care delivery system. Colorado’s plan is unique because it allows clients to keep their doctors and existing network of providers. Other states are implementing the demonstration in a managed care setting, which in some cases may require a client to change providers.

Why is it important to focus on Medicare-Medicaid enrollees?

Clients who receive both Medicare and Medicaid rely almost entirely on government programs to help meet their health needs. Generally, these clients suffer from multiple chronic conditions. They can also have cognitive impairments, low literacy, and face housing isolation. Compared to average Medicaid recipients, they generally require a higher level of care but face more barriers to receiving the right services at the right time and place. To reduce these barriers, the program will improve care coordination for Medicare-Medicaid enrollees.

A new study by the RAND Corporation* measured the association between care coordination and health care utilization. They concluded that for Medicare beneficiaries with diabetes, congestive heart failure or emphysema, greater care coordination is beneficial to both the client and the health system. Improving care coordination is associated with fewer hospitalizations, fewer complications and lower costs.

The conflicting coverage policies and incentives of Medicare and Medicaid are a major challenge to improving the health of Medicare-Medicaid enrollees. The system serving Medicare-Medicaid enrollees is fragmented, which results in unnecessary and duplicative services. While efforts are underway to better coordinate Medicare and Medicaid programs at the federal level, states play an important role in defining and testing solutions as well. This program gives the Department an opportunity to better meet the needs of Medicare-Medicaid enrollees in Colorado.

What are the program’s goals?

CMS identified the goals as:

- Improved health outcomes for full benefit Medicare-Medicaid enrollees.
- Improved enrollee experience through enhanced coordination and quality of care.
- Decreased unnecessary and duplicative services, and the resulting costs.

In order to address these goals, the Department seeks to provide greater integration between the ACC program, other Medicaid programs serving the enrollees, and the Medicare program. It is also working to improve transitions of care into and out of Long-Term Services and Supports (LTSS). Additionally, the Department will make it easier for enrollees to understand their benefits and navigate the systems of care.

How does the program work?

The Department has identified several key strategies that will help meet the goals of the program. These include: the Service Coordination Plan (SCP), cross-provider communication agreements, disability competent care and a beneficiary's rights and protections alliance.

The Service Coordination Plan (SCP):

- Tool that will help coordinate client care across providers
- Documents medical, social and behavioral needs, and client short-term and long-term goals
- Completed with the client
- Promotes person-centered care

Cross-Provider Communication Agreements:

- Strengthen relationships across providers and improve coordination in serving clients
- Written agreements describing the process for identifying and working with clients
- Creates accountability and identifies organization responsibility to client

Disability Competent Care:

- Ensuring physical, cultural and program accessibility
- Inventory for clients so they know where to go for accessible care
- Collaboration with local advocacy groups to provide training to providers

Beneficiary's rights and protections alliance created to ensure:

- Beneficiary health, safety, and access to quality services
- Beneficiaries are informed about their care options
- Access to the grievance and appeal process for both Medicare and Medicaid

What is happening now?

- The ACC: Medicare-Medicaid Program will be implemented September 1st.
- The Department is developing an evaluation plan that will utilize rapid cycle feedback to make improvements to the program.
- The Department is continuing to work with the Advisory Subcommittee and stakeholders to monitor and improve the program.

For more information, including provider trainings, please visit the [Department's website](#).

CONTACTS:

Program: [Van Wilson](#)
303-866-6352

Media: [Marc Williams](#)
303-866-3144

* Hussey, PS. et al. "Continuity and the Costs of Care for Chronic Disease". JAMA. May, 2014; 174:

Accountable Care Collaborative Fact Sheet

The Accountable Care Collaborative (ACC) is a Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC receive the regular Medicaid benefit package, and belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP).

The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes.

The program began in the spring of 2011. There are now more than 600,000 enrollees.

Central Goals

- Improve health outcomes through a coordinated, client-centered system; and
- Control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

Key Components:

Seven **Regional Care Collaborative Organizations (RCCOs)** provide:

- Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- Care coordination among providers and with other services such as behavioral health, long-term supports and services, Single Entry Point (SEP) programs and other government social services such as food, transportation and housing;
- Provider network development and management; and
- Provider support such as assistance with care coordination, referrals, clinical performance and practice improvement and redesign.

The **Statewide Data and Analytics Contractor** (Treo Solutions):

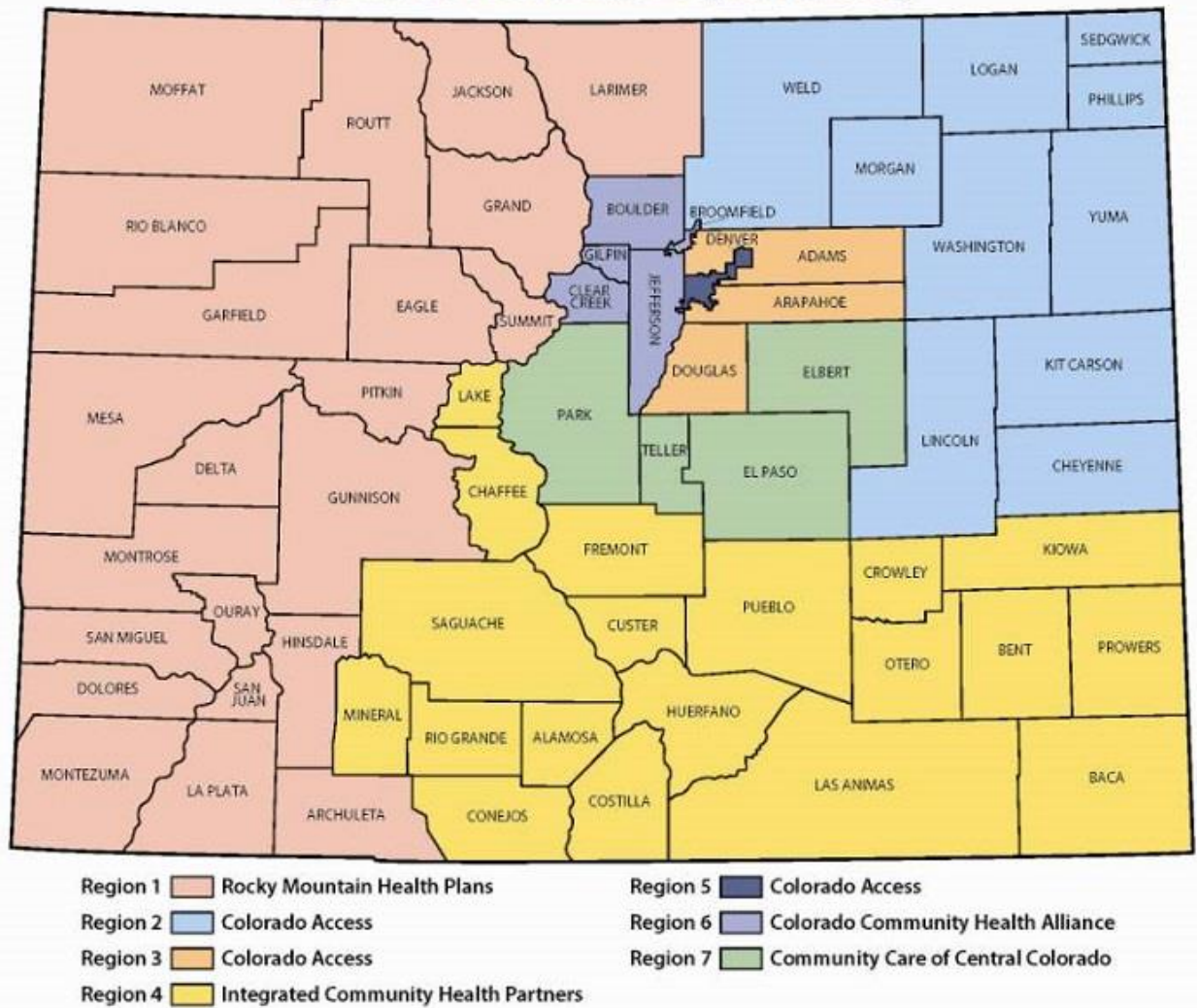
- Builds and implements the ACC data repository;
- Creates reports using advanced health care analytics;
- Hosts and maintains a Web Portal;
- Provides a continuous feedback loop of critical information;
- Fosters accountability and ongoing improvement among RCCOs and providers; and
- Identifies data-driven opportunities to improve care and outcomes.

Primary Care Medical Providers (PCMPs) are affiliated with a RCCO and act as “medical homes” for clients. As a medical home, the PCMP will coordinate and manage a client’s health needs across specialties and along the continuum of care.

Colorado has received national attention due to the progress and composition of the Accountable Care Collaborative Program. Many states are watching and monitoring Colorado’s implementation of the program.

RCCO Map

**Colorado's Accountable Care Collaborative
Regional Care Collaborative Organization Map**



RCCO Customer Service Contacts- For Clients

If client lives in this county:	Contact this RCCO:
Region 1 Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit	Rocky Mountain Health Plans 970-254-5771 (local) 1-800-667-6434 (toll-free) acc.rmhp.org
Region 2 Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	Colorado Access 303-368-0035 (local) 1-855-267-2094 (toll-free) www.coaccess-rcco.com
Region 3 Adams, Arapahoe, Douglas	Colorado Access 303-368-0037 (local) 1-855-267-2095 (toll-free) www.coaccess-rcco.com
Region 4 Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache	Integrated Community Health Partners 1-855-959-7340 (toll-free) www.ichpcolorado.com
Region 5 Denver	Colorado Access 303-368-0038 (local) 1-855-384-7926 (toll-free) www.coaccess-rcco.com
Region 6 Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	Colorado Community Health Alliance 303-260-2888 (local) 1-877-919-2888 (toll-free) www.cchacares.com
Region 7 El Paso, Elbert, Park, Teller	Community Care of Central Colorado 719-314-2560 (local) 1-866-938-5091 (toll-free) www.mycommunitycare.org

Medicare-Medicaid Program: Frequently Asked Questions

What are the benefits of this program?

This new program will help your Medicare and Medicaid work together better, making it easier for you to get the services you need. In this new program, we will work with you to help you, your doctors, and others to coordinate your care and services. We can also help you find social and community services in your area.

Will my current benefits or services be disrupted if I participate in this program?

No, you will still have all the same Medicare-Medicaid benefits. All benefits and services will continue as normal including social and community supports or case management, pharmacy services, durable medical benefits, Home and Community based Services and Long-Term Supports and Services, and all other government benefits such as social security or food assistance.

Will I still be able to use my current providers for the services I receive?

Yes, you will still have your same providers.

Will I lose my Medicare and Medicaid benefits if I don't participate in this program?

No, if you choose not to participate in this program, you will still have the same Medicare and Medicaid benefits.

Will I need to get approval from anyone before I can see my doctor or access services?

No. Prior approval is not required to see your physician or receive services.

What about privacy, who will see my records and information?

All of your records and information will continue to be subject to existing privacy regulations, which restricts the sharing of your health information without your prior written consent.

Who do I call when I have questions about my services?

For questions regarding Medicaid services, please contact Medicaid customer service at 800-221-3943. For questions regarding Medicare services, please contact Medicare customer service at 1-800-MEDICARE (1-800-633-4227)

Eligibility and Enrollment Requirements

Eligibility

Beneficiaries ***must meet all*** of the following criteria to be eligible for assignment to this Demonstration:

- Be enrolled in Medicare Parts A and B and eligible for Part D; and
- Receive full Medicaid benefits under FFS arrangements;
- Have no other private or public health insurance; and
- Be a resident of the State.

Beneficiaries ***not eligible*** for assignment excluded from enrollment in this Demonstration include:

- Individuals enrolled in a Medicare Advantage plan, the Program of All-inclusive Care for the Elderly (PACE), the Denver Health Medicaid Choice Plan, or the Rocky Mountain Health Plan;
- Individuals who are residents of an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID); and
- Individuals who are participating in the Colorado House Bill 12-1281 ACC Program Payment Reform pilot.

Enrollment:

The Department will use a passive enrollment process that attributes Medicare-Medicaid beneficiaries to the RCCO in the geographic area and based on existing beneficiary-provider relationships.

Why a phased-in approach?

The Department will use a seven (7) month phase-in to enroll Medicare-Medicaid beneficiaries into the Demonstration. This deliberate, phased-in approach will allow the Department to optimize solid infrastructure that already exists and to build upon that foundation as more beneficiaries are enrolled. In preparation for the Demonstration, the Department is categorizing, on a monthly basis, potentially eligible Demonstration enrollees into a matrix distinguished by RCCO, county, delivery system, and provider type. The four delivery systems are: community relatively well, waiver, high waiver, and skilled nursing facility. The Department anticipates enrolling no more than 7,500 beneficiaries per month based on the following strategy:

Individuals receive advance notice and have sufficient time and opportunity to make an informed choice about participation in the Demonstration and the ACC Program. Individuals who do not wish to participate in the Demonstration and ACC Program may opt out or request disenrollment at any time. Regardless of enrollment status, entitlement or access to Medicaid or Medicare services does not change.

