CARE COORDINATION

Title:		Policy Number:	
Care Coordination		Policy Number: 01.5	
Responsible Department:		**Author:**	**Approver:**
Care Coordination		Hannah Wurster	Jennifer Hale-Coulson
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Applicability	
☒NHP Staff (including contractors) ☒NHP Providers ☒NHP State Contract Requirements (Local or Federal Requirements) ☐NHP Rocky Mountain Health Plans Contract Requirements	**Policy applies to:** NHP's Medicaid line of business

Regulatory Information / Resources and References	
Federal or state regulations and/or accreditation requirements: 42 CFR § 438.62 10 CCR 2505-10 8.013 10 CCR 2505-10 8.014.7 42 CFR Part 2 45 CFR §§ 160, 162, and 164 HB21-1289 G.A. v. Bimestefer Settlement Agreement	**References:** Health First Colorado Managed Care Contract Region 2 between NHP and HCPF Administrative Services Agreement between NHP and RMHP Agreements with Delegated Entities

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I. Overview

This policy outlines Northeast Health Partners' (NHP's) approach to delivering whole-person, tiered Care Coordination services to all eligible Members. It defines roles and responsibilities, establishes procedures for identifying and engaging Members, and sets expectations for care planning, documentation, collaboration across systems, and monitoring. The goal of this policy is to ensure consistent, equitable, and effective Care Coordination that improves Member outcomes, reduces gaps in care, and aligns with contractual and regulatory requirements.

II. Purpose

The purpose of this policy is to establish clear standards and responsibilities for NHP, and applicable subcontractors, in the delivery of Care Coordination services. These services are designed to improve

Member health outcomes through proactive outreach, individualized care planning, cross-system collaboration, and timely connection to needed resources. This policy ensures that all Members have access to consistent, high-quality Care Coordination that addresses their whole person needs.

III. Scope

This policy applies to NHP staff and all individuals or entities delivering Care Coordination services to NHP's assigned Medicaid members under subcontractor agreements. It includes activities carried out directly by NHP or through Delegated Entities. The policy covers the full range of Care Coordination services across all acuity tiers and is intended to ensure consistency and accountability in the delivery of these services by all individuals and entities acting on behalf of NHP.

IV. Definitions

A. **Attribution** – The method used to link Members to their medical home, or PCMP.
B. **Behavioral Health Administrative Services Organization (BHASO)** – A regional organization that supports behavioral health access and provides care coordination for uninsured and underinsured Coloradoans.
C. **Care Coordination** – Outreach, education, collaboration, and intervention activities that integrate Members' medically necessary care across systems. It facilitates the appropriate delivery of physical health, behavioral health, oral health, specialty care, and other services. It aims to prevent disease progression, reduce overutilization and unnecessary costs, reduce gaps in care, and improve Members' experience of care.
D. **Care Coordinator** – Any individual providing Care Coordination services on behalf of NHP. This includes NHP staff, Network Providers, and Delegated Entities.
E. **Care Team** – Providers, family members, organizations, and support persons who help promote a Member's health and well-being. This may include: PCMP, behavioral health providers, specialty care providers, caseworkers, school staff, caregivers, legal advocates, and others.
F. **Case Management Agency (CMA) –** Organizations that assist individuals and families with accessing necessary services, resources, and support programs to meet their needs.
G. **Client Over-Utilization Program (COUP) –** A program to assist Members who are shown, through development and review of Client utilization pattern profiles, to have a history of unnecessary or inappropriate utilization of care services.
H. **Colorado System of Care (CO-SOC) –** A statewide integrated system providing family-oriented and home- or community-based services to youth with intense behavioral health needs, with the overarching goal of meeting their needs and avoiding out-of-home placements.
I. **Delegated Entity** – An organization, provider, or PCMP with a contractual agreement to provide Care Coordination services on NHP's behalf. Delegated entities are subject to oversight by NHP.
J. **Department** – Colorado Department of Health Care Policy and Financing.
K. **Dual Eligible Special Needs Plan (D-SNP) –** A specialized Medicare Advantage plan that provides healthcare benefits for beneficiaries that have both Medicare and Medicaid coverage.

L. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) –** A Medicaid benefit that provides comprehensive and preventive health care services for children under age 21.
M. Home and Community-Based Services (HCBS) – Services that help Medicaid Members receive services in their own homes and communities rather than institutions or other isolated settings.
N. **Health First Colorado** – Colorado's Medicaid program.
O. **Health Insurance Portability and Accountability Act (HIPAA) –** Federal regulations that provide comprehensive protection for protected health information. NHP and its contracted providers adhere to HIPAA regulations.
P. **Long-Term Support Services (LTSS) –** Health care programs available to help people who have disabilities or older adults with their daily activities.
Q. **Member**— Any individual who is eligible for Health First Colorado and assigned to NHP.
R. **Northeast Health Partners (NHP)** –Regional Organization for Health First Colorado Region 2.
S. **Primary Care Medical Provider (PCMP)** – A primary care provider contracted with a RAE to participate in the Accountable Care Collaborative as a Network Provider.
T. **Provider** - Any health care professional or entity that has been accepted as a provider in the Colorado Medicaid program, Colorado's CHP+ program, or the Colorado Indigent Care Program, as determined by the Department.
U. **Protected Health Information (PHI)** – Information that can be used to identify a Member as defined in the State of Colorado Contract between NHP and the Department.
V. **Psychiatric Residential Treatment Facility (PRTF)** – Inpatient psychiatric facility for children and youth who need intensive psychiatric care but do not require the level of care of an inpatient hospital setting.
W. **Qualified Residential Treatment Program (QRTP) –** A program providing residential trauma-informed treatment designed to address the needs of children with serious emotional or behavioral health disorders or disturbances.
X. **Regional Accountable Entity (RAE)/Regional Organization** – A single regional entity responsible for implementing the Accountable Care Collaborative within its region.

V. POLICY

ROLES AND RESPONSIBILITIES

NHP and its subcontractors share responsibility for ensuring Care Coordination services are accessible, equitable, and compliant with applicable regulations. Roles and responsibilities include the following:

NHP RESPONSIBILITIES

- Ensure that Care Coordination services are available to all Medicaid Members assigned to Region 2, regardless of which entity delivers the service.
- Deliver Care Coordination services directly and through agreements with Delegated Entities to ensure coordinated and accessible care for all assigned Members.

- Establish agreements with Delegated Entities to ensure Care Coordination is delivered in alignment with NHP policies and data is shared. Require that all Care Coordination activities are documented in NHP's care management system, Essette.
- Directly provide services at no cost when other entities do not provide the service or when Members from special populations require direct support.
- Maintain oversight and accountability for the quality, consistency, and accessibility of Care Coordination services provided through subcontracted arrangements.
- Ensure that Care Coordination interventions are provided by a continuum of professionals who have adequate knowledge of systems and services to meet Member's needs.
- Provide Care Coordination tools, documentation processes, and standardized training materials to support consistent service delivery by subcontractors and partner organizations.
- Uphold non-discrimination principles in the delivery of Care Coordination, in alignment with the "Colorado for All" initiative. Thus, NHP bans discrimination based on race, color, ethnicity, national origin, ancestry, age, disability, sex, sexual orientation, gender, gender identity or expression, religion, creed, or political beliefs.
- Ensure that policies and procedures prohibit discrimination based on clinical complexity, demographic factors, or any protected category.
- Comply with all Department policies and guidance relevant to Care Coordination.
- Work with the Department to stratify population into tiers and identify trends, avoidable costs, and impactable populations.
- Collect, clean, collate, and submit Care Coordination data to the Department in the required format. Analyze Department and NHP data to use an information-based approach for care.

Delegated Entity Responsibilities

- Deliver Care Coordination services in accordance with NHP policies, state and federal regulations, and the terms of the subcontractor agreement.
- Ensure that all Members have equal access to services and that care is not denied or limited based on demographic or clinical characteristics.
- Adhere to NHP's expectations for communication, coordination, and documentation. This includes ensuring that all Care Coordination activities are entered into NHP's care management system, Essette, in accordance with established standards and timelines.
- Ensure staff complete training modules provided by NHP. New staff must complete training modules within 30 days of hire; ongoing staff must complete training modules annually.
- Participate in NHP's monitoring, oversight, and audit processes to ensure compliance with contractual, policy, and regulatory requirements.

Care Coordinator Responsibilities

- Treat all Members with dignity and respect, ensuring equitable access to services regardless of background or presenting condition.
- Comply with applicable privacy and confidentiality laws, including HIPAA, 42 CFR Part 2, and NHP policies and procedures governing when and how Member information may be shared, including requirements for informed consent.

  - Share Member information only when necessary to support care and in accordance with legal standards for Treatment, Payment, and Health Care Operations (TPO).
  - Exercise professional judgment when making disclosures and, whenever feasible, engage Members in discussions about information sharing.
  - Seek guidance from a supervisor or the NHP Compliance Officer when there is uncertainty about privacy or consent requirements.
- Maintain current knowledge of NHP and Department priorities, models, and expectations to ensure alignment with program goals.
- Conduct outreach, assessment, care planning, and engagement interventions in alignment with NHP policies and procedures.
- Document all outreach, engagement, assessments, care planning, and coordination activities in Essette within required timeframes, ensuring accuracy, clarity, and completeness.
- Use Essette, care plans, and engagement with Member to monitor and improve the effectiveness of Care Coordination activities.
- Seek supervision and support to enhance quality of care.

Lead Care Coordinator Responsibilities

Each Member receiving Care Coordination is assigned a Lead Care Coordinator (LCC) responsible for overseeing that Member's Care Coordination services. The LCC plays a central role in ensuring that Care Coordination is person-centered, comprehensive, and well-integrated across providers and systems. The following outlines how LCCs are assigned.

- The LCC may be a staff member from NHP, a delegated entity, a Network Provider, or a partner organization.
- Assignment is based on who is best positioned to support the Member's needs, with preference given to the individual or organization with the most direct and sustained engagement.
- For Members eligible for Colorado's System of Care (CO-SOC), the assigned LCC is an NHP Care Coordinator until a High Fidelity Wraparound (HFW) facilitator begins engagement. At that point, the NHP Care Coordinator remains engaged but defers to the HFW facilitator as the lead.
- NHP tracks and monitors LCC assignments and outreach activities to ensure Care Coordination efforts are not duplicated across entities.

The Lead Care Coordinator is responsible for ensuring Care Coordination is Member-centered, integrated, and documented. Key responsibilities include, but are not limited, to the following:

- Serve as the primary point of contact for the Member and their Care Team.
- Facilitate multidisciplinary Care Team meetings.
- Develop, update, and monitor the Member's Comprehensive Care Plan.
- Ensure timely follow-up and coordination of care transitions.
- Obtain necessary consents and share care plan information appropriately.
- Track Member progress and criteria for discharge from Care Coordination.
- Coordinate with other systems/agencies when the Member receives services across entities.

- Document care plans, care transitions, team meetings, and other coordination activities in Essette, in accordance with NHP's standards and timelines. Gather information from entities who do not use Essette and upload it to ensure that all documentation is in one place.
- If the LCC is from a Provider or organization not required to use Essette, send documentation to an NHP Care Coordinator who will upload it to Essette.

Staff Training Requirements

NHP offers all providers delivering Care Coordination services access to training materials that support their knowledge and expertise. NHP reviews and updates training materials at least every six months to ensure they reflect current best practices and program requirements.

NHP requires staff from Delegated Entities to annually participate in specific training modules. NHP provides these trainings, which include, but are not limited to the following topics:

- Department Fee-for-Service physical health benefits
- Medicaid policies
- NEMT, including out-of-state NEMT
- Out of state care
- In-home benefits, such as private duty nursing or long-term home health
- EPSDT
- NHP's Population Management Strategic Plan and Care Coordination models
- NHP's care management system, Essette
- Identification and resolution of health-related social needs
- Member rights and responsibilities
- Grievance and appeals
- Advanced Directives
- Nondiscrimination policies
- Cultural competency and accessibility
- Creative Solutions

Monitoring, Oversight, and Reporting

Ongoing Monitoring

Routine monitoring is a foundational element of NHP's Care Coordination program and is essential to ensuring service quality, accountability, and alignment with contractual and regulatory expectations. Monitoring helps identify strengths, address gaps, and support continuous improvement across all Care Coordination activities. NHP conducts ongoing review of Care Coordination activities to assess quality, adherence to policy, and program performance. Monitoring activities include the following:

- Reviewing care coordination documentation in Essette.
- Monitoring outreach and engagement efforts.
- Tracking timeliness and completeness of care plans and care transitions.
- Identifying service gaps or duplicative efforts.

- Monitoring Member experience and engagement patterns.
- Assessing performance metrics.

Subcontractor Meetings and Communication

To support alignment and continuous improvement, NHP requires Delegated Entities to participate in regular, structured meetings. These meetings foster a shared understanding of expectations, strengthen communication between partners, and allow for proactive resolution of service delivery challenges. A representative from each subcontracted entity's leadership is required to attend these meetings. Participation in the following meetings is required:

- Monthly Care Coordination meetings to review expectations, contractual deliverables, performance metrics, training needs, barriers to service delivery, results from audits, and operational or strategic issues.
- Quarterly contract meetings to conduct higher-level performance and partnership reviews and to evaluate overall contract compliance.
- Ad hoc meetings, including care consultations and operational planning, as needed.

Audits

NHP conducts formal audits of each Delegated Entity at least annually to ensure compliance with policy and contractual expectations. Audits follow this high-level process:

- NHP contacts the Delegated Entity to schedule the audit and describe its scope;
- NHP reviews documentation in Essette;
- NHP evaluates of care plans, outreach efforts, and opt-out documentation;
- NHP assesses the Delegated Entity's adherence to required care coordination processes.