Enrollment Details

Monthly Client Enrollment by Classification – 7500 clients/month maximum						
MONTH ONE	MONTH TWO	MONTH THREE	MONTH FOUR	MONTH FIVE	MONTH SIX	MONTH SEVEN
FBMMes currently in ACC						
Community Relatively Well PCP in ACC	Community Relatively Well PCP in ACC					
	Community Relatively Well PCP not in ACC	Community Relatively Well PCP not in ACC	Community Relatively Well PCP not in ACC			
		Waiver Low PCP in ACC	Waiver Low PCP not in ACC	Waiver Low PCP not in ACC		
				Waiver High PCP not in ACC		
					SNF residents for which CO Medicaid is primary payer	Remainder of SNF residents for which CO Medicaid is primary payer

Enrollment Materials for each Monthly Enrollment Group

T-MINUS 33 DAYS TO ENROLLMENT	T-MINUS 30 DAYS TO ENROLLMENT
Welcome Marketing Letter	Notice of Enrollment Letter & Enrollment Packet

Client Enrollment Classifications Explained

Community Relatively Well	These members are not nursing home certifiable and do not live in a nursing facility nor use waiver services on a consistent basis.
Waiver Low	These members are not living in a nursing facility and utilizing waiver services on a consistent basis. A longitudinal study was conducted to tease out any members receiving sporadic waiver services.
Waiver High	These members are also not living in a nursing facility, but are very high utilizers of waiver services. These members had to have an average PMPM of greater than \$4,800 in waiver services to be considered as part of this Delivery System.
Skilled Nursing Facility Population	These members reside in a nursing facility and have a nursing facility level of care. A member must have at least three consecutive months of nursing facility service to be considered as part of this population. This results in members with less than the three months of nursing facility service to be considered “short term”, these members are captured in one of the other Delivery Systems.

Section II:

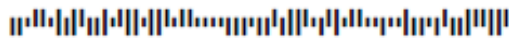
Client Information



This letter is your only notice about this change.

If you are hearing impaired call TTY: 1-888-876-8864

Alternative formats of this document will be provided upon request. For more information call 303-839-2120.



John Smith
12345 Anywhere St
City, ST ZIP

RC3 1

<July 17, 2013>

Your Medicaid number:
<999999>

Dear <John>,

On <September 1, 2013>, you are being enrolled in a new program for people who have both Medicare and Medicaid. This new program is called the Accountable Care Collaborative (ACC) Medicare-Medicaid Program and it will help your Medicare and Medicaid work together better, making it easier for you to get the services you need.

In this new program, your local Regional Care Collaborative Organization, <Colorado Access>, will work with you. <Colorado Access> will help you, your doctors, and others to coordinate your care and services. <Colorado Access> can also help you find social and community services in your area.

Our information shows:

Your doctor is (or is part of) <ABC Family Practice>

Your Regional Care Collaborative Organization is <Colorado Access>.
<999-999-9999>

Your RCCO will contact you within the next few months to see how they can help you with your Medicaid and Medicare benefits. If you would like help immediately, please contact your RCCO at <999-999-9999>

What do you have to do to be in the new program?

You don't have to do anything. You are automatically in the program. After <September 1, 2013>, <Colorado Access> will contact you to explain how the new program can help you.

Please read the other information in this packet to learn more about the program and better understand how it can help you.

If you need behavioral health services

Being enrolled in this program does not change where you can get your behavioral health services for you or for your family members. All behavioral health services will continue to be provided by <Behavioral Healthcare Inc.> at <720-490-4400 or 1-877-349-7379 toll free.>



This letter is your only notice about this change.

If you are hearing impaired call TTY: 1-888-876-8864

Alternative formats of this document will be provided upon request. For more information call 303-839-2120.



Questions you may have:

1. Why do I want to be in this new program?

It allows your doctors and the Regional Care Collaborative Organization to better coordinate your services, making it easier for you to get the services you need.

2. Will this new program cost me money?

No, there is no additional cost to you.

3. Will I still be able to see the doctors I have now?

Yes

4. Do I have to fill out paperwork?

No, you will be a member as of <September 1, 2013.>

5. Are my benefits going to change?

No, you still have the same Medicare and Medicaid benefits.

Do you have other questions?

Please note that this is your enrollment letter. It is the only formal notice you will receive. If you have other questions or need more information, please see below.

What if you don't want to be in the new program?

If you don't want to be in this program, please tell us by calling HealthColorado at <1-888-367-6557.> You can call Monday to Friday, 8 a.m. to 5 p.m. You may call before <September 1, 2013> or at any time in the future. The call is free.

If you would like to:

Call:

Number:

Learn more about the program and other community resources

<Colorado Access>

<999-999-9999>

Sincerely,
The Colorado Department of Health Care Policy and Financing

Client Co-Pays

Co-pays are small amounts of money a client pays for services like office visits, medications and hospital stays. Some services do not have co-pays. American Indians do not have co-pays.

The ACC program may also cover a client's Medicare premiums, deductibles and co-insurance.

Service Type	Service	Co-Pay
Inpatient Hospital Services	Care at a hospital when a client stays in the hospital	\$10 for each covered day, or 50% of the average daily rate hospital allows, whichever is less
Outpatient Hospital Services	Care at a hospital when a client is not staying in the hospital	\$3 each visit
PCMP and Specialist Services	Care a client gets from his/her PCMP or specialists outside of a hospital	\$2 each visit
Optometrist Visit	Visit to an eye specialist	\$2 each visit
Podiatrist Visit	Visit to a foot doctor	\$2 each visit
Rural Health Clinic/ FQHC Services	Visit to a health center or clinic	\$2 each day of service
Laboratory Services	Blood tests and other lab work	\$1 each day of service
Radiology Services	X-rays	\$1 each day of service Dental x-rays do not have co-pays
Prescription Services (each prescription or refill)	Medications	\$1 for generic drugs \$3 for brand name drugs

Benefits

Both Medicare and Medicaid have large benefit packages that vary depending on the type of coverage per client. This list is intentionally short and should be used as a resource to help determine benefits information.

If a *client* has questions about their benefits, refer them to:

Medicare Customer Contact Center
1-800-MEDICARE
Or <http://www.medicare.gov/>

Medicaid Customer Contact Center
1-800-221-3943
TDD 1-800-659-2656
Customer.Service@hcpf.state.co.us
Or www.colorado.gov/HCPF

Office hours are Monday to Friday, 7:30 a.m. to 5:00 p.m. (except holidays). The call is free.

Appeals & Grievances

Step 1

Client should talk to their PCMP or RCCO

Step 2

If a client is still having trouble, they should contact the Ombudsman for Medicaid Managed Care at:

- 303-830-3560 (Denver)
- 1-877-435-7123 (outside of Denver)
- TTY: 1-888-876-8864 (hearing impaired)
- Email: help123@maximus.com

Step 3

If a client believes they were denied services without cause, they can appeal and ask for a State Fair Hearing. Client should call the Colorado Office of Administrative Courts at **303-866-2000**.

Or, write to:

Colorado Office of Administrative Courts
633 17th Street
Suite 1300
Denver, CO 80202

Important Phone Numbers

Help with Medicaid Services

Health*Colorado*

303-839-2120 (Denver Metro Area)

1-888-367-6557 (all other areas)

www.healthcolorado.org

Refer a client to Health*Colorado* if they need to change providers, change Medicaid plans or to get a copy of this book in a different format.

Medicaid Customer Contact Center

1-800-221-3943

TDD 1-800-659-2656

www.Colorado.gov/hcpf

Refer a client to the Medicaid Customer Contact Center if they have questions about services, benefits, need help finding other health care providers, or are not sure who to call.

Ombudsman for Medicaid Managed Care

303-830-3560 (Denver Metro Area)

1-877-435-7123 (all other areas)

Help123@maximus.com

Refer a client to the Ombudsman for Medicaid Managed care if they need help filing a grievance or appeal related to Medicaid benefits, or they need help solving problems with quality of care.

Help with Medicare Services

Medicare Customer Contact Center

1-800-MEDICARE

www.medicare.gov

Refer a client to Medicare Customer Contact Center if they have questions about their Medicare services or benefits.

Colorado State Health Insurance and Assistance Program (SHIP)

1-888-696-7213

Refer a client to SHIP if they have questions about Medicare enrollment or Medicare benefits.

Long-Term Care Ombudsman

1-800-288-1376

www.thelegalcenter.org

Refer a client to the Long-Term Care Ombudsman if they need help understanding options for long-term care, need help choosing a long-term care facility, or have a complaint about care at a nursing home or assisted living residence.

Medicare Quality Improvement Organizations
KEPRO- Beneficiary and Family Centered Care
1-844-430-9504

Refer a client to this organization if they have concerns about the quality of care relating to their Medicare services.

Other Helpful Numbers

FirstTransit
1-855-264-6368

www.medicaidco.com

Refer a client if they need help arranging transportation to an appointment.

Nurse Advice Line (24-Hour)
1-800-283-3221

Call for health care advice at any time. A nurse is always there to help.

Colorado Legal Services
303-837-1321
www.coloradolegalservices.org

Subject to available resources, CLS may be able to provide legal assistance or information regarding a civil legal matter including an appeal of the denial of Medicaid or Medicare eligibility or services.

Suicide Hotline
1-800-273-8255
www.suicide.org

Tobacco Free Living
1-800-784-8669
www.coquitline.org

Informacion en Espanol
303-839-2120 o 1-888-367-6657

Section III:

Client Resources

Behavioral Health Services

A client can get behavioral health services through a Behavioral Health Organization (BHO). Their PCMP and RCCO can work with mental health providers and with providers that help with substance abuse. Here is a list of counties and their BHOs.

For a behavioral health crisis: Metro Crisis Line at 1-888-855-1222

Suicide hotline: 1-800-273-TALK (1-800-273-8255)

If a client lives in this county:	Have them contact this BHO:
Denver	Access Behavioral Care (ABC) 303-751-9030 (Denver Metro Area) 1-800-984-9133 (toll-free) www.coaccess.com/accessbehavioral-care
Adams, Arapahoe, Douglas	Behavioral HealthCare, Inc. (BHI) 720-490-4400 (Denver Metro Area) 1-877-349-7379 (toll-free) www.bhicares.org/members.htm
Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	Foothills Behavioral Health Partners (FBHP) 303-432-5950 (Denver Metro Area) 1-866-245-1959 (toll-free) www.fbhpartners.com/members.htm
Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	Access Behavioral Care (ABC) Northeast 970-221-8508 (Denver Metro Area) 1-844-880-8508 (toll free) www.coaccess.com/accessbehavioral-care
Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Otero, Ouray, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller	Colorado Health Partnerships (CHP) 1-800-804-5008 (toll-free) www.yourchp.org

The Aging and Disability Resource Center

The Aging and Disability Resource Center Program is designed to streamline access to Long Term Services and Supports (LTSS) for all income levels and adult populations- including older adults (60+), adults with disabilities (18+), caregivers, and providers. This redesigned entry point system will reduce fragmented and duplicative services by improving care coordination and care transitions.

CONTACTS:

Adams 303.480.6700	Denver 303.480.6700	Kit Carson 719.346.7158	Philips 970.867.9409
Alamosa 719.589.4511	Dolores 970.264.0502	La Plata 970.264.0502	Pitkin 970.468.0295 X117
Arapahoe 303.480.6700	Douglas 303.480.6700	Lake 719.539.3341	Prowers 719.383.4002
Archuleta 970.264.0502	Eagle 970.468.0295 X117	Larimer 970.498.7757	Pueblo 719.538.6611
Baca 719.383.4002	El Paso 719.471.2096	Las Animas 719.845.1133	Rio Blanco 970.244.8400
Bent 719.383.4002	Elbert N/A	Lincoln 719.346.7158	Rio Grande 719.589.4511
Boulder 303.441.1617 TTY 303.441.3986	Fremont 719.539.3341	Logan 970.867.9409	Routt 970.244.8400
Broomfield 303.480.6700	Garfield 970.244.8400	Mesa 970.244.8400	Saguache 719.589.4511
Chaffee 719.539.3341	Gilpin 303.480.6700	Mineral 719.589.4511	San Juan 970.264.0502
Cheyenne 719.346.7158	Grand 970.468.0295 X117	Moffat 970.244.8400	San Miguel 970.249.2436
Clear Creek 303.480.6700	Gunnison 970.249.2436	Montezuma 970.264.0502	Sedgwick 970.867.9409
Conejos 719.589.4511	Hinsdale 970.249.2436	Montrose 970.249.2436	Summit 970.468.0295 X117
Costilla 719.589.4511	Huerfano 719.845.1133	Morgan 970.867.9409	Teller 719.689.3584
Crowley 719.383.4002	Jackson 970.468.0295 X117	Otero 719.383.4002	Washington 970.867.9409
Custer 719.539.3341	Jefferson 303.480.6700	Ouray 970.249.2436	Weld 970.346.6952
Delta 970.249.2436	Kiowa 719.383.4002	Park N/A	Yuma 970.867.9409

State and Local Disability Resources

Although the list below is not all-inclusive, it contains some organizations that may be contacted for different types of disability expertise:

Ability Connection Colorado

<http://abilityconnectioncolorado.org>

Advocacy Denver

www.advocacydenver.org

Colorado Advisory Council for Persons with Disabilities

<http://coloradodisabilitycouncil.org>

Colorado Center for the Blind

<http://coloradocenterfortheblind.org>

Colorado Commission for the Deaf and Hard of Hearing

<http://www.ccdhh.com>

Colorado Cross Disability Coalition

www.ccdconline.org

Colorado Developmental Disabilities Council

www.coddc.org

Colorado Statewide Independent Living Council

<http://coloradosilc.org>

Family Voices Colorado

<http://familyvoicesco.org>

Hearing Loss Association of America, Colorado Chapter

www.Hearinglosscolorado.org

Parkinson Association of the Rockies

www.parkinsonrockies.org

Rocky Mountain ADA Center, Health Care & the ADA

<http://adainformation.org/healthcare>

Rocky Mountain Down Syndrome Association

www.rmDSA.org

Rocky Mountain Stroke Center

www.strokecolorado.org

The Arc of Colorado

www.thearcofco.org

The Colorado Association of the Deaf

www.cadeaf.org

Non-Emergency Transportation

Medicaid

If a client doesn't have a way to get to and from their Medicaid appointments, Medicaid can help.

If a client lives in one of these counties, they can call First Transit at **1-855-264-6368**:

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer or Weld

If a client lives in any other county, they can call the county's Department of Social Services or your RCCO. Clients can find the RCCO for their county on page X of this booklet.