To assess consistency and adherence to documentation standards, NHP applies a standardized sampling and scoring methodology during each annual audit. The following approach is used to evaluate performance across member records:

- 10 members are selected for care plan review
- 10 members are selected for opt-out documentation review
- To pass, the entity must meet the following thresholds:
    - Score 80% or higher on each care plan section
    - Achieve an aggregate score of 80% or higher across all care plan sections

Audit criteria are based on documentation standards outlined in NHP's contractual agreements, NHP policies, and the NHP Provider Manual.

Corrective Action Process

The Corrective Action Process (CAP) is a critical component of NHP's oversight framework, designed to promote accountability, support quality improvement, and ensure timely resolution of performance issues. When audits or monitoring activities identify deficiencies, NHP may initiate a CAP to guide remediation efforts and prevent recurrence. If deficiencies are identified through a Care Coordination audit, NHP may initiate a CAP, which may include the following, as appropriate:

- Technical assistance

- Required action plans with timelines for remediation
- Follow-up monitoring or re-audits to confirm improvement
- Contractual consequences for ongoing noncompliance

Performance Evaluation and Quality Improvement

NHP reviews audit and monitoring results regularly to inform:

- Subcontractor performance improvement
- System-wide training priorities
- Strategic planning for care model enhancements
- Reporting to the Department and external stakeholders

NHP leverages findings from oversight activities to identify trends, address systemic issues, and support continuous improvement in Care Coordination services.

Measuring Effectiveness

Care Coordinators must document all outreach, interventions, and activities documented in NHP's care management system, Essette. With Essette, NHP has a centralized mechanism for monitoring outcomes and measuring effectiveness. NHP uses Essette reports to create data dashboards that compile information specific to performance standards and other important metrics. These data are used to identify gaps in Member engagement, Care Coordination services, Member outcomes, and collaborative efforts. This allows NHP to enact program improvements, both systemic and individualized, that increase Members' experience of care and key performance metrics. The monitoring and oversight processes described above in this policy ensure that NHP is holding Delegated Entities and Providers accountable to the policies described here and to high quality care.

Additionally, Care Coordinators use Essette, care plans, and their relationships with Members to track the effectiveness of their outreach and interventions. Having all documentation in Essette allows Care Coordinators to take a broad view of a Member's care and ascertain how various services and factors impact Member health. Using care plans that are tracked in Essette, Care Coordinators can monitor Member progress toward goals and identify emerging needs. These, in combination with a collaborative relationship with the Member, allow Care Coordinators to monitor the effectiveness of their work.

NHP shares information on Care Coordination performance metrics and outcomes in various meetings, including with Program Improvement Advisory Committees (PIAC), NHP's Quality Improvement Committee (QIC), Member advisory boards, Delegated Entities, and the Department. These meetings provide NHP with opportunities to elicit and incorporate feedback from stakeholders to assess and improve the Care Coordination program. Also, NHP's Director of Quality Improvement and QIC develop an annual quality improvement plan and conduct an annual QI evaluation to monitor performance and identify areas to target improvement, including within the Care Coordination program.

Care Coordination Approach

NHP's Care Coordination program has several goals:

- Improve Members' experience of care.
- Empower Members to take an active role in their health and care management.
- Prevent disease onset and progression.
- Reduce unnecessary, avoidable, and duplicative services and costs.
- Reduce gaps in care across Medicaid programs and state benefits.

To achieve these goals, NHP takes a comprehensive and Member-centered approach. Care Coordinators involve Members as active participants in care, respecting their preferences, goals, values, and cultural beliefs. They ensure that Members are aware of their rights, including the right to decline services or to replace their Care Coordinator. Care Coordinators take a trauma-informed approach and work to ensure that outreach efforts and interventions are linguistically and culturally appropriate to each Member.

Services are provided at the point of care whenever possible and targeted at both short- and long-term healthcare needs. Care Coordinators provide support at a frequency and intensity appropriate to the Member's situation. They communicate regularly with Members, parents/guardians, Care Teams, and other relevant parties to align care and avoid duplication. They assist Members in obtaining medically necessary services by making referrals, addressing barriers, collaborating across systems, and supporting transitions. Care coordinators also work to keep Members out of hospitals and institutional care so that they receive treatment in the least restrictive setting.

NHP has a distinct child and youth Care Coordination strategy that incorporates the unique needs and developmental stages of Members under age 21. NHP utilizes various resources, including the Colorado Child and Youth Behavioral Health Implementation Plan (CCYBHIP) and the Healthy Kids Colorado Survey, to inform and update Care Coordination strategies for children and youth. Care Coordinators working with children, youth, and families have specialized knowledge in child/youth development, family functioning, and resources specific to this population. Care Coordinators implement interventions specific to this age range. This includes supporting access to EPSDT benefits, identifying resources to meet basic needs, using age-appropriate screening tools, and facilitating access to family strengthening programs. When needed, Care Coordinators make referrals to specialty care, condition management programs, and behavioral health services that meet the child or youth's needs.
NHP's Care Coordination approach stratifies Members into a three-tier model based on acuity. A Member's tier may change at any time based on individual need.

Table 1. Care Coordination Tiers

Tier	Member Description	Approach
Tier 1: Preventive Health Education	All Members	Support Member access to preventive care and education.
Tier 2: Rising Risk	Members with an increased risk of developing more complex health needs. 2-3% of Members.	Proactively engage Members to stabilize health, prevent escalation to complex care needs, reduce avoidable hospital utilization, and improve health outcomes

Tier 3: Complex Care Coordination and Management	Members with complex needs, multiple conditions, and/or high utilization. 10% of Members.	Proactively engage Members in evidence-based, multidisciplinary, longitudinal, and intensive interventions to improve Member health and prevent overutilization.

POPULATION

NHP uses a risk stratification tool, ImpactPro, to stratify all Region 2 Members into the three-tier Care Coordination model. ImpactPro applies advanced algorithms to assess Member risk across multiple domains. It analyzes a combination of demographic, medical, behavioral health, pharmacy, and encounter data using more than 300 rules across 23 clinical risk categories and 21 actionable risk factors. NHP can customize ImpactPro to adjust algorithms as needed. In working with Members, Care Coordinators have discretion to move Members in and out of tiers based on clinical needs, Member preferences, and referrals from Providers. Initial stratification serves as a starting point for targeting outreach and interventions, rather than a permanent designation.

Care Coordinators comply with Department and NHP requirements for Care Coordination with Members identified as special initiative or priority populations. Specific interventions are listed below in this policy. Department and NHP special and priority populations include the following:

- EPSDT-eligible children and youth
- Members experiencing high-risk pregnancies
- Medically complex newborns
- Children/youth in foster care, including those emancipating from foster care
- Children and Youth Eligible for CO-SOC
- Members in Permanent Supportive Housing
- Members identified as At-Risk for Institutionalization and At-Risk Transition
- Members eligible for services through any Department 1115 Waiver
- Members transitioning from incarceration
- Members who are transplant recipients with an SUD diagnosis
- Members admitted to Freestanding Psychiatric Hospitals or Colorado Mental Health Hospitals
- Dually Enrolled Members on D-SNP plan
- Members receiving or eligible for Long-Term Supports and Services
- Members in Client Overutilization Program
- Members transitioning between RAEs
- Members who frequently seek care outside of their PCMP or who are unattributed.

MEMBER ENGAGEMENT, OUTREACH, AND REFERRAL

NHP informs Members about Care Coordination services through the Member handbook, NHP's website, and collaboration with CBOs and Providers. NHP has a confidential online referral form and a toll-free phone line to reach the Care Coordination team. NHP conducts outreach through multiple methods – phone, text, email, letter, and in-person – to facilitate Member engagement.

Members can be referred to or identified for Care Coordination through several means:

- Member self-referral via NHP's website or the toll-free Care Coordination phone line.
- Provider or partner organization referral via NHP's website or the toll-free phone line.
- Clinical rounds, care consultations, and Care Team meetings.
- Clinical and claims data feeds, including but not limited to the ADT feed, CMA case manager data feeds, the Inpatient Hospital Transitions data feed, and the Nurse Advice Line Data feed.
- Department lists of specific populations, such as COUP and the Department of Corrections.

NHP uses data feeds, Department lists, and other NHP-identified lists of Members to generate Campaigns within NHP's Care Coordination platform, Essette. Campaigns identify a specific group of Medicaid members for proactive outreach and intervention. Campaigns are typically configured to address a common need or goal—such as improving follow-up after hospitalization, scheduling well-child visits, or re-engaging members identified as high-risk or low-utilization. Once the population is defined, NHP uses Essette to assign Members to Care Coordinators or Care Coordination teams.

Through these mechanisms, NHP identifies and monitors Members in need of Care Coordination interventions across all three tiers of the model. This includes identifying Members in need of care transition support, regardless of tier. NHP identifies any Member who is referred to acute, residential, or inpatient behavioral health facilities. NHP refers this Member to Care Coordination, regardless of whether they are admitted. Care Coordinators implement care transition procedures and interventions to support these Members. These procedures are described in this policy under "Care Transitions."

Upon receiving an individual referral or a list of Members, Care Coordinators outreach each Member in a manner that supports engagement. First, care coordinators begin outreach attempts promptly:

- For urgent/emergent referrals, outreach occurs within 2 hours.
- For individual non-urgent referrals, outreach occurs within 48 hours.
- For lists of Members, outreach occurs within 30 days for each Member. Certain populations require outreach on a shorter timeline. Also, NHP may instruct Care Coordinators to initiate outreach on a shorter timeline for certain campaigns or referrals.

If the first outreach attempt is not successful, Care Coordinators attempt to contact Members again, for a total of three outreach attempts if needed. The three outreach attempts must be reasonably spaced over a 30-day outreach window so that Members have an opportunity to respond. Care Coordinators also must use at least two communication methods (phone call, text, email, in-person). If a Member has not responded to any outreach attempts in this 30-day window, the Care Coordinator closes the referral. With the same time constraints listed above, the Care Coordinator confirms receipt of the referral and provides updates on the outcome of the referral to the referring party. Members have the right to decline Care Coordination services at any time without repercussions.

Documentation

NHP documents all referrals in Essette. Care Coordinators document all outreach efforts in NHP's care management system, Essette, within 48 hours. Documentation includes the date, time, modality, and

outcome of each outreach attempt. The Care Coordinator documents the outcome of outreach attempts, which include: successful engagement, unable to reach, and declined services. When a Member is successfully engaged, the Care Coordinator records the next steps, including the date, time, and method of the next engagement with the Member.

Assessment and Care Planning

Within 30 days of engaging with a Member, the Lead Care Coordinator (LCC) conducts a comprehensive assessment. First, the LCC gathers existing screening tools, assessments, and treatment plans. Based on gaps in existing information, the LCC completes the assessment by evaluating physical health, behavioral health, health-related social needs, strengths, resources, and goals.

Next, the LCC collaborates with the Member and their Care Team to develop a Comprehensive Care Plan. This plan must be completed within 90 days of initial Member engagement. For Tier 3 Members, the LCC updates the Comprehensive Care Plan at least twice per year while the Member is engaged in Care Coordination, and more often if needs change. When the LCC is from another agency, one that is not contracted to provide NHP Care Coordination, NHP Care Coordinators do not complete a new Comprehensive Care Plan but instead obtain and follow the goals of the other agency.

Comprehensive Care Plans contain, at minimum, the following components:

- Member-identified, measurable, and time-bound goals for whole-person care.
- A list of all entities and individuals involved in the Member's care (the Care Team).
- Identification of the Member's Lead Care Coordinator.
- Frequency of engagement with the Member and/or their Care Team.
- Individualized criteria for the Member's successful discharge from Care Coordination services.

Documentation

Care Coordinators document assessments and Comprehensive Care Plans in Essette within 48 hours. For assessment and screening tools, this includes the date completed, the tools used, and the results. For the Comprehensive Care Plan, the minimum components listed above must be documented. The Care Coordinator also uploads assessments, tools, treatment plans, discharge plans, and any relevant documents gathered from Providers and partner organizations.

Interventions

NHP uses both risk stratification and population segmentation to guide the initial alignment and deployment of Care Coordination interventions. Specifically, Care Coordinators use the results of the ADT, Health Needs Survey, Inpatient Hospital Transitions (IHT), and the Nurse Advice line to inform outreach and interventions, regardless of risk level. By prioritizing timely outreach and engagement without requiring the Member to meet risk-based criteria, NHP ensures flexibility and responsiveness in addressing emerging needs across the Region 2 population.

Upon engagement and care planning, Care Coordinators target interventions based on each Member's Comprehensive Care Plan. Interventions align with NHP's Care Coordination approach, as described above in this policy. Care Coordinators ensure that interventions are developmentally appropriate, evidence-based, trauma-informed, culturally appropriate, and at a frequency and intensity that meets the Member's needs. In their interventions, Care Coordinators avoid duplicating Care Coordination interventions that are provided through HCBS waivers, LTSS programs, and other services and programs. Frequent communication with key partners helps minimize duplication.

Special policies apply when working with Members identified as Tier 3: Complex Care Coordination Management. Care Coordinators must work with Tier 3 Members to update the Comprehensive Care Plan at least twice a year and whenever needs significantly change. Care Coordinators meet with Tier 3 Members at least once per month to provide support and monitor the care plan. Care Coordinators also monitor care closely to support Members when care transitions occur.