If a client is not sure how to contact their county, they can call the Medicaid Customer Contact Center at **1-800-221-3943 (TDD 1-800-659-2656)**.

When a client calls, they need to have these ready:

- Name and Medicaid ID number
- Address and phone number
- Doctor's name, address and phone number
- The time of their appointment

Medicare

In some cases, a client may be able to get limited, medically necessary non-emergency ambulance transportation if all of these apply:

- Such transportation is needed to obtain treatment or diagnose a client's health condition.
- The use of any other transportation method could endanger a client's health.
- Client has a written order from their doctor stating that ambulance transportation is necessary due to their medical condition.

Section IV: Provider Resources

Billing and Claims

If a *provider* has questions about Medicaid:

- billing and bulletin;
- correspondence, inquiries and adjustments;
- enrollment, changes,
- signature authorization and claim requisitions,

Xerox State Healthcare

1-800-237-0044

Or 1-800-237-0757

Office hours are Monday to Friday 8:00 a.m. to 5:00 p.m.

SERVICE COORDINATION PLAN

FOR ACCOUNTABLE CARE COLLABORATIVE: MEDICARE-MEDICAID PROGRAM ENROLLEES

Goal of the Service Coordination Plan:

To promote proactive, person-centered, strength-based coordination of services and supports; including physical health needs for individuals with complex conditions and system-level oversight and support for individuals receiving case management from other agencies.

CLIENT SUMMARY PAGE

DATE ENROLLED: __/__/__

RCCO: _____

DATE OF SCP: __/__/__

SCP AUTHOR: _____

DATE OF SCP REVIEW: __/__/__

SCP AUTHOR ORGANIZATION: _____

REASON FOR SCP: (choose one) ☐ new, ☐ six-month review, ☐ change in condition, ☐ change in goals, ☐ resolution of goals, ☐ Care transition (e.g., hospital discharge, move from facility into community, etc.), ☐ resolution of action steps.

1. WHICH DESCRIPTION BEST FITS THE CLIENT'S OVERALL STATUS?

- ☐ a. The client is stable with no risk for serious complications and death (beyond those typical of the client's age).
☐ b. The client is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the client's age).
☐ c. The client is likely to remain in fragile health and have ongoing high risks of serious complications and death.
☐ d. The client had serious progressive conditions that could lead to death within a year.
☐ e. The client's condition is unknown or unclear to the respondent.

2. HIGH-RISK PRIORITIZATION: ☐ YES (1) / ☐ NO (0)

3. CLIENT SUMMARY AND NEXT STEPS

BASIC DEMOGRAPHICS

4. CLIENT INFORMATION

a. LAST NAME		b. FIRST NAME	
c. STREET ADDRESS		d. CITY	e. ZIP
f. COUNTY	g. EMAIL		
h. TELEPHONE #		<input type="checkbox"/> Home	<input type="checkbox"/> Cell
ALTERNATE #		<input type="checkbox"/> Work	<input type="checkbox"/> Other
		<input type="checkbox"/> Home	<input type="checkbox"/> Cell
		<input type="checkbox"/> Work	<input type="checkbox"/> Other
i. DOB	j. GENDER	k. MARITAL STATUS	l. CLIENT ID
			Medicare:
			Medicaid:
m. COMMUNICATION REQUIREMENTS			
n. PREFERRED LANGUAGE			
o. PREFERRED MEANS OF COMMUNICATION <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail			
<input type="checkbox"/> In Person <input type="checkbox"/> Through Caregiver or Legal Guardian <input type="checkbox"/> Other: _____			

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5. CLIENT CONTACT HISTORY

a. ☐ CLIENT CONTACTED, DOES NOT WANT PLAN
i. EXPLAIN:

b. ☐ CLIENT CONTACT INFORMATION NOT VALID

c. ☐ ATTEMPTED CONTACT, NO RESPONSE

DATES: ____/____/____ ____/____/____ ____/____/____

6. CASE MANAGEMENT / CARE COORDINATION AGENCY

a. DOES INDIVIDUAL CURRENTLY RECEIVE ON-GOING CASE MANAGEMENT SERVICES (SEP/CCB): ☐ YES (1) / ☐ NO (0)

NAME	AGENCY	PHONE	EMAIL	ASSESSMENTS/ CARE PLAN	RELEASE OF INFORMATION
*LEAD					

**MEDICAL HISTORY**

7a. DIAGNOSES:

b. PROGNOSSES

c. IS THIS LIST COMPLETE?: ☐ YES (1) / ☐ NO (0)

8. RECENT HOSPITALIZATIONS and EMERGENCY DEPARTMENT VISITS

DATE	REASON	CARE TRANSITION PLAN GENERATED AND DISSEMINATED	FOLLOW-UP VISIT(S)

9. MEDICATIONS: Data Source ☐ SDAC ☐ PCMP ☐ Member ☐ Other _____

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[illegible]

12. PERSON(S) INVOLVED IN CREATING PLAN	
<input type="checkbox"/> Client <input type="checkbox"/> Family Member <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Other _____	
13. CLIENT'S LONG-TERM GOAL(S)	
14. CLIENT'S SHORT-TERM GOAL (1) (GOAL IS MUTUALLY AGREED ON BY CLIENT AND COORDINATOR)	
a. GOAL:	
b. CLIENT OBJECTIVES:	
START DATE: ____/____/____	STATUS UPDATE: ____/____/____
c. CARE COORDINATOR/CASE MANAGER ACTION STEPS:	
d. OUTCOME:	
<input type="checkbox"/> Completed ____/____/____ <input type="checkbox"/> Revised ____/____/____	<input type="checkbox"/> No longer pertinent- life or health change ____/____/____ <input type="checkbox"/> Client request to discontinue ____/____/____
e. UPDATES :	
15. SHORT TERM GOAL (2) (GOAL IS MUTUALLY AGREED ON BY CLIENT AND COORDINATOR)	
a. GOAL:	
b. CLIENT OBJECTIVES:	
START DATE: ____/____/____	STATUS UPDATE: ____/____/____
c. CARE COORDINATOR/CASE MANAGER ACTION STEPS:	
d. OUTCOME:	
<input type="checkbox"/> Completed ____/____/____ <input type="checkbox"/> Revised ____/____/____	<input type="checkbox"/> No longer pertinent- life or health change ____/____/____ <input type="checkbox"/> Client request to discontinue ____/____/____
e. UPDATES:	
16. SHORT TERM GOAL (3) (GOAL IS MUTUALLY AGREED ON BY CLIENT AND COORDINATOR)	

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a. GOAL:	
b. CLIENT OBJECTIVES: START DATE: ____/____/____ STATUS UPDATE: ____/____/____	
c. CARE COORDINATOR/CASE MANAGER ACTION STEPS:	
d. OUTCOME: <input type="checkbox"/> Completed ____/____/____ <input type="checkbox"/> No longer pertinent- life or health change ____/____/____ <input type="checkbox"/> Revised ____/____/____ <input type="checkbox"/> Client request to discontinue ____/____/____	
e. UPDATES:	
17. CLIENT'S ASSENT	
a. <input type="checkbox"/> Client Goals were reviewed/updated with <input type="checkbox"/> client/ <input type="checkbox"/> authorized representative in person. Date: ____/____/____ x _____	
b. <input type="checkbox"/> Client Goals were reviewed/updated with <input type="checkbox"/> client/ <input type="checkbox"/> authorized representative by phone. Date: ____/____/____ x _____	

PROVIDER INFORMATION		
18. PRIMARY CARE PROVIDER		
a. CLINIC NAME		
b. PROVIDER NAME	c. PHONE	
d. STREET ADDRESS	e. CITY	f. ZIP
g. EMAIL ADDRESS		
h. CONTRACTED TO ACC <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2)	i. DATE OF LAST VISIT	
j. WHO DOES THE CLIENT CONSIDER THEIR PRIMARY PROVIDER TO BE?		
k. REFERRALS AND SPECIALISTS INVOLVED WITH CLIENT CARE		
DATE OF REFERRAL	PROVIDER NAME	STATUS OF VISIT/SERVICES
19. PROVIDER (1) <input type="checkbox"/> N/A		
a. PROVIDER TYPE	RELEASE OF INFORMATION <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: ____/____/____	
b. PROVIDER NAME	c. PHONE	
d. STREET ADDRESS	e. CITY	f. ZIP
g. EMAIL ADDRESS		
h. DATE OF LAST VISIT		
i. ADVICE AND RECOMMENDED FOLLOW-UP:		

j. ADDITIONAL SERVICES RECOMMENDED:			
20. PROVIDER (2) <input type="checkbox"/> N/A			
a. PROVIDER TYPE:		RELEASE OF INFORMATION <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__	
b. PROVIDER NAME		c. PHONE	
d. STREET ADDRESS		e. CITY	f. ZIP
g. EMAIL ADDRESS			
h. DATE OF LAST VISIT			
i. ADVICE AND RECOMMENDED FOLLOW-UP:			
j. ADDITIONAL SERVICES RECOMMENDED:			
21. PROVIDER (3) <input type="checkbox"/> N/A			
a. PROVIDER TYPE		RELEASE OF INFORMATION <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__	
b. PROVIDER NAME		c. PHONE	
d. STREET ADDRESS		e. CITY	f. ZIP
g. EMAIL ADDRESS			
h. DATE OF LAST VISIT			
i. ADVICE AND RECOMMENDED FOLLOW-UP:			
j. ADDITIONAL SERVICES RECOMMENDED:			
22. ADDITIONAL PROVIDERS <input type="checkbox"/> N/A			
TYPE	NAME	AGENCY	RELEASE OF INFORMATION
			<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__
			<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__
			<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__
			<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__
			<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (2) <input type="checkbox"/> N/A (3) Date: __/__/__

23. ASSESSMENT NARRATIVE	
a. CULTURAL/SPIRITUAL CONSIDERATIONS	

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b. LANGUAGE/COMMUNICATION		
c. URGENT NEEDS		
Barriers To Care/Access:		
d. TRANSPORTATION REQUIREMENTS OR PREFERENCES <input type="checkbox"/> N/A		
i. <input type="checkbox"/> Fixed route bus	iv. <input type="checkbox"/> Paratransit/demand response eligibility	vii. <input type="checkbox"/> Taxi
ii. <input type="checkbox"/> Personal vehicle	v. <input type="checkbox"/> Non-Medical transportation to Day Program	viii. <input type="checkbox"/> Medical transportation
iii. <input type="checkbox"/> Family or Friends	vi. <input type="checkbox"/> Door-to-Door Attendant	ix. <input type="checkbox"/> Other:
Barriers To Care/Access:		
e. TRANSPORTATION ASSISTANCE NEEDED <input type="checkbox"/> N/A		
i. <input type="checkbox"/> Travel training	v. <input type="checkbox"/> Orientation and mobility instruction	viii. <input type="checkbox"/> Escort
ii. <input type="checkbox"/> Para transit scheduling	vi. <input type="checkbox"/> Non-medical transportation	ix. <input type="checkbox"/> Medical transportation
iii. <input type="checkbox"/> Vehicle transfer	vii. <input type="checkbox"/> Training for fixed-route bus	x. <input type="checkbox"/> Other:
iv. <input type="checkbox"/> Eligibility establishment for paratransit/demand response use		
Barriers To Care/Access:		
f. EMPLOYMENT/SCHOOL INFORMATION		
Barriers To Care/Access:		
g. PHYSICAL DISABILITY		
i. <input type="checkbox"/> Mobility	Describe:	
ii. <input type="checkbox"/> Physical	Describe:	
iii. <input type="checkbox"/> Hearing	Describe:	
iv. <input type="checkbox"/> Vision	Describe:	
v. <input type="checkbox"/> Multiple Disabilities	Describe:	
vi. <input type="checkbox"/> Specific Disability	Describe:	
h. INTELLECTUAL DISABILITY, INCLUDING DELIRIUM AND DEMENTIA		
i. ASSISTIVE TECHNOLOGY NEEDS <input type="checkbox"/> N/A		
i. <input type="checkbox"/> Mobility appliances	v. <input type="checkbox"/> Shower bench	ix. <input type="checkbox"/> Lifting chair
ii. <input type="checkbox"/> Shower chair	vi. <input type="checkbox"/> Transfer equipment	x. <input type="checkbox"/> Home modifications
iii. <input type="checkbox"/> Cane, walker, crutch	vii. <input type="checkbox"/> Power wheelchair	Describe: _____
iv. <input type="checkbox"/> Manual wheelchair	viii. <input type="checkbox"/> Brace(s) or Prosthetic(s)	xi. <input type="checkbox"/> Other
Client Still Needs:		Describe: _____
Barriers To Care/Access:		
j. EXISTING MENTAL HEALTH/SUBSTANCE USE DISORDER		
Barriers To Care/Access:		
k. PREFERENCE FOR LIVING ARRANGEMENT (identify any housing concerns)		
Barriers To Care/Access:		
l. COMMUNITY RESOURCES USED		
Barriers To Care/Access:		
m. FOOD		
Barriers To Care/Access:		
n. CHILD AND OTHER DEPENDENT CARE		
Barriers To Care/Access:		

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How to Use the Service Coordination Plan

To support Accountable Care Collaborative: Medicare-Medicaid Enrollees

INTRODUCTION

The federal government requires Regional Care Collaborative Organizations (RCCOs) to work directly with each beneficiary enrolled in the Accountable Care Collaborative: Medicare-Medicaid Enrollees (ACC: MME) Program and complete a Service Coordination Plan (SCP).

- Clients determined to be **high-risk** must have a SCP completed **IN PERSON within 90 days of enrollment** in the ACC: MME.
- **All other clients** must have a SCP completed **within 120 days of enrollment** in the ACC: MME, by phone or in person at the RCCO's discretion.
- The SCP is required to be **reviewed no less frequently than every six months**.