General care coordination interventions include, but are not limited to, the following:

- Outreaching all Region 2 Members to promote evidence-based preventive care, including well visits, health screenings, immunizations, comprehensive oral evaluations, and dental screenings. This includes facilitating access to EPSDT benefits for Members under age 21.
- Developing, updating, and documenting Comprehensive Care Plans.
- Screening for short- and long-term health needs. Using evidence-based tools for physical, behavioral, and oral health, as well as the Health-Related Social Needs tool.
- Assisting Members in accessing community resources that support their needs, such as housing vouchers, food assistance, or support groups.
- Identifying and addressing barriers to health, such as transportation issues or medication management challenges.
- Making referrals to address Member needs. Following up on referrals to increase Member engagement and success.
- Collaborating with the Member's Care Team and other relevant individuals or organizations.
- Convening or attending regular meetings with the Member's Care Team.
- Participating in multidisciplinary teams for Members with co-occurring physical and behavioral health conditions and/or those involved with multiple agencies.
- Conducting clinical case management for Members with complex health and social needs.
- Coordinating care transitions, including acute facility discharge, RAE reassignment, emancipation from foster care, and moves from institutional to community care.

In addition to these, there are interventions that Care Coordinators implement for adults and youth in each Care Coordination tier, as well as for special initiative and priority populations.

Interventions by Tier and Age Group

Adults Tier 1 (Preventive Health Education)

- Connect Members to health education and wellness programs.

- Facilitate Members' access to primary care and preventive services. Help Members with scheduling; provide reminders; offer transportation and accompaniment.
- Outreach Members who are unattributed to help them select a primary care provider and attend a well visit.
- Make referrals to specialty providers, including behavioral health, when needed.
- Help Members access resources and support services (e.g., transportation, housing, nutrition).
- Educate Members on their Medicaid benefits.

Adults Tier 2 (Rising Risk)

All Tier 1 interventions, as well as the following:

- Conduct proactive outreach to Members identified as rising risk.
- Establish short-term, individualized care plans aimed at stabilizing social, behavioral, and health-related risk factors.
- Educate Members on their Medicaid benefits, available support services, and waiver eligibility to encourage engagement in preventive programs.
- Support Members in accessing primary care, specialty care, preventive services, and community-based programs that address emerging needs.
- Engage Members with early signs of overutilization to promote timely, appropriate care and reduce avoidable emergency use.
- Coordinate care transitions according to policies listed below, under "Care Transitions."
- Monitor for escalating risk factors and initiate warm handoffs to Tier 3 Complex Care Coordination and Management when criteria are met.
- Address emerging barriers to care, such as lack of transportation, housing or food insecurity, or limited pharmacy access.
- Follow up on missed appointments, particularly for specialty or preventive care, and assist Members with rescheduling.
- Use preventive interventions to support Members' medication adherence and management of chronic conditions.

Adults Tier 3 (Complex Care Coordination and Management)

All Tier 1 and Tier 2 interventions, as well as the following:

- Conduct proactive outreach to Members identified as having complex care needs.
- Collaborate with Member and Care Team to assess needs and establish a Comprehensive Care Plan within 90 days of engagement. Update the plan when the Member's needs change, and at minimum twice per year.
- Meet with the Member at least once per month to provide support.
- Support Members with multiple chronic conditions and/or frequent emergency room visits. Align care across PCMPs, specialists, home health, and pharmacy services to reduce readmissions.

- Help Members with intellectual or developmental disabilities and high support needs by working closely with a Community Centered Board (CCB) or CMA, and caregivers to maintain service continuity and access to LTSS.
- Coordinate care transitions according to the policies listed below, under "Care Transitions."

Children/Youth Tier 1 (Preventive Health Education)

- Educate families on Medicaid and EPSDT benefits. Facilitate their access to EPSDT screenings and services to address physical, oral, and behavioral health.
- For Members who are newly eligible for EPSDT or who have not accessed EPSDT benefits in the last year, conduct proactive outreach to encourage engagement in preventive care.
- Facilitate Members' access to primary care and preventive services. Help Members and/or caregivers with scheduling; provide reminders; offer transportation and accompaniment.
- Outreach Members who are unattributed to help the Member or their caregiver select a PCMP and initiate well visits.
- Connect families to family strengthening and parent education programs, such Head Start, Healthy Steps, Nurse-Family Partnership, and Parents as Teachers.
- Assess the family's Social Determinants of Health and basic needs, including housing, food, and childcare.
- Connect families to resources to meet their basic needs.
- Conduct basic screenings for child/youth health and well-being.
- Make referrals to specialty care and behavioral health services that address Member needs.
- Encourage engagement in school-based behavioral health services, such as Project AWARE.
- For children/youth with IDD, connect families to HCBS waiver services, support programs, and community resources.

Children/Youth Tier 2 (Rising Risk)

All Tier 1 interventions, as well as the following:

- Conduct proactive outreach to families of Members identified as rising risk.
- Establish short-term, individualized care plans aimed at stabilizing social, behavioral, and health-related risk factors.
- Educate Members and/or caregivers on their Medicaid benefits, available support services, and waiver eligibility to encourage engagement in preventive programs.
- Support families of young children in accessing Early Intervention services when a developmental delay or other qualifying condition is identified.
- Work with Case Management Agencies (CMAs) to collaborate on care for youth with chronic conditions or disabilities.
- Connect families of young children demonstrating rising risk to dyadic evidence-based services, such as Child First.
- For children/youth with moderate behavioral health needs, make referrals appropriate to individual needs, such as: trauma-focused therapy, home-based services, intensive outpatient programs, SUD treatment, medication management, and wraparound.

- Coordinate care transitions according to policies listed below, under "Care Transitions."
- Engage Members with early signs of overutilization to promote timely, appropriate care and reduce avoidable emergency use.
- Monitor for escalating risk factors and initiate warm handoffs to Tier 3 Complex Care Coordination and Management when criteria are met.
- Address emerging barriers to care, such as lack of transportation, housing or food insecurity, or limited pharmacy access.
- Follow up on missed appointments and assist caregivers/Members with rescheduling.

Children/Youth Tier 3 (Complex Care Coordination and Management)

All Tier 1 and Tier 2 interventions, as well as the following:

- Conduct proactive outreach to Members identified with complex care needs.
- Collaborate with Member, family/caregivers, and Care Team to assess needs and establish a Comprehensive Care Plan within 90 days of engagement. Update the plan when the Member's needs change, and at minimum twice per year.
- Meet with Member and caregivers (when developmentally appropriate) at least once per month to provide support.
- Support Members with multiple chronic conditions and/or frequent emergency room visits. Align care across PCMPs, specialists, home health, and pharmacy services to reduce readmissions.
- Help Members with intellectual or developmental disabilities and high support needs by working closely with a Community Centered Board (CCB) or CMA, schools, and caregivers to maintain service continuity and access to LTSS.
- Coordinate care across various systems, such as Child Welfare, Juvenile Justice, and behavioral health providers.
- As needed, refer children/youth to an Enhanced Standardized Assessment to help determine the level of care.
- Coordinate care with residential and inpatient facilities, including QRTP, PRTF, Crisis Stabilization Units, and inpatient hospitals.
- Support the ICPC process for youth placed out of state for treatment.
- Support justice-involved youth by working with facilities to implement transition support.
- Coordinate intensive support services – HFW and waivers – for youth with very complex needs.
- Coordinate care transitions according to policies listed below.
- See below under "Department-identified specialized populations" for a description of CO-SOC interventions.
- See below under "NHP Priority Populations" for a description of interventions for medically fragile newborns, and foster care involved children/youth.

Interventions for Priority and Special Initiative Populations

EPSDT-Eligible Children and Youth

- Educate families about EPSDT benefits and support their access to screenings and services.
- Outreach new EPSDT-eligible Members within 60 days of enrollment.
- Outreach EPSDT-eligible Members who have not accessed EPSDT benefits in the last 12 months at least once annually.

Members Experiencing High-Risk Pregnancies

- Help with access to prenatal care, wraparound services, and relevant community programs, such as Nurse Family Partnership.

Medically Complex Newborns

- Work with families and relevant partner programs (e.g., Healthy Communities), support access to Medicaid benefits, and offer education on HCBS waivers and Early Intervention.

Children/Youth in Foster Care

- Monitor and support preventive care; maintain communication with the youth's Care Team.
- When a youth is emancipating from foster care, outreach and engage the youth at least six months prior to and until at least one year after emancipation.
    - Implement evidence-based practices; coordinate with relevant community-based programs; assess transition readiness; and offer transition education.

Children/Youth who are Eligible for CO-SOC

An NHP LCC oversees Care Coordination for these Members until HFW services are in place. The LCC:

- Refers the youth to an ESA, following specific timeliness expectations and processes determined in collaboration with the Department. If the Member has already completed an ESA in the last six months, the LCC will obtain a copy of the ESA in lieu of requesting a new one
- Tracks treatment plans, discharge plans, and progress in treatment
- Participates in treatment team meetings, communicate with providers, and support discharge planning
- Helps youth and families navigate services, resources, and benefits
- Monitors and supports back-end RAE processes (e.g., utilization management, provider relations)
- Refers the Member to HFW and MST or FFT
- Through participation in team meetings at the residential facility, ensures that HFW can begin 30 days prior to Member
- Facilitates consents and releases information to allow information sharing; information to share includes the ESA, CANs, CANS Decision Support matrix, enhanced HFW care planning, and level of care determinations
- Once HFW services are in place, passes the LCC role off to the HFW facilitator; continues participating in HFW facilitator-led meetings and supporting engagement in CO-SOC
- Supports family's engagement in CO-SOC until Member transitions out of program; provides ongoing care coordination for at least 6 months after Member completes CO-SOC engagement;

if the Member struggles to maintain stability in the community, refers the Member to intensive behavioral health services.

For Members initially eligible CO-SOC but determined ineligible for services or for Members who decline, NHP offers Tier 3 Care Coordination that aligns with the Member's needs. This includes referring the youth to medically necessary behavioral health services and coordinating care transitions.

Members in Permanent Supportive Housing

- Promote housing stability and support continuity of services.
- For Members enrolled in PSH but waiting for housing, conduct outreach at least once quarterly.
- Make referrals to physical and behavioral health services and follow-up to support engagement.

Members At-Risk for Institutionalization or Transition

- Care Coordinators begin outreach within 10 days of receiving the Department list to provide, at the minimum: care transition support, information and referrals to community-based resources, and/or referrals to HCBS services.

Members Eligible for 1115 Waiver and Services

- Care Coordinators follow Department requirements for supporting Members eligible for services through a 1115 Waiver.
- Initiatives include pre-release care coordination for justice-involved Members, community re-entry services, housing resources, and transitional services.

Members Transitioning from Incarceration

- Prior to release, provide support consistent with waivers or federal requirements, including an assessment to identify needs the Member may have upon release.
- Outreach these Members within 7 days of release.
- Support Members with enrollment in Medicaid, care with a PCMP, behavioral health services, medication support, employment programs, and food assistance.
- Outreach Members deemed incompetent to connect them with restoration services, even those not covered by Medicaid. Coordinate with the Office of Civil and Forensic Mental Health.
- Coordinate with CDOC, DYS, jails, or other RAEs to support Members who were likely to be but not assigned to Region 2.

Members who are Transplant Recipients with a SUD Diagnosis

- Care Coordinators comply with the Department's SUD Diagnosis protocol.
- To support Care Coordination efforts, NHP makes relevant resources easily available to hospital transplant teams, including on NHP's website.

Members Admitted to Freestanding Psychiatric Hospitals or Colorado Mental Health Hospitals

NHP works with these facilities to support collaboration and establish processes for Members' care transitions. NHP designates a Lead Care Coordinator as the liaison to complete all the care transition interventions described below in this policy, and specifically the following:

- Collaborate with Providers to expedite discharge, provide treatment in the least restrictive setting, and support the Member's engagement with covered services upon discharge.
- Ensure that a discharge plan is developed within one business day of the Member's admission.
- Attend treatment team meetings and discharge planning meetings.
- Ensure the Member is scheduled for a behavioral health appointment within seven days of discharge or one business day for Members receiving Assertive Community Treatment (ACT).
- Outreach the Member within 72 hours of discharge to review the discharge plan, coordinate follow-up appointments, engage in medication reconciliation, and answer any questions.
- Arrange transportation when needed to follow-up appointments.
- Facilitate sharing of information so that the aftercare Provider receives the discharge progress note. For Members receiving ACT, provide the discharge note to the Provider within 24 hours.

Dually-Enrolled Members on a D-SNP Plan

- Collaborate with D-SNP plans to align Medicaid services, eliminate duplication, and ensure aligned approach to care.
- See more details below in this policy, under "Collaboration with Other Systems"

Members Receiving or Eligible for Long-Term Supports and Services

- Collaborate with CMAs, support access to HCBS waivers, align care plans, support transitions, address service gaps, and ensure timely access to services.

Members in Client Overutilization Program

- Review quarterly reports from NHP, conduct outreach to each identified individual, and complete and submit a feedback report in accordance with program timelines.

Members Transitioning between RAEs

- Work directly with Care Coordinators and other relevant staff at the receiving or sending RAE to ensure that the Member has continued access to services and treatment.
- Facilitate a warm handoff between the two RAEs.

Members Unattributed or Frequently Seeking Care Outside Their PCMP

- Outreach all Members who are identified as unattributed to help them select a PCMP.
- Outreach new Members who are unattributed within 90 days of their Medicaid enrollment.
- Outreach both groups to support them in attending a PCMP visit or other preventive care.

DOCUMENTATION

Care Coordinators document all interventions, meetings, and updated Comprehensive Care Plans on Essette within 48 hours. Care Coordinators also document all ongoing outreach attempts to the Member and relevant communication with members of the Care Team. Team meetings are documented in Essette using templates provided by NHP and/or the Department. Documentation not only allows for data reporting, but it also supports the Care Coordinator in guiding care and monitoring outcomes.