The goal of the SCP is to promote proactive, person-centered, strength-based coordination of services and supports, including:

- Physical and behavioral health needs for clients with complex conditions,
- System-level oversight and support for clients receiving case management from other agencies.

The SCP documents the client's long and short-term goals, and it becomes the blueprint for meeting those goals and improving health outcomes. The RCCOs and PCMPs will use a SCP that contains required, standardized elements to collaborate with the client and to identify and coordinate among the client's other service providers.

The SCP is intended to complement, rather than duplicate, other assessments or care plans currently in place (e.g., through HCBS waiver programs). To prevent duplication, strengthen relationships, and improve coordination in serving program enrollees, RCCOs and delegated care coordinators are expected to follow established written protocols describing the process for collaborating with SEPs, CCBs, BHOs, hospitals, home health organizations, disability organizations, skilled nursing facilities, hospice organizations, and other community resources.

RCCOs are responsible for ensuring SCP completion and timely review and updates, even when care coordination is delegated to a PCMP or other contractor, as well as for providing training and guidance as needed. Whether or not the RCCO or its delegate choose to use the SCP document, CMS and the Department require documentation that each of the domains was reviewed and completed accordingly.

PERSON-CENTERED, APPROPRIATE CARE

The Department, RCCOs, and PCMPs will promote the coordination of all necessary covered benefits and additional supports to clients in a manner that is sensitive to the client's functional and cognitive needs, language and culture, and personal preferences and choices. Additionally, care coordination must allow for caregiver involvement and take into account appropriate care settings, with a preference for the home and community when preferred by the client.

Clients have the right to review and/or obtain copies of their SCP at any time.

GENERAL PROCESS FOR COMPLETING A SCP

First, determine if the client receives on-going case management services and identify the organization(s) providing those services.

For clients receiving on-going case management services:

1. Determine who is providing services for the client and request applicable information to assist with SCP completion.

2. To the extent that the cooperating providers deem the requested information to be within treatment, payment, or health care operations (TPO), or the client has agreed to provide a HIPAA-compliant waiver, obtain copies of any service plans, care plans or assessments.
3. Review the shared documents for SCP applicable information.
4. Complete as much of SCP as possible from available information.
5. Speak with the client and, with their input, identify any gaps in services.
6. With client, determine long and short-term goals and action steps.
7. Document information as appropriate on the SCP.

For clients not receiving on-going case management services:

1. Gather data and information from available sources, including information from the Benefits Utilization System (BUS) and/or the Statewide Data and Analytics Contractor (SDAC).
2. Complete as much of the SCP as possible from available information.
3. Speak with the client and, with their input, identify any gaps in services.
4. With client, determine long and short-term goals and action steps.
5. Document information as appropriate on the SCP.

SCP UPDATE REQUIREMENTS

The Service Coordination Plan **must be updated by the RCCO or designee at least every six months regardless of client status.** The Department also expects the SCP to be updated upon:

1. A significant change in the client's needs,
2. A critical incident, such as:
 - a. Emergency room visit
 - b. Unexpected hospitalization
 - c. Injury
 - d. Abuse or neglect
3. Any care transition (e.g., discharge from hospital, discharge from rehab at skilled nursing facility, etc.).
4. Client, family or provider request

OBTAINING CLIENT INFORMATION VIA EXISTING DATA-SOURCES

In some cases, information in the SCP will be obtained via the Benefits Utilization System (BUS) and/or the Statewide Data and Analytics Contractor (SDAC).

Note: only clients enrolled in Home and Community Based Waiver Services (HCBS) will have information in the BUS.

DESCRIPTION OF FIELDS AND EXPECTATIONS FOR COMPLETING A SERVICE COORDINATION PLAN

CLIENT SUMMARY PAGE

ADMINISTRATIVE INFORMATION

DATE ENROLLED: Enter the date the client was enrolled into the RCCO.

DATE OF SCP: Enter the begin date of the Service Coordination Plan.

DATE OF SCP REVIEW: Enter the date the SCP is reviewed.

RCCO: Enter the name of the RCCO.

SCP AUTHOR: Enter the name of the person completing the SCP.

SCP Author Organization: Enter the name of the organization for which the author works.

REASON FOR SCP: Enter the reason for the SCP (choose one): new, six-month review, critical incident, care transition (e.g., hospital discharge, move from facility into community, etc.), change in condition, change in goals, resolution of goals, or resolution of action steps.

1. WHICH DESCRIPTION BEST FITS THE CLIENT'S OVERALL STATUS: Choose the most appropriate description of the client's current health status and prognosis.

2. HIGH-RISK PRIORITIZATION: Note if the client is or is not prioritized as "High Risk."

3. CLIENT SUMMARY AND NEXT STEPS: This section is completed AFTER the SCP is thoroughly created and reviewed, as it records a high-level summary of the assessment that includes brief notes about the client's current condition and supports, including: physical, behavioral, social supports, major stressors or barriers, and information about next steps.

BASIC DEMOGRAPHICS

4. Client Information Section (most of this information is found in SDAC, BUS and/or monthly reports provided from the Department).

a. LAST NAME: Enter the client's last name.

b. FIRST NAME: Enter the client's first name.

c-f. STREET ADDRESS, CITY, ZIP, and COUNTY: Enter the client's primary address information.

g. EMAIL: Enter the client's primary email address.

h. TELEPHONE NUMBER AND ALTERNATE NUMBER: Enter the client's preferred and, if applicable, alternate phone number. Designate each number as Home, Cell, Work or Other.

i. DOB: Enter the client's date of birth in the following format: 01-01-2001.

j. GENDER: Enter the client's gender (i.e., Female, Gender queer/Androgynous, Intersex, Male, Transgender, Transsexual, Cross-dresser, Female to Male-FTM, Male to Female-MTF, or Other).

k. MARITAL STATUS: Enter single, married, domestically partnered, or divorced.

l. CLIENT ID: Enter the client's Medicare and Medicaid identification numbers.

m. COMMUNICATION REQUIREMENTS: Enter requirements necessary for effective communication with the client (i.e., speak loudly, translation needed, assistive technology needed, etc.).

n. PREFERRED LANGUAGE: Enter the client's preferred language.

o. PREFERRED MEANS OF COMMUNICATION: Check the appropriate box: Home Phone, Cell Phone, Work Phone, Email, Mail, In Person, Through Caregiver or Legal Guardian, or Other.

5. CLIENT CONTACT HISTORY

If initially unable to contact a client, RCCOs or their designee are required to attempt to contact the client at least three times during every six-month period.

a. CLIENT CONTACTED, DOES NOT WANT PLAN (EXPLAIN): If a client has been successfully contacted and states that they do not want a SCP created on their behalf, the SCP author must explain why the client made that choice.

NOTE: Clients who decline a SCP must still be contacted every six months for mandatory follow-up.

b. CLIENT CONTACT INFORMATION NOT VALID: Select this if the SCP author determines that the client's contact information is not valid. The SCP author must then work with medical providers and/or other case managers/care coordinators to try and obtain correct contact information. If correct contact information is not located, the SCP

author must regularly review SDAC data to determine if the client received services and/or updated contact information.

- c. **ATTEMPTED CONTACT, NO RESPONSE:** The SCP author must attempt contact three times when attempting to reach a client. If unsuccessful, the SCP author is expected to try again, in six months, to contact the client.

6. CASE MANAGERS/CARE COORDINATION AGENCY

a. DOES CLIENT CURRENTLY RECEIVE ON-GOING CASE MANAGEMENT SERVICES?

Select YES if the client does currently receive on-going case management services (e.g., SEP/CCB case manager, CMHC case manager, etc.). Select NO if the client does not currently receive on-going case management services.

If the client does currently receive on-going case management services, the SCP author contacts case managers to review existing service plan/care plan/assessment and evaluate what role the RCCO or designee will play in care coordination. **A summary of this process and the outcomes must be documented in the Assessment Narrative section, "Gaps in Care, Duplication of services and Areas to Address," particularly the RCCO or designee's responsibility related to care coordination for the client.**

When clients are receiving on-going case management, the RCCOs or designees are still expected to contact the client personally to introduce themselves and the ACC: MME Program and discuss any services or supports the client needs that are not being addressed by the other case managers.

NAME/AGENCY/PHONE/EMAIL: If the client is currently receiving case management services, the RCCO or designee will talk with the client and existing case managers to identify who has the most frequent contact with the client and is most appropriate to serve as the client's primary contact/case manager. This "lead" care coordinator should be entered in the first row. Then enter the names of any other care coordinators involved in the client's care. Also enter the applicable agency, phone number and email addresses.

ASSESSMENTS/CARE PLANS, RELEASE OF INFORMATION: Document if assessments/care plans have been requested or obtained, and indicate if the appropriate permissions (release of information, etc.) are in place.

7. MEDICAL HISTORY

The purpose of this section is to capture key medical information recorded in the SDAC and/or electronic health record. Depending on the licensure and knowledge of the care coordinator, this information is used to identify potential concerns about medications and treatments. At a minimum, this information is used to:

- Guide coordination of physical and behavioral health treatment;
- Prevent unnecessary emergency room visits and hospitalizations;
- Address barriers to appropriate care, including primary care and specialty care visits;
- Assist with medication management; and
- Flag clients taking medications that are associated with abuse or overdose.

The SCP author is expected to contact the appropriate case managers and/or medical professionals to discuss any concerns.

- a. **DIAGNOSES:** Enter the client's diagnoses as reported in claims data and/or shared by providers or case managers. This should be a comprehensive list of the actual diagnoses made by health care providers; this is not the place to record what the client believes to be their primary diagnoses.
- b. **PROGNOSIS:** Enter the prognosis for each diagnosis according to the best information available.
- c. **IS THIS LIST COMPLETE:** Select YES or NO.

8. RECENT HOSPITALIZATION AND EMERGENCY DEPARTMENT VISITS: For recent hospitalizations and emergency department visits, enter the date and reason. Note if a care transition plan was generated and disseminated. Finally, note any follow-up visit(s).

9. MEDICATIONS: Enter the client's list of medications based on data in the SDAC or available from providers. An attached list is acceptable, provided the SCP refers to the attachment.

a. IS THIS LIST COMPLETE: Select YES or NO.

10. MEDICATION QUESTIONS/CONCERNS: Record any questions and/or concerns related to access, conflicting prescriptions, over or under utilization, adherence, cost, etc.

11. BARRIERS TO APPROPRIATE CARE: Record any questions and/or concerns related to access to primary or specialty providers, transportation, follow up, etc.

CLIENT GOALS

12. PERSON(S) INVOLVED IN CREATING PLAN: Select all clients who contributed in the creation of the plan and goals: Client, Family Member, Legal Guardian, Authorized Representative, Other.

13. CLIENT'S LONG-TERM GOAL(S):

Using person-centered language, enter the client's long-term goal.

Considerations:

- What would they like to happen as a result of their care?
- What would they like to be able to do that they cannot currently do?
- What is the most important thing they want to achieve related to their chronic disease?

Be sure take a holistic approach and consider all aspects of the clients' health, including behavioral and physical health.

Examples of long-term goals:

- "I want to be able to travel to Florida for a family reunion next year."
- "I want to feel happy."
- "I want to feel stronger so that I can move into the community."

14-16. CLIENT'S SHORT-TERM GOAL(S):

a. GOAL: The client's identified short-term goal(s) should be specific, measurable, attainable, relevant, time-based, and must be mutually agreed upon between the client and the SCP author.

Add as many or as few short-term goals as needed and desired by the client.

Examples:

- "Client wants to cut back on smoking over the next three months."
- "Client wants to understand how to use her blood pressure medication by the end of January."
- "Client wants to be able to communicate with PCMP and address questions and concerns at next medical appointment."

Coordinators should facilitate formation of realistic goals. For example, someone with a terminal illness may not be able to meet a goal to "live another 20 years," but they might have obtainable goals related to quality of life.

b. CLIENT OBJECTIVES: Enter the objectives that will assist the client to attain the short-term goal(s), and enter the start date for those objectives. Enter as many or as few objectives as needed to assist the client to reach the short-term goal being addressed.

START DATE: Enter the starting date of the goal.

STATUS UPDATE: Enter the date when the goal was updated.

c. CARE COORDINATOR/CASE MANAGER ACTION STEPS: List the identified action steps that the client, the SCP author, their personal care worker or other caregivers, or health care providers can take to achieve the client's short-term goal(s). These interventions should be established mutually with the client.

For example, the interventions(s) for the above goal(s) might be:

- Client and Care Coordinator will discuss strategies to decrease or quit smoking.
- Client will ask their doctor about using blood pressure medication at next visit.
- Client and Care Coordinator will prepare list of questions to bring to the next doctor appointment.

d. OUTCOME: As needed, update the outcome by selecting either Completed, Revised, No longer pertinent, or Client request to discontinue, and then add the date.

Goals that continue from one review period to the next should be copied and continued with modifications, as needed, for specific action steps.

e. UPDATES: Record any helpful narrative when the SCP is revised, updated, or when new information becomes available.

17. CLIENT ASSENT: After the long and short-term goals have been identified, the client signs to indicate their participation in, and agreement with, the goals. Indicate if the client was contacted in person or by phone and add the date when the client reviewed and agreed to the goals and objectives.