Discharge from Care Coordination

Through close monitoring of the Comprehensive Care Plan and frequent contact with Members, Care Coordinators identify when goals are met and a Member may be ready for discharge. Care Coordinators collaborate with Members to develop a discharge plan specific to Care Coordination services. This plan includes relevant resources, how to restart Care Coordination services if needed, and the Member's identified support persons. Care Coordinators document the discharge plan in Essette and ensure that Members know how to access additional services if needed.

Members may also choose to decline or end Care Coordination services at any point. Care Coordinators respect this choice and document it in Essette. They also ensure that Members are aware that Care Coordination services remain available and how to access them.

Documentation

Care Coordinators document the discharge in Essette within 48 hours. Documentation includes updates to the Comprehensive Care Plan, a summary of progress and outcomes, date of the discharge, the reason Care Coordination has ended, and information provided to the Member about follow-up care.

Care Transitions

NHP Care Coordinators support Members' health and health-related social needs by facilitating coordinated, collaborative, and successful transitions between levels of care and systems. These efforts prevent adverse health outcomes, overutilization, readmissions, and emergency department visits. Care Coordinators use evidence-based models and adhere to programmatic guidelines set by the Department and NHP, including:

- Hospital Transformation Program (HTP)
- Inpatient Hospital Transitions (IHT)
- Creative Solutions/Complex Solutions (CS)
- Colorado Mental Health Hospitals and private Freestanding Psychiatric Hospitals
- Assertive Community Treatment (ACT)
- Out-of-state hospitals and residential programs.

Care Coordinators support care transitions for priority populations undergoing changes in the level of care or placement. All care transition policies apply for these groups, and Care Coordinators also implement the interventions described above in this policy, under "Interventions."

Care Coordinators facilitate care transitions for any Members discharging from or moving between out-of-home treatment facilities, including emergency departments, physical health hospitals, behavioral health hospitals, Colorado Mental Health Hospitals, Freestanding Psychiatric Hospitals, 72-hour holds, crisis services, residential programs, QRTP, PRTF, and nursing facilities.

Identification

NHP identifies Members for care transition support through data feeds and direct communication with providers and facilities. NHP participates in treatment team meetings and behavioral health clinical rounds, during which Members may be identified as undergoing care transitions. NHP also identifies members through daily monitoring of Essette referrals, ADT feeds, CMA case manager data feeds, the Inpatient Hospital Transitions data feed, and the Nurse Advice Line Data feed. NHP configures referral campaigns and data feeds to identify Members preparing to discharge from inpatient/residential facilities, overutilizing the emergency department (ED), experiencing multiple readmissions, frequently interfacing with crisis support, changing RAEs, or transitioning from out-of-state facilities.

When possible, NHP establishes agreements with treatment facilities and Providers to identify Members undergoing care transitions, share data, and clarify roles and responsibilities. Hospitals have access to a Hospital Transformation Program (HTP) provider portal to share data relevant to care transitions. Hospital staff input member details and the reason for visit, including ED visits and inpatient hospitalizations. Upon receiving this information via the portal, NHP verifies Member information and refers the Member to Care Coordination for care transition support.

NHP assigns a Lead Care Coordinator (LCC) to any Member identified as undergoing a care transition. The assigned LCC acts as a liaison among the Member, facility, Care Team, and aftercare Providers. The LCC directs, monitors, and documents all care transition activities. In the case that another entity does not provide care transition activities that are assigned to them, the LCC addresses these gaps by either facilitating the activities or identifying a provider who can. The LCC is assigned based on Member preference, situation, and unique needs. For example, if a Member is in an out-of-state facility, NHP identifies an LCC with experience and training in ICPC and NEMT.

When a Member is admitted to an acute facility, NHP will initiate contact and inform the facility of the Member's assigned Lead Care Coordinator. Facilities will be asked to share data with NHP, including:

- The date and time the Member was admitted to their facility.
- Treatment plans, progress updates, and incident reports.
- The Member's planned discharge date and discharge plan.

If facilities are not responsive to outreach by the LCC, the LCC reaches out to their supervisor to identify next steps to engage the facility and/or elevate concerns.

Care Transition Interventions

The Lead Care Coordinator then enacts specific care transition interventions, which include:

- Regular communication with the Member and the facility.

- Gathering releases and consents to facilitate information sharing across the Care Team.
- Notifying the Member's PCMP and other parties of the Member's admission to the facility.
- Convening regular team meetings with the facility, Member, and members of the Care Team. Team meetings include frequent monitoring of Member's readiness for discharge, as well as collaborative strategies to prevent readmission or overutilization.
- Addressing barriers that arise related to access to care, quality of care, and discharge.
- When other efforts have been exhausted and support from Department staff is needed, initiating Creative/Complex Solutions.
- Participating in discharge planning upon the Member's admission to a facility. Discharge planning is documented and aimed at meeting the Member's needs while minimizing their time in a facility. The LCC works with the discharging facility to designate responsibilities for discharge planning and care to reduce duplication.
- When a Member is in an out-of-state facility, managing out-of-state NEMT and ICPC processes and attending to the unique needs of the Member (e.g., arranging family visits).
- Addressing patterns of overutilization or readmissions by educating the Member on appropriate care settings, implementing evidence-based interventions, updating the care plan, coordinating with PCMPs and providers, linking the Member to community-based services, addressing barriers to care, and facilitating access to condition management or behavioral health services.
- Upon the Member's discharge, notifying the Care Team and tracking services in the discharge plan in order to monitor and support the Member's engagement with these services.

The LCC ensures that Members engage in timely and appropriate follow-up care after discharge from a facility. Outreach and follow-up appointments must occur within designated time frames:

- The LCC reaches out within 2 business days of discharge to confirm or arrange follow-up care with an appropriate and qualified health care professional.
- For physical health hospital visits, follow-up care should occur within 30 days of discharge.
- For all behavioral health facilities, follow-up care should occur within 7 days of discharge.
- For Members receiving ACT services, a follow-up ACT appointment occurs within 1 business day of discharge, and Care Coordinators ensure that ACT providers receive a discharge note prior to that follow-up appointment.
- For Members who accessed crisis support services, mobile crisis response providers conduct outreach within 5 days to support follow-up care.

The LCC sends appointment reminders and addresses any potential barriers to follow-up care, such as transportation or language, and sends appointment reminders. The LCC also supports medication reconciliation by coordinating with the facility, Member, and treatment providers to ensure that Member can access necessary medication and ask any questions. The LCC ensures that the follow-up Provider has access to the Member's discharge plan and progress note.

Next, the LCC supports the Member in establishing step-down care, such as outpatient behavioral health services, condition management programs, home-based services, long-term care, group homes, and

skilled care facilities. The LCC also supports the Member in accessing community resources that support their stabilization, such as housing, food assistance, transportation, and support groups. For Members frequently utilizing the ED or experiencing facility readmissions, the LCC engages in trauma-informed interventions and collaboration across providers to address root causes and reduce readmissions.