PROVIDER INFORMATION

18. PRIMARY CARE MEDICAL PROVIDER (PCMP)

a. CLINIC NAME: As appropriate, determine what clinic the client goes to for medical and/or behavioral services.

b. PROVIDER NAME: Enter the name of the physician.

c-g. PHYSICIAN CONTACT INFORMATION: Enter the physician's contact information, including: phone, street address, city, zip and email address.

h. ATTRIBUTED TO ACC: Select YES if the client's physician is attributed to the ACC (PCMP). Select NO if the client's physician is not attributed to the ACC (PCP).

i. DATE OF LAST VISIT: Enter the date of the client's last visit with the physician.

j. WHO DOES THE CLIENT CONSIDER THEIR PRIMARY PROVIDER TO BE: As appropriate, determine who the client considers to be their PCMP/PCP. If there is a discrepancy, the SCP author should review SDAC claims history and talk with case managers or providers to identify who is actually providing the majority of primary physical or behavioral health care services. If the ACC attributed PCMP is truly not the primary provider and the client-identified primary providers is eligible to serve as a PCMP, the RCCO should work with the client to change the attribution.

k. REFERRALS AND SPECIALISTS INVOLVED WITH CLIENT CARE: Determine if the physician has made any referrals. If so, enter the date of the referral, the provider's name and the date of the visit, if that visit occurred. If referral visits have not been completed, the SCP author will assist the client to follow-through on referrals.

19-21. PROVIDER(S): Select N/A if there are no other specialists, physical, or behavioral healthcare providers involved in the client's care.

a-h. If applicable, enter the Provider Type (e.g., OT, SLP, Behavioral Health, etc.), the Provider Name and contact information, including: phone, street address, city, zip and email address. Also, enter the date of the client's last visit with the provider.

i. ADVICE AND RECOMMENDED FOLLOW-UP: Record any known advice or recommendations regarding follow-up from the provider. Determine if the client has completed the follow-up and assist the client with all uncompleted items.

j. ADDITIONAL SERVICES RECOMMENDED: Record any known services or referrals the provider recommends. Determine if the client has completed the services/referrals and assist the client with all uncompleted items.

22. ADDITIONAL PROVIDERS:

Select N/A if no other providers are involved in the client's care. Otherwise, record the Type, Name, Agency, and Release of Information (ROI). Select N/A if there are no applicable ROIs related to the client's care coordination needs. Otherwise, record the date of the release

ASSESSMENT NARRATIVE

After carefully reviewing any and all existing assessments, and having met with or spoken to the client, the SCP author summarizes elements of the client's needs, concerns or considerations in the appropriate section of the Assessment Narrative. For those domains that are not applicable to the client, select N/A. This information is then be used to guide the conversation with the client about their long and short-term goals.

a. CULTURAL/SPIRITUAL CONSIDERATIONS: Enter any cultural and/or spiritual considerations pertinent to understanding the client's health within the context of their life and environment.

b. LANGUAGE/COMMUNICATION: Enter any linguistic or communication considerations (e.g., monolingual Spanish, uses TTY, etc.).

c. URGENT NEEDS: Enter any urgent needs. Note any barriers to care or access.

d. TRANSPORTATION REQUIREMENTS OR PREFERENCES: Select N/A if there are no transportation requirements or preferences. Otherwise, select the applicable options. If the client's requirements or preferences do not appear as a choice, select "Other" and then enter the appropriate information. Note any barriers to care or access.

e. TRANSPORTATION ASSISTANCE NEEDED: Select NA if there are no transportation assistance needs identified. Otherwise, select the applicable options. If the client's transportation assistance needs do not appear as a choice, select "Other" and then enter the appropriate information. Note any barriers to care or access.

f. EMPLOYMENT/SCHOOL INFORMATION: Enter any employment or school information. Note any barriers to care or access.

g. PHYSICAL DISABILITY: Select and describe any physical disabilities, if applicable.

h. INTELLECTUAL DISABILITY, INCLUDING DELIRIUM AND DEMENTIA: Describe any intellectual, cognitive, or memory related disability, if applicable.

- i. ASSISTIVE TECHNOLOGY NEEDS:** Select NA if the client has no assistive technology needs. Otherwise, select the applicable options. If the client has assistive technology needs that have not been addressed, state what is still needed. Note any barriers to care or access.
- j. EXISTING MENTAL HEALTH/SUBSTANCE USE DISORDER:** Enter any existing mental health/substance use disorders. Note any barriers to care or access.
- k. PREFERENCE FOR LIVING ARRANGEMENT:** Enter the client's preferences for living arrangements. Note any barriers to care or access.
- l. COMMUNITY RESOURCES USED:** Enter a list of all community resources the client currently utilizes. Document any discussed resources the client might additionally utilize. Note any barriers to care or access.
- m. FOOD:** Enter any relevant information about food/nutritional issues. . Note any barriers to care or access.
- n. CHILD AND OTHER DEPENDENT CARE:** Enter any relevant information about children or other dependents. Note any barriers to care or access.
- o. FAMILY AND OTHER CLOSE CONNECTIONS:** Enter any relevant information about family or other close connections. Note any barriers to care or access.
- p. OTHER:** Enter any information pertinent to the SCP that has not been captured above.
- q. GAPS IN CARE, DUPLICATION OF SERVICES AND AREAS TO ADDRESS:** Provide a summary of all the areas in the Assessment Narrative that a client requires assistance. Identify any gaps in services or duplication in services here. Indicate actions the SCP author and the client will take to address issues.

ADDITIONAL CLIENT INFORMATION

24. FAMILY/FRIEND/AUTHORIZED REPRESENTATIVE SUPPORT

Select NA if this section is not applicable to the client.

- a-c.** Otherwise, note if the client "Lives with family/friend," or if the "Family/friend lives close by." Then note if the "Family/friend is available to assist with" elements of care, and if so, enter what kinds of assistance they are able to provide (e.g., transportation to doctor appointments, bill paying, etc.).
- e-i.** Enter the Primary Family/Friend's Name and contact information, including street address, phone, and email. Also indicate if a Release of Information has been obtained by the client in order to share information with this family/friend/authorized representative.

25. DECISION MAKER INFORMATION

Enter NA if this section is not applicable to the client.

- a-b.** Otherwise, enter the legal guardian's Name and Phone Number, if applicable.
- c-d.** Enter the Power of Attorney's name or Medical Power of Attorney's name, if applicable.
- e.** Enter any information about Advanced Directives, if applicable.
- f-h.** Enter the Name, Phone, and email address of a client-identified emergency contact.

26. IMPORTANT INFORMATION NOT CAPTURED IN THE SERVICE COORDINATION PLAN

Enter any information not captured in the SCP that is needed to help address barriers or gaps to appropriate care and services. Include any information that is needed to help clients engage in their care and reach their health care goals.

Provider Communication Agreements (Protocols)

Written Protocol to Strengthen Relationships and Improve Coordination Among Colorado Beneficiary Rights and Protections Programs through an Alliance

Intent

The protocol establishes an alliance among the organizations that will provide Beneficiary Rights and Protections services to full benefit Medicare-Medicaid enrollees who participate in Colorado's Demonstration to Integrate Care for Medicare-Medicaid Enrollees (the Demonstration). These organizations will build a structure for communication and interaction involving the Department of Health Care Policy and Financing (the Department) and the Centers for Medicare & Medicaid Services (CMS). The Department's Demonstration proposal has been submitted to CMS and is based on Colorado's existing managed fee-for-service environment in which there is no single, statewide Ombudsman. Supplemental funding opportunities to be pursued by the Department in accordance with CMS-sponsored Financial Alignment Models for Medicare-Medicaid Enrollees include State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling and Support for Demonstration Ombudsman Programs.

To best serve the Demonstration's enrollees, this protocol is designed to be collaborative and to draw upon the expertise of each participant, each of which will continue to maintain its individual mission, statutory role, and regulatory responsibilities. The protocol aims to draw upon systems and information currently available, reflecting a commitment to administrative simplification and continuous improvement.

Purpose

The purpose of the protocol is to promote collaboration among Beneficiary Rights and Protections service organizations and between the alliance of these organizations and each applicable managing agency within the state to better serve their shared clients. This protocol fosters the common aims of (1) assistance to and advocacy on behalf of Medicare-Medicaid enrollees who have grievances or complaints, (2) seamless access to the various services provided by members of the Beneficiary Rights and Protections alliance, (3) education and information about enrollee rights, (4) recommending options for change in the provision of Beneficiary Rights and Protections services, and the overarching aim of (5) support for the Demonstration in providing integrated services to enrollees: care coordination, benefits and eligibility coordination, and quality of service accountabilities are recognized as important in improving outcomes.

Process

Establish a work group among Colorado organizations providing Beneficiary Rights and Protections services to:

- Discuss individual roles and responsibilities, common and differing services, and ways to work together to effectively serve Medicare-Medicaid enrollees in the Demonstration.
- Prepare a preliminary draft of a protocol to establish an alliance among the organizations; share the draft with the Regional Care Collaborative Organizations (RCCOs) whose staff will ensure the coordination of care for Demonstration enrollees; and adjust the draft as necessary with input from the RCCOs and discussion among the alliance members.
- Submit the draft protocol as a recommendation to the Demonstration's Advisory Subcommittee and the Department.
- Revise the draft protocol as appropriate, issue in final form, and obtain the signatures of the participating organizations to implement the protocol.

Elements

Regular Meetings

The participating organizations in the alliance will meet regularly, no less frequently than quarterly for the duration of the Demonstration, to:

- Receive information from the Department and the RCCOs on the progress of the Demonstration and in the progress toward the implementation of related State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling and Support for Demonstration Ombudsman Programs.
- Develop a set of definitions for services provided under the classification of Beneficiary Rights and Protections.
- Share information and data on the Beneficiary Rights and Protections services provided by each organization.
- Raise, discuss, and provide advice and recommendations to the alliance members and to the Department on problems and issues.

The alliance will determine agendas and required or requested attendees. Representation from the CMS Regional Office and Medicare-Medicaid beneficiaries of the Demonstration's Advisory Subcommittee will be permanent invitees.

Access to Department Resources

The Department will provide ongoing assistance and support for problem resolution between regular meetings of the alliance. The Department will work with alliance members to address issues such as Medicaid eligibility, benefits, or other topics related to the Demonstration that affect Beneficiary Rights and Protections for Medicare-Medicaid enrollees in the Demonstration.

Information Sharing

The participating organizations in the alliance will develop methods to share existing information, protected from any improper disclosure by all applicable privacy and confidentiality rules and regulations. Such information will provide a statewide and Demonstration-wide view of Beneficiary Rights and Protections services. Such information will be provided to the Department for analysis

and feedback to the alliance members. Alliance members will bring information and de-identified case experiences to their regular meetings with the Department, RCCOs, and CMS so that patterns and trends of beneficiary difficulties can be identified. No official data sharing by the organizations is expected; however, sharing aggregate information to provide case patterns and examples is encouraged. Methods and procedures for sharing information will be developed by the members of the alliance with consultation from the Department. Alliance members will review common Beneficiary Rights and Protections data within the Demonstration and the State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling and Support for Demonstration Ombudsman Programs.

Recommend Process Improvements

Alliance members will bring process problems as well as best practices to the regular meetings. The purpose of discussions to address problems and successes is to identify training needs, improvements in educational materials, and improvements in processes to ensure participants in the Demonstration are seamlessly served when they seek assistance with a Beneficiary Right or Protection issue. Through their joint deliberations, alliance members will provide recommendations to the Department for development, implementation, or issuance of training or informational materials and/or process improvements to better serve Demonstration enrollees. The Alliance will provide recommendations for coordination, communication and dissemination of Beneficiary Rights and Protections program information from all related CMS funding sources.

Membership

The current members of the alliance include:

- The Department
- The Seven Regional Care Collaborative Organizations
- The Long-term Care Ombudsman
- The Medicaid Managed Care Ombudsman
- The State Health Insurance Assistance Program
- Colorado Center on Law and Policy
- Colorado Cross-Disability Coalition

Permanently invited guests include:

- The Medicare Quality Improvement Organization
- Colorado Legal Services
- The CMS Regional Office
- Medicare-Medicaid beneficiaries of the Demonstration's Advisory Subcommittee

Attached to this protocol is a matrix of service categories provided by members of the alliance who provide Beneficiary Rights and Protections services to Medicaid and/or Medicare beneficiaries in Colorado.

Review

Protocols will be reviewed no less frequently than quarterly. Any changes will be recommended to the Demonstration's Advisory Subcommittee and the Department (January 2014 and thereafter).

Matrix of Beneficiary Rights and Protections Services by Organization

			LTC	MMCO	QIO	SHIP	CCLP
Enrollees							
Medicare			X		X	X	
Medicaid			X	X		X	X
Complaints/Grievances							
Medicare			X		X	X	
Medicaid			X	X			
Individual Advocacy/Appeals							
Medicare						X	
Medicaid				X			
Refer Law/Reg Enforcement							
Medicare			X	X *		X *	
Medicaid			X	X *		X *	
System Advocacy							
Medicare			X		X	X	
Medicaid			X	X			X
Education and Information							
Medicare			X		X	X	
Medicaid			X	X			
Enrollment Assistance							
Medicare						X	
Medicaid							
Legal Rep							
Medicare							
Medicaid							

*When appropriate, will refer for legal assistance or to DORA

Written Protocols to Strengthen Relationships and Improve Coordination Between Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may also be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of BHO and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, mutual definitions, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to assist collaboration between BHOs and RCCOs to better serve their shared Medicare-Medicaid enrollees and Medicaid clients. These protocols foster the BHO and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

BHO and RCCO core activities include (1) identification of shared clients, (2) understanding coordination responsibilities, (3) prioritization of shared clients, (4) regular contact and communication, and (5) mutually agreed upon support functions.

Identification of Shared Clients and Overall Key Performance Indicator Data

The following process will occur monthly with the point of contact assigned by the BHO and the RCCO Contract Manager serving as the single points of contact:

- The Statewide Data and Analytics Contractor (SDAC) will provide each RCCO with a list of individuals currently enrolled in the RCCO who have also received services from the BHO in the past 12 months.
- To be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the SDAC will provide a list to each RCCO that includes only the minimally necessary information for each individual: (1) Medicaid identification number, (2) last name, (3) first name, (4) date of birth, (5) county of residence, and (6) primary care medical provider (PCMP) if one is linked to the individual.
- Each RCCO Contract Manager will sort the list by BHO service area, noting county, and forward the list to the appropriate designated BHO contact.
- RCCOs and BHOs may collaboratively decide the flow of HIPAA-compliant information either from RCCO to BHO or BHO to RCCO.

Understanding Coordination Responsibilities

- BHOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as performance measures review and other client support as needed.
- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as key performance measures review and other client support as needed.

Prioritization of Shared Clients

- Monthly, BHOs and RCCOs will prioritize shared clients based on the needs of the client and each organization's knowledge of and experience with the clients.
- BHOs and RCCOs will schedule meetings to ensure that they organize coordination activities for individual clients appearing on each organization's priority list to the extent resources are available.
- Target groups for consideration may include, but are not limited to, persons with serious mental illness, co-morbid conditions, and depression or anxiety management in collaboration with primary care.

Contact and Communication

- As the client expresses choices in navigating service needs through the BHO, RCCO, or both, BHOs and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination needs; determine which organization fulfills the majority of those care coordination needs; identify the appropriate primary care coordination manager; have additional conversations; and engage other resources as needed.
- BHOs and RCCOs will use data analysis and client feedback as appropriate to identify trends or types of situations where coordinated care management works well and does not work well; such consideration may include examining trends in health conditions, the number of comorbidities, emergency room visit frequency, or prior authorization requests.

- BHOs and RCCOs will utilize these discussions and trends to create, define and streamline care coordination activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.
- BHOs and RCCOs will consider assigning care managers and workgroups from both organizations to shared clients in a way that facilitates conversations and activities between BHO and RCCO care managers and with the individual clients.

Mutually Agreed Upon Support Functions

- BHOs and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaborative activities may include but are not limited to, collaborative data analysis and regular leadership or stakeholder meetings.

Timeline

BHOs and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (November 2012).
- Present protocols in preliminary draft form to the Demonstration's Advisory Subcommittee (December 2012).
- Conduct preliminary testing and make any necessary adjustments (January-May 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (June 2013).
- Recommend protocols to the Department (July 2013).
- Implement protocols (August 2013).
- Assess protocols quarterly (October 2013 and thereafter).

Written Protocols to Strengthen Relationships and Improve Coordination Between Community Centered Boards (CCBs) and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of CCB and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to assist collaboration between CCBs and RCCOs to better serve their shared Medicare-Medicaid enrollees and Medicaid clients. These protocols foster the CCB and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

CCB and RCCO core activities include (1) identification of shared clients, (2) understanding coordination responsibilities, (3) prioritization of shared clients, (4) contact and communication, and (5) mutually agreed upon support functions.

Identification of Shared Clients

The following process will occur monthly with the CCB Case Management Director or designee and the RCCO Contract Manager or designee serving as the points of contact:

- The Statewide Data and Analytics Contractor (the SDAC) will provide each RCCO with a list of individuals currently enrolled in the RCCO who also receive home and community-based services (HCBS).
- The SDAC may use information such as targeted case management (TCM) claims data, provider number, and current procedural terminology (CPT) codes to determine access to case management services through the CCB over a rolling twelve-month period.
- To be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the SDAC will provide a list to each RCCO that includes only the minimally necessary information for each individual: (1) Medicaid identification number, (2) last name, (3) first name, (4) date of birth, (5) county of residence, and (6) primary care medical provider (PCMP) if one is linked to the individual.
- Each RCCO Contract Manager or designee will sort the list by county and forward the list to the appropriate CCB Case Management Director or designee based on the CCB's county service area.
- CCBs and RCCOs will work together at a local level to identify clients who are Medicaid recipients but not identifiable by the SDAC (e.g., on wait lists, served by locally funded programs).

Understanding Coordination Responsibilities

- CCBs will continue to fulfill their contractual case management responsibilities for clients, most of whom are persons with developmental disabilities; these responsibilities include activities such as assisting clients in obtaining needed waiver services, community services, and public benefits; assisting clients in obtaining housing, food, dental and vision care, and behavioral intervention services; monitoring client health care needs; monitoring provided services; and making referrals to community services for clients with developmental disabilities on waitlists.
- Regional Care Collaborative Organizations will continue to fulfill their contractual responsibilities for clients, which include activities such as coordinating medical transportation; attending physician or specialist visits with the client as requested and appropriate; making referrals to sources for housing, food, and dental care; providing system navigation support for clients with behavioral and physical health conditions; establishing care plans for goals clients would like to achieve; connecting clients with medical homes; supporting clients in active engagement with care teams; and providing other client support as needed.

Prioritization of Shared Clients

- Regularly, but not less than quarterly, CCBs and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.
- CCBs and RCCOs will schedule meetings to ensure that they organize coordination activities for the top tiers of clients appearing on each organization's priority list.

Contact and Communication

- As the client expresses choices in navigating service needs through the CCB, RCCO, or both, CCBs and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination needs; determine which organization fulfills the

majority of those care coordination needs; ensure Medicaid waiver responsibilities for persons with disabilities are fulfilled by the appropriate contracted entity; identify which organization is responsible for primary care coordination, without jeopardizing any contractual requirements, and who interacts with the client the most; have additional conversations and engage other resources as needed (e.g., the client's family members, PCMP, behavioral health provider); and include the individual client's choices throughout the care coordination decision-making process.

- CCBs and RCCOs will use data analysis and client feedback as appropriate to identify trends or types of situations where care coordination works well and does not work well; consideration may include, but not be limited to, examining trends in areas such as health conditions or emergency room visit frequency.
- CCBs and RCCOs will utilize these discussions and trends to streamline care coordination activities in a way that maximizes client outcomes and permits the CCBs and RCCOs to apply resources effectively and efficiently.
- CCBs and RCCOs will consider assigning representatives from both organizations to shared clients in a way that facilitates conversations and activities between CCBs and RCCOs and with the individual clients.

Mutually Agreed Upon Support Functions

- CCBs and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaboration activities may include but not be limited to RCCOs assisting clients on CCB waitlists, CCBs helping RCCOs to find and/or connect shared clients with a primary care medical home, and either CCBs or RCCOs referring clients not currently enrolled in but who may benefit from CCB or RCCO services.

Timeline

CCBs and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (October-November 2012).
- Present protocols in preliminary draft form to the Demonstration's Advisory Subcommittee (December 2012).
- Conduct preliminary testing and make any necessary adjustments (January-May 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (June 2013).
- Recommend protocols to the Department (July 2013).
- Implement protocols (August 2013).
- Assess protocols quarterly (October 2013 and thereafter).

Written Protocols to Improve Accessibility for Persons with Disabilities¹ Between Disability Organizations² and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are meant to be relevant to the successful support of persons with disabilities in the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may be useful to the Accountable Care Collaborative (ACC) as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of representatives from disability organizations and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss roles and responsibilities, common and differing elements of education and support, and ways to work together to better serve Demonstration enrollees with disabilities.
- Prepare a preliminary draft of disability-focused protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

¹ The definition used here is consistent with Section 12102 of the Americans with Disabilities Act of 1990 and the ADA Amendments Act of 2008, Public Law 110-325, Retrieved from <http://www.ada.gov/pubs/ada.htm>, in which persons with disabilities are defined to include those who have a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or are being regarded as having such an impairment.

² Disability organizations are defined to include any Demonstration enrollee with a disability, their family members, or individual caregivers; disability care providers; county health nurses; advocates; and other disability-focused entities run by and for persons with disabilities served in the Demonstration.

Elements

The purpose of the protocols is to assist collaboration between disability organizations and RCCOs to better serve Demonstration enrollees with disabilities. According to the Medicare-Medicaid Coordination Office, between 2006 and 2011:³

- The total number of Medicare-Medicaid enrollees increased almost 18% from 8.6 million to 10.2 million.
- Medicare-Medicaid enrollees with a disability grew from 37% to 41%.
- The number of Medicare-Medicaid enrollees under the age of 65 with a disabling condition escalated faster than those over the age of 65.

These protocols foster the disability organization and RCCO common aims of (1) improving health outcomes for Demonstration enrollees regardless of disability, (2) improving Demonstration enrollee experience through increased access to disability-competent care,⁴ and (3) decreasing unnecessary and duplicative services and costs.

Disability organization and RCCO core activities include (1) increasing provider awareness of compliance responsibilities set forth in federal and state statutes including but not limited to the Civil Rights Act of 1964,⁵ the Rehabilitation Act of 1973,⁶ and the Americans with Disabilities Act (ADA) of 1990;⁷ (2) furnishing provider information and training as practical solutions to improve

³ The Medicare-Medicaid Coordination Office, Data Analysis Brief, Medicare-Medicaid Dual Enrollment from 2006 through 2011, February 2013, Retrieved from http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

⁴ Resources for Integrated Care, Resources for Plans and Providers for Medicare-Medicaid Integration, supported by the CMS Medicare-Medicaid Coordination Office in conjunction with The Lewin Group and the Institute for Healthcare Improvement, Retrieved from <https://www.resourcesforintegratedcare.com/concepts/disability-competent-care>

⁵ Public Law 88-352, 78 United States Statutes at Large 241, Retrieved from http://library.clerk.house.gov/reference-files/PPL_CivilRightsAct_1964.pdf

⁶ U.S. Government Printing Office, Rehabilitation Act, 87 Stat. 355, Public Law 93-112, September 26, 1973, Retrieved from <http://www.gpo.gov/fdsys/granule/STATUTE-87/STATUTE-87-Pg355/content-detail.html>

⁷ Americans with Disabilities Act of 1990 and the ADA Amendments Act of 2008, Public Law 110-325, Retrieved from <http://www.ada.gov/pubs/ada.htm>

accessibility for Demonstration enrollees with disabilities; and (3) supporting Demonstration enrollees as well as their family members and caregivers with contact information and educational materials related to disability-competent care.

Increasing Provider Awareness

Disability organizations and RCCOs will work together to engage the disability community and increase provider awareness of federal and state compliance responsibilities related to disability-competent care. Provider assistance may include but not be limited to sharing and discussing resources related to accessible health care such as those found in Attachment A at the end of this document.

Furnishing Provider Information and Training

Examples of disability organization and RCCO provider information and training activities may include but are not limited to:

- Providing initial and ongoing disability awareness and competency training to RCCO personnel, new and existing providers, and other community partners serving Demonstration enrollees with disabilities.
- Including information and training materials for Demonstration enrollees with disabilities in newsletters, on websites, and through other appropriate media sources.
- Assisting with preparation for standardized accessibility reviews that identify common barriers to disability-competent care and that develop transition plans to remove such barriers and include accommodation strategies for Demonstration enrollees with disabilities.
- Offering information and support for website development and electronic resource compliance to improve access by Demonstration enrollees with disabilities in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973, as amended.⁸
- Identifying and utilizing qualified local disability resources such as those found in Attachment B at the end of this document.
- Utilizing qualified resources to assist in assessing and supporting overall improvement in provider accessibility and disability-competent care.

Disability organization and RCCO personnel will work collaboratively with providers to identify ways to eliminate barriers with minimal effort and expense. Some examples of low and no-cost steps to improve access to health care practices may be found at the end of this document in Attachment C.

Supporting Demonstration Enrollees

Demonstration organizations and RCCOs will continue to support Demonstration enrollees with disabilities as well as their family members and caregivers with contact information and

⁸ U.S. Department of Health and Human Services, *What is section 504 and how does it relate to Section 508?*, Retrieved from <http://www.hhs.gov/web/508/section504.html>

educational materials related to disability-competent care that conform to federal and state guidelines. Such support activities may include but not be limited to:

- Making information about ADA compliance and disability-competent care available to providers before Demonstration implementation and to Demonstration enrollees with disabilities before enrollment and in the Demonstration enrollment packets.
- Encouraging attendance by Medicare-Medicaid enrollees with disabilities at regular state and local Demonstration stakeholder and advisory meetings.
- Presenting disability relevant meeting topics for discussion such as best practices associated with disability-competent care, overcoming barriers to disability-competent care, and feedback for providers.

Timeline

Disability organizations and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (November 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (December 2013).
- Recommend protocols to the Department (December 2013-January 2014).
- Implement protocols for testing (January 2014).
- Assess protocols quarterly and make any necessary adjustments (April 2014 and thereafter).

Attachment A: Resources for Accessible Health Care⁹

Below are several electronic links to national and state websites and publications that provide additional resources to support this protocol.

Publications

- Access to Medical Care for Individuals with Mobility Disabilities (U.S. Departments of Justice and Health and Human Services)
http://www.ada.gov/medcare_ta.htm or
<http://www.hhs.gov/ocr/civilrights/understanding/disability/adamobilityimpairmentsguidance.pdf>
- ADA Update: A Primer for Small Business (U.S. Department of Justice)
<http://www.ada.gov/regs2010/smallbusiness/smallbusprimer2010.htm> or
<http://www.ada.gov/regs2010/smallbusiness/smallbusprimer2010.pdf>
- Americans with Disabilities Act of 1990, As Amended
<http://www.ada.gov/pubs/adastatute08.htm> or <http://www.ada.gov/pubs/adastatute08.pdf>
- Communication with People who are Deaf or Hard of Hearing in Hospital Settings (U.S. Department of Justice)
<http://www.ada.gov/hospcombr.htm> or
<http://www.ada.gov/hospcombrprt.pdf>
- Disability-Competent Care Self-Assessment Tool (Centers for Medicare & Medicaid Services)
<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DCCAssessmentTool.pdf>
- Proposed Accessibility Standards for Medical Diagnostic Equipment (U.S. Access Board)
<http://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/proposed-standards>
- The Current State of Health Care for People with Disabilities (National Council on Disability)
<http://www.ncd.gov/publications/2009/Sept302009>

Websites

- Guidelines and Standards (U.S. Access Board)
<http://www.access-board.gov/guidelines-and-standards>
- Office for Civil Rights (U.S. Department of Health & Human Services)
<http://www.hhs.gov/ocr/office/index.html>
- Information and Technical Assistance on the Americans with Disabilities Act, Barrier-Free Health Care Initiative (U.S. Department of Justice)
<http://www.ada.gov/usao-agreements.htm>

⁹ Compiled by Jana L. Burke, Mariposa Professional Services, Colorado Springs, CO, 719/229-0629.

- Resources for Integrated Care (The Medicare-Medicaid Coordination Office in the Centers for Medicare & Medicaid Services, The Lewin Group, and the Institute for Healthcare Improvement)
<https://www.resourcesforintegratedcare.com/>

State and Local Resources

- Colorado Advisory Council for Persons with Disabilities
<http://coloradodisabilitycouncil.org/>
- Colorado Cross Disability Coalition
<http://www.ccdonline.org/>
- Rocky Mountain ADA Center, Health Care & the ADA
<http://adainformation.org/healthcare>

Attachment B: Local Disability Resources

Although the list below is not all-inclusive, it contains some organizations that may be contacted for different types of disability expertise:

- Ability Connection Colorado, <http://abilityconnectioncolorado.org/>
- Advocacy Denver, <http://www.advocacydenver.org/>
- American Council of the Blind of Colorado, <http://www.acbco.org/>
- American Federation for the Blind, <http://www.afb.org/default.aspx>
- Colorado Center for the Blind, <http://coloradocenterfortheblind.org/>
- Colorado Commission for the Deaf and Hard of Hearing, <http://www.ccdhh.com/>
- Colorado Developmental Disabilities Council, <http://www.coddcc.org/>
- Colorado Family for Hands & Voices, <http://www.handsandvoices.org/chapters/colo.htm>
- Colorado Post-Polio Organization, <http://www.polioplace.org/history/collection/colorado-post-polio-organization>
- Colorado Statewide Independent Living Council, <http://coloradosilc.org/>
- Easter Seals Colorado, http://www.eastersealsco.org/about_us.html
- Family Voices Colorado, <http://familyvoicesco.org/>
- Hearing Loss Association of America, Colorado Chapter, <http://www.hearinglosscolorado.org/>
- JFK Partners, <http://www.ifkpartners.org>
- National Federation of the Blind, <https://nfb.org/>
- Parkinson Association of the Rockies, <http://www.parkinsonrockies.org/>
- Rocky Mountain Down Syndrome Association, <http://www.rmdsa.org/>
- Rocky Mountain Stroke Center, <http://www.strokecolorado.org/>
- The Arc of Colorado, <http://www.thearcofco.org/>
- The Colorado Association of the Deaf, <http://www.cadeaf.org/>
- United Cerebral Palsy, <http://ucp.org/>

Attachment C: Steps to Improve Access to Health Care Practices¹⁰

Federal and state laws require health care professionals to ensure their services are accessible to clients with disabilities as well as their family members and caregivers. A range of no-cost and affordable solutions exists to assist health care providers in making facilities accessible and offering disability-competent care. Practical examples include but are not limited to:

1. Working together with qualified persons with disabilities in response to requests for reasonable modification of policies, procedures, and practices.
2. Eliminating obstacles from parking lot to building entrances and exits (e.g., snow, ice, leaves, debris along the path of travel).
3. Providing ease of door access (e.g., adjust automatic door closers to allow sufficient time to enter and exit, use a pressure gauge to ensure that less than five pounds of pressure is necessary to open any door).
4. Creating a facility access policy for service animals.
5. Providing disability etiquette training for all administrative and service personnel.
6. Training front-desk personnel to appropriately assist persons with disabilities in completing any intake paperwork or required forms.
7. Furnishing facility and practice information in alternate formats (e.g., large print, assistive technology for sensory impairments, other electronic and information technology).
8. Identifying local sign language interpreting agencies (e.g., make accurate contact information available to front-desk personnel, schedule an interpreter before the appointment).
9. Ensuring wheelchair accessibility and periodic staff training for safe transfer techniques (e.g., to and from examining tables, clutter-free examining rooms, wheelchair accessible scales for weighing, at least one examining room large enough to accommodate individuals with mobility devices).

¹⁰ Developed by Jana L. Burke, Mariposa Professional Services, Colorado Springs, CO, 719/229-0629.

Written Protocols to Strengthen Relationships and Improve Coordination Between Home Health Organizations and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may also be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of home health organizations and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to assist collaboration between home health organizations and RCCOs to better serve their shared Medicare-Medicaid enrollees and Medicaid clients. These protocols foster the home health organizations and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

Home health organization and RCCO core activities include (1) identification of shared clients, (2) understanding coordination responsibilities, (3) prioritization of shared clients, (4) contact and communication, and (5) mutually agreed upon support functions.

Identification of Shared Clients

The following process will occur monthly with the home health administrator or designee and the RCCO Contract Manager or designee serving as the points of contact.

The Statewide Data and Analytics Contractor (SDAC) will provide each RCCO with a list of individuals currently enrolled in the RCCO who also have claims that reflect home health services. While this functionality is being developed:

- The Department will provide a list of home health service codes to the RCCOs.
- RCCOs will generate a list of all clients with home health services from the raw claims data to determine which home health organizations are used most often in their regions. This stratified list of organizations will serve as a starting point for establishing relationships.
- Home health organizations will notify the appropriate RCCO at the time that eligibility verification for services is obtained and reflects that a client is enrolled in the RCCO.

Understanding Coordination Responsibilities

- Home health organizations will continue to fulfill their responsibilities for clients, which include, but may not be limited to, activities such as skilled services; coordinating services with physicians; obtaining prior authorizations; transitions of care from one facility to another or to and from home and community; and other client support as needed.
- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as coordinating medical and non-medical care; attending physician or specialist visits with the client as requested and appropriate; making referrals to sources for housing, food, and dental care; providing system navigation support; establishing care plans for goals clients would like to achieve; connecting clients with medical homes; and other client support as needed.

Prioritization of Shared Clients

- Regularly, but not less than quarterly, home health organizations and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.
- Home health organizations and RCCOs will schedule meetings to ensure that they organize coordination activities for the top tiers of individual clients appearing on each organization's priority list.

Contact and Communication

- As the client expresses choices in navigating service needs, home health organizations and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination and transition needs; determine which organization fulfills the majority of those needs; identify the appropriate primary care coordination manager; have additional conversations and engage other resources as needed.
- Home health organizations and RCCOs will use data analysis and client feedback as appropriate to identify trends or types of situations where coordinated care management works well and does not work well.

- Home health organizations and RCCOs will utilize these discussions and trends to streamline care coordination and transition activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.
- Home health organizations and RCCOs will consider assigning care managers from both organizations to shared clients in a way that facilitates conversations and activities between home health organizations and RCCO care managers and with the individual clients.

Mutually Agreed Upon Support Functions

- Home health organizations and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaboration activities may include but not be limited to RCCOs notifying home health organizations of inpatient admission or discharge dates and providing access to the PCMP directory to identify a list of possible medical homes for clients in search of a primary care physician and home health organizations helping RCCOs find clients and connect them with medical homes.

Timeline

Home health organizations and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (January-March 2013).
- Present protocols in preliminary draft form to the Demonstration's Advisory Subcommittee (June 2013).
- Conduct preliminary testing and make any necessary adjustments (June 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (July 2013).
- Recommend protocols to the Department (July 2013).
- Implement protocols (August 2013).
- Assess protocols quarterly (October 2013 and thereafter).

Written Protocols to Strengthen Relationships and Improve Coordination Between Hospice Organizations and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of Hospice Organizations and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).
- Develop process for RCCOs and Hospice Organizations to collectively service client needs within a RCCO region of residence as well as when client needs are coordinated by two or more RCCOs.

Elements

The purpose of the protocols is to assist collaboration between Hospice Organizations and RCCOs to better serve their shared Medicare-Medicaid enrollees and Medicaid clients. These protocols foster the Hospice Organizations and RCCO common aims of (1) improving health outcomes for individuals by providing essential care and support to clients suffering from terminal illness, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

Hospice Organizations and RCCO core activities include (1) identification of clients who are transitioned from a RCCO to a Hospice Organization for care coordination, (2) identification of clients who may have care coordination needs beyond those related to terminal illness, (3) an understanding of coordination responsibilities, (4) prioritization of shared clients, (5) contact and communication, and (6) mutually agreed upon support functions.

Identification of Shared Clients

RCCOs will generate a list of all Medicare-Medicaid clients who received hospice services from the raw claims data for the past six months to determine which Hospice Organizations are currently used in their regions. This stratified list of organizations will serve as a starting point for establishing relationships.

The following process will occur as needed but no less than quarterly with the Hospice Organization representatives and the RCCO Contract Manager or designee serving as the points of contact.

- Hospice Organizations will notify the appropriate RCCO at the time that eligibility verification for services is obtained and reflects that a client is enrolled in the RCCO.
- The RCCO Contract Manager or designee and Hospice Organization representative will review their shared client list together to verify accuracy and ensure hospice and non-hospice care needs are being met.
 - To be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Statewide Data and Analytics Contractor (SDAC) will provide a list to each RCCO that includes only the minimally necessary information for each client: (1) Medicaid identification number, (2) last name, (3) first name, (4) date of birth, (5) county of residence, and (6) primary care medical provider (PCMP) if one is linked to the client.

Understanding Coordination Responsibilities

- Hospice Organizations will continue to fulfill their responsibilities for clients, which include, but may not be limited to, activities such as providing client physical, emotional, spiritual, and social support relating to the terminal illness and coordinating with the RCCO for other client support as needed.
- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as coordinating care needs that are not covered under the hospice benefit and coordinating with the Hospice Organization for other client support as needed.

Prioritization of Shared Clients

- Monthly, the Hospice Organization representative and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.
- Hospice Organizations and RCCOs will schedule meetings to ensure that they organize coordination activities for the clients currently enrolled in hospice who have care coordination needs beyond hospice-covered needs; clients who may benefit from hospice care; and clients who are discharged from hospice and require care coordination by the RCCO.

Contact and Communication

- As the client expresses choices in navigating service needs, Hospice Organizations and RCCOs will incorporate the individual client's preferences whenever possible; discuss each

priority client's care coordination and transition needs; determine which organization fulfills the majority of those needs; identify the appropriate primary care coordination manager; have additional conversations; and engage other resources as needed.

- Hospice Organizations and RCCOs will use data analysis and client feedback to identify trends or types of situations where coordinated care management works well and does not work well; such consideration may include review of shared coordination clients and live discharged clients who are transitioned to a RCCO for ongoing care coordination.
- Hospice Organizations and RCCOs will utilize these discussions and trends to streamline care coordination and transition activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.
- Hospice Organizations and RCCOs will consider assigning care managers from both organizations to shared clients in a way that facilitates conversations and activities between Hospice Organization representatives and RCCO care managers and with the individual clients.

Mutually Agreed Upon Support Functions

- Hospice Organizations and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaboration activities may include other health care and community-based providers who are participating in the client's end-of-life care.

Timeline

Hospice Organizations and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (June-August 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (September 2013).
- Recommend protocols to the Department (no later than October 2013).
- Implement protocols for testing (no later than November 2013).
- Assess protocols quarterly and make any necessary adjustments (January 2014 and thereafter).

Written Protocols to Strengthen Relationships and Improve Coordination Between Hospitals and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may also be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between a small number of hospitals and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to assist collaboration between hospitals and RCCOs to better serve their shared Medicare-Medicaid enrollees and Medicaid clients. These protocols foster the hospitals and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

Hospital and RCCO core activities include (1) identification of shared clients, (2) identification of client needs and community barriers that affect utilization patterns, (3) understanding coordination responsibilities, (4) prioritization of shared clients, (5) identification of common issues to support collaboration among all hospitals and RCCOs throughout the state, (6) contact and communication, and (7) mutually agreed upon support functions.

Identification of Shared Clients The hospitals and RCCOs continue to explore methods and opportunities to identify shared clients. Some of these efforts include very labor-intensive protocols (e.g., faxes and phone calls as well as high-tech solutions such as Colorado Regional Health Information Organization (CORHIO) products). Monthly, a representative from the hospital

and the RCCO Contract Manager will meet to discuss and work to improve identification processes.

Understanding Coordination Responsibilities

- Hospitals will continue to fulfill their responsibilities for clients, which include, but may not be limited to, activities such as admission, discharge and transitions of care, and other client support as needed.
- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as supporting and partnering with those hospital representatives around admissions, discharge and transitions of care, and other client support as needed.

Prioritization of Shared Clients

- Monthly, hospitals and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.
- Hospitals and RCCOs will schedule meetings to ensure that they organize coordination activities for the top tiers of individual clients using each organization's method of prioritizing.

Contact and Communication

- As the client expresses choices in navigating service needs, hospitals and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination and transition needs; determine which organization fulfills the majority of those needs; identify the appropriate primary care coordination manager; have additional conversations; and engage other resources as needed.
- Hospitals and RCCOs will use data analysis and client feedback as appropriate to identify trends or types of situations where coordinated care management works well and does not work well; such consideration may include level of care, socioeconomic determinants, ability to navigate resources, behavioral health, etc.
- Hospitals and RCCOs will utilize these discussions and trends to streamline care coordination and transition activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.
- Hospitals and RCCOs will consider assigning care managers from both organizations to shared clients in a way that facilitates conversations and activities between hospitals and RCCO care managers and with the individual clients.

Mutually Agreed Upon Support Functions

- Hospitals and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaboration activities may include but not be limited to admissions, discharge, and transitions of care.

Timeline

Hospitals and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (January-March 2013).
- Present protocols in preliminary draft form to the Demonstration's Advisory Subcommittee (June 2013).
- Conduct preliminary testing and make any necessary adjustments (June 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (July 2013).
- Recommend protocols to the Department (July 2013).
- Implement protocols (August 2013).
- Assess protocols quarterly (October 2013 and thereafter).

Written Protocols to Strengthen Relationships and Improve Coordination Between Skilled Nursing Facilities (SNFs) and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between Skilled Nursing Facilities (SNFs) and RCCO representatives who volunteer to participate and represent their broader interests.
- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.
- Prepare a preliminary draft of protocols.
- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.
- Revise the draft and share with broader constituencies for additional input and comment.
- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to foster collaboration between SNFs and RCCOs to better serve their shared Medicare-Medicaid beneficiaries and Medicaid clients. These protocols foster the SNF and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

SNF and RCCO core activities include (1) identification of shared clients, (2) understanding coordination responsibilities, (3) prioritization of shared clients, (4) contact and communication, and (5) mutually agreed upon support functions.

Identification of Shared Clients

The following process will occur monthly or as needed with a SNF designee and the RCCO Contract Manager or designee serving as the primary points of contact:

- The SNF will check the client's eligibility at time of admission to the SNF utilizing the Medicaid web portal and identify RCCO affiliation if present.

- The SNF will notify the appropriate RCCO of the client's admission within three business days or the timeframe mutually agreed upon (see diagram and notes in Attachment A).
- RCCO Contract Manager or designee and SNF designee will coordinate efforts on client discharge planning to ensure the client's needs and wishes are being addressed (see diagram and notes in Attachment A).
- As soon as possible or within three days prior to discharge, the SNF will contact the RCCO to coordinate a meeting with the client, family, and/or designated representative and to ensure an individualized approach to the client's transition of setting and services.

Understanding Coordination Responsibilities

- SNFs will continue to fulfill their responsibilities for clients, which include, but may not be limited to, activities such as skilled services, coordinating services with physicians; obtaining prior authorizations; facilitating transitions of care from one facility to another or to and from home and community; and providing other client support as needed.
- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as coordinating medical and non-medical care; attending physician or specialist visits with the client as requested and appropriate; making referrals to sources for housing, food, and dental care; providing system navigation support; establishing care plans for goals clients would like to achieve; connecting clients with medical homes; and providing other client support as needed.

Prioritization of Shared Clients

- No less than quarterly, SNFs and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.
- SNFs and RCCOs will schedule meetings to ensure that they organize coordination activities for the top tiers of individual clients appearing on each organization's priority list.

Contact and Communication

- As the client expresses choices in navigating service needs, SNFs and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination and transition needs; determine which organization fulfills the majority of those needs; identify the appropriate primary care coordination manager; have additional conversations; and engage other resources as needed.
- SNFs and RCCOs will use data analysis and client feedback to identify trends or types of situations where coordinated care management works well and does not work well.
- SNFs and RCCOs will utilize these discussions and trends to streamline care coordination and transition activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.

- SNFs and RCCOs will consider assigning care managers from both organizations to shared clients in a way that facilitates conversations and activities with individual clients and between SNFs and RCCOs.

Mutually Agreed Upon Support Functions

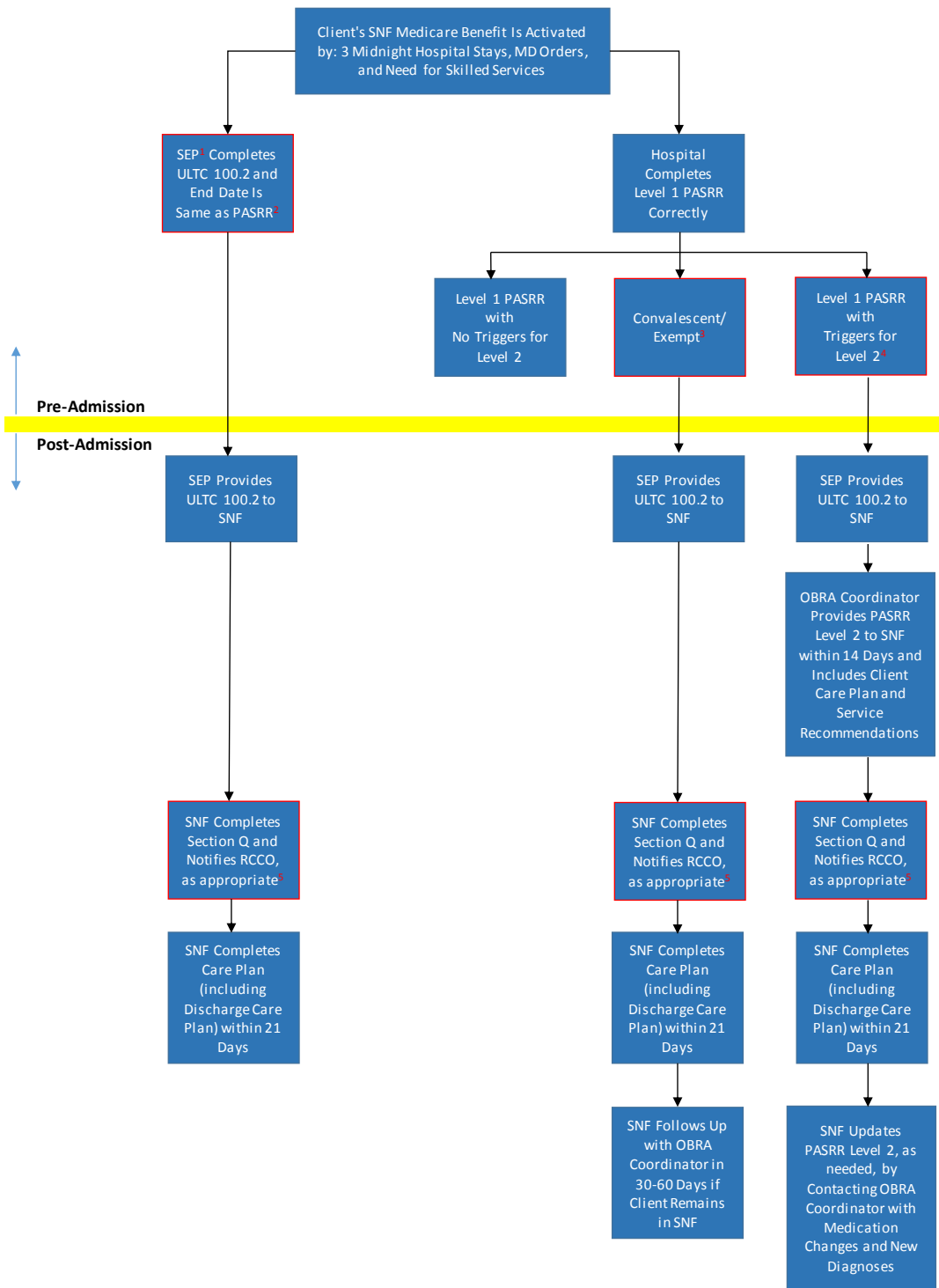
- SNFs and RCCOs will continue to explore additional ways to support each other and the clients they serve.
- Such collaboration may include but not be limited to activities such as RCCOs providing access to the Primary Care Medical Provider (PCMP) directory to identify a list of possible medical homes for clients in search of a primary care physician and SNFs helping RCCOs find clients and assist in connecting them with medical homes.

Timeline

SNFs and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (September 2013).
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (December 2013).
- Recommend protocols to the Department (December 2013/January 2014).
- Implement protocols for testing (January 2014).
- Assess protocols quarterly and make any necessary adjustments (April 2014 and thereafter).

Attachment A: Skilled Nursing Facility (SNF) Pre-Admission and Post-Admission Process



Notes:

- ¹ SEP completes ULTC 100.2 before or upon admission to SNF for clients who are in co-pay days and need Medicaid to pay co-pays.
- ² This applies only to Convalescent/Exempt outcomes.
- ³ Convalescent/Exempt stays are 30-60 days that apply to individuals with major mental illness, intellectual disability, or developmental disability.
- ⁴ The PASRR has Level 2 triggers, but the individual will not receive those services while in the SNF due to the short length of stay.
- ⁵ Completion of Section Q determines discharge preference and potential. Typically, three possibilities are:
 - a. Discharge is not a goal, but long-term maintenance is.
 - b. Discharge is a goal, but the client is not ready. The care plan is targeted toward discharge with periodic reassessments by the care team (SNF, RCCO, client, etc.). The SEP will complete a new ULTC 100.2, and the RCCO will assist with community services and supports.
 - c. Discharge is a goal, and the client is ready. The SNF will notify the Utilization Review Contractor (URC), Single Entry Point agency (SEP), and RCCO, as appropriate, of intent to discharge.

Section V: Glossary of Terms

Glossary of Terms

Accountable Care Collaborative (ACC) Program is a Colorado Medicaid program designed to improve beneficiaries' health and reduce costs. Medicaid beneficiaries enrolled in the program receive the regular Medicaid benefits package on a Fee-for-Service (FFS) payment basis, are assigned to a Regional Care Collaborative Organization (RCCO), and choose a Primary Care Medical Provider (PCMP).

Attribution is the process or set of rules the State uses to associate or link a beneficiary to a PCMP and/or a RCCO in the ACC Program.

Behavioral Health Organization (BHO) is an entity contracting with Colorado's Department of Health Care Policy and Financing to provide only behavioral health services.

Beneficiaries for the purposes of this Demonstration are those individuals who are enrolled in Medicare Parts A and B and eligible for Medicare Part D; and receive full Medicaid benefits under FFS arrangements, regardless of age; and have no other private or public health insurance; and are a resident of the State. Beneficiaries are also referred to as Medicare-Medicaid enrollees.

Care Coordination is a process used by a person or a team to assist beneficiaries in gaining access to Medicare, Medicaid, and waiver services regardless of the funding source of these services. It is the deliberate organization of beneficiary care, service, and support activities between two or more participants (including the beneficiary) who are involved to facilitate the appropriate delivery of health care services. It involves bringing together personnel and other needed resources to carry out all required beneficiary care, service, and support activities, and it is often managed by the exchange of information among participants responsible for different aspects.

Centers for Medicare & Medicaid Services (CMS) is a branch of the U.S. Department of Health and Human Services. It is the federal agency responsible for administering the Medicare and Medicaid programs as well as the Children's Health Insurance Program.

Client/Family-Centered is used to refer to bringing the perspectives of clients and their families directly into the planning, deliver, and evaluation processes of health care.

Community Centered Board (CCB) is a private non-profit organization designated in Colorado statute as the single entry point into the LTSS system for persons with developmental disabilities. A CCB is responsible for case management services including intake, eligibility determination, service plan development, arrangement for services, delivery of services (either directly and/or through purchase), and monitoring. A CCB is also responsible for assessing service needs and developing plans to meet those needs in its local service area.

Covered Services is the set of services to be coordinated as part of this Demonstration.

Customer Contact Center is the Department's managed call center established to respond to inquiries about any Department of Health Care Policy and Financing program.

Department is the Colorado Department of Health Care Policy and Financing.

Enrollment is the process used to place eligible beneficiaries into the ACC Program and associate beneficiaries with a Regional Care Collaborative Organization. Enrollment is closely related to attributing a beneficiary to a Primary Care Medical Provider while taking into account existing beneficiary relationships with Medicare providers.

Long-term Services and Supports (LTSS) is a wide variety of services and supports that provide persons with disabilities and with chronic conditions choice, control, and access to a full continuum of services that assure optimal outcomes such as independence, health, and quality of life. Services are intended to be person-driven, inclusive, effective and accountable, sustainable and efficient, coordinated and transparent, and culturally competent. Medicaid allows for the coverage of LTSS through several vehicles and across a spectrum of settings, including home and community-based and institutional settings such as hospitals, intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities.

Managed Fee-for-Service (MFFS) is an arrangement in which quality and utilization are improved through greater payer-provider collaboration than in traditional Fee-for-Service (FFS) programs. Most or all payments for services remain FFS with little or no insurance risk to providers. Payments may be based on such arrangements as bundling of certain services and/or incentives for high quality and efficient performance.

Service Coordination Plan is a standardized tool utilized by RCCOs and PCMPs in the Demonstration to coordinate with other providers and to collaborate with the beneficiary to document the beneficiary's basic demographic information; release of information; cultural and linguistic considerations; prioritized domains of care; short- and long-term goals and objectives; available interventions and potential methods; contacts and objective timelines; and timeframes for updates and revisions.

Primary Care Medical Provider (PCMP) is one of the Accountable Care Collaborative (ACC) Program's three main components. It is the designation for a primary care provider participating in the ACC Program who serves as the Medicaid beneficiary's main health care provider and medical home where the beneficiary receives the majority of primary care services. The PCMP helps to identify the most appropriate service provider for beneficiaries who need specialty care.

Regional Care Collaborative Organization (RCCO) is one of the Accountable Care Collaborative (ACC) Program's three main components. Each RCCO is responsible for connecting Medicaid beneficiaries, and the Demonstration's Medicare-Medicaid beneficiaries, to providers and for assisting beneficiaries in finding community and social services in their area. The RCCO helps providers communicate with beneficiaries and with each other to ensure that beneficiaries receive coordinated care.

Single Entry Points (SEPs) are state agencies that determine functional eligibility for community-based LTSS programs, provide care planning and case management for individuals in these programs, and make referrals to other resources.

Statewide Data and Analytics Contractor (SDAC) is one of the Accountable Care Collaborative (ACC) Program's three main components. It provides the Department, RCCOs, and PCMPs with client utilization and program performance data. It provides a continuous feedback loop of critical information to foster accountability and ongoing improvement.