Documentation

The LCC maintains up-to-date documentation and monitors care transitions by inputting care plans, discharge plans, meeting notes, interventions, and all communication in Essette within 48 hours.

The LCC obtains and uploads to Essette the following information from the discharging entity: discharge plan, crisis follow-up plan, safety plan, IHT documentation, and other relevant care plans or documentation. The LCC is responsible for ensuring any missing information is located and recorded or uploaded to Essette. If the facility's discharge planning did not include the LCC or NHP or if the facility will not share a discharge plan, the LCC should report this to NHP and document this event.

Creative Solutions/Complex Solutions

NHP leads and facilitates Complex Solutions meetings for adults and Creative Solutions meetings for children to identify solutions for members experiencing significant barriers to care, including difficult placements. In these situations, a multidisciplinary approach that includes Department staff is warranted. Prior to initiating Creative/Complex Solutions, the Lead Care Coordinator makes efforts to identify solutions through other means, such as care consultations or collaboration with facilities. When Complex/Creative Solutions are needed, the LCC guides the process, following guidelines and templates provided by the Department and NHP. The LCC convenes meetings that include at minimum the Member, NHP staff, Department staff, and the Care Team. Other participants may include family members, representatives from the county's Department of Human Services, CMA providers, school staff, legal team members, and utilization management team members. In these meetings, the LCC presents an agenda focused on the Member's current situation and identified barriers to care. The attendees collaborate on exploring potential solutions and identifying concrete action steps to be taken. The LCC shares meeting notes, action steps, and information on follow-up meetings with the attendees. They also ensure that action steps are taken and fill any gaps in the necessary steps.

Documentation

The LCC uses the Department template to document and track Creative/Complex Solutions processes. Documentation includes the following:

- Efforts to identify Member solutions prior to initiating Creative/Complex Solutions.
- Minutes from meetings: participants, goals, topics discussed, and action items.
- A plan for care transition support between higher levels of care and step-down services, including those with wait lists.
- If solutions are unsuccessful, reasons and a plan to prevent similar outcomes in the future.
- An updated Comprehensive Care Plan, when appropriate.

The LCC uploads this template and any other notes or documentation to Essette within 48 hours.

Collaboration with Other Systems

NHP is committed to offering Members high quality Care Coordination that is accessible, culturally grounded, and integrated across systems. Therefore, collaboration with community partners is essential. NHP has ongoing collaborative relationships with many Community-Based Organizations (CBOs), Case Management Agencies (CMAs), BHASOs, Child Welfare agencies, D-SNPs, and justice system agencies. These collaborations allow NHP to capitalize on the expertise and presence of local entities, as well as offer Care Coordination in the least restrictive setting. To continue building these community partnerships, NHP uses environmental scans, Department and NHP Health Equity Plans, and other relevant data to identify populations and locations appropriate for expansion. Additionally, NHP is working with Rocky Mountain Health Plans to connect with organizations in Larimer County, which is new to NHP in ACC Phase 3.

Collaboration with community partners requires shared understanding, strong relationships, and frequent communication. NHP offers collaborating organizations access to NHP's data management system, Essette. NHP also works with community partners to establish data sharing agreements, requesting that they share data on outreach, Member engagement, and outcomes. Additionally, NHP establishes documented agreements with community partners that address, at minimum, the following:

- The collaborative work responsibilities.
- Standards, processes, and workflows for cross-agency collaboration regarding: Member outreach and referrals, case consultations, care transitions, shared meetings, and education/training.
- Roles and responsibilities, including who serves in the LCC role under which circumstances.
- Data sharing and analysis protocols.
- A process for escalating concerns when necessary.

When communicating with community partners about specific Members and their care, NHP affiliated Care Coordinators adhere to applicable Federal and State requirements related to protected health information. This includes 45 CFR, parts 160 and 164, subparts A and E (HIPAA). Care coordinators also comply with 42 CFR Part 2 to ensure that drug and alcohol information remains confidential. Consent is required before disclosing any such information.

Strategies and procedures for collaboration with specific community partners are as follows:

Community-Based Organizations

NHP continues to collaborate with and build the network of CBOs serving Region 2. This includes working with CBO partners to identify and engage hard-to-reach Members, as well as Members with inappropriate utilization patterns. NHP and CBOs also work together to help Members engage in evidence-based preventive care.

NHP supports CBOs to expand their infrastructure by giving them access to training materials, especially those relevant to the work of peer support professionals, behavioral health providers, and Community Health Workers. For CBOs with Community Health Workers registered through CDPHE but ineligible for

Medicaid Fee-For-Service, NHP offers support and partners with these organizations to avoid gaps in services and duplication of efforts. NHP works with CBOs to build a bidirectional referral network and collaborative network. CBOs have access to NHP's Care Coordination referral form and phone line, and NHP tracks referrals sent by CBOs for data reporting.

Case Management Agencies

NHP also has long-standing and collaborative relationships with CMAs serving Region 2 Members. To support shared Members, NHP provides CMAs with a dedicated email address and phone line so that they can submit referrals, send information, ask questions, and provide updates. NHP staff respond to CMA communication promptly, within two business days. NHP provides a referral form to Long-Term Service Providers (LTSS) so that they can easily make Care Coordination referrals.

NHP also meets on a regular basis with CMAs for caseload reviews and monthly check-ins. Through these regular meetings, NHP monitors the collaborative relationship and identifies strategies for continued performance improvement. CMAs use a Department tool for care and case management, and NHP monitors Members' care through this tool as well.

To further support CMA program improvement, NHP participates in Department initiatives specific to oversight, monitoring, training, and Member/caregiver experience. NHP staff engage in cross-functional group meetings led by the Department, as well as supports efforts to revise data collection tools targeted for the HCBS population. Moreover, NHP works with CMA partners and the Department to report on and improve member and caregiver experience. This reporting is completed in a format agreed upon by NHP and the Department.

Dual Eligible Special Needs Plans

Next, NHP works with D-SNPs to support dually-enrolled Medicaid and Medicare Members. NHP monitors ADT feeds every day to promptly identify D-SNP Members and offer care coordination in line with the interventions described above in this policy. This includes Members admitted to Skilled Nursing Facilities and inpatient facilities.

NHP's Administrative Services Organization (ASO), Rocky Mountain Health Plans (RMHP), is the state's largest D-SNP payor. NHP and RMHP have a close working relationship and use integrated systems for both claims and care coordination, both of which facilitate communication regarding dually eligible Members. To support collaboration with all D-SNPs, NHP establishes data sharing agreements to facilitate information exchange. NHP collaborates with all D-SNPs that serve Region 2 Members to analyze the benefit structure between D-SNP and Medicaid, coordinate services, and educate Providers in improving utilization and outcomes.

Behavioral Health Administrative Services Organizations

NHP works with the Region 2 BHASO to establish processes for working together on behavioral health. This includes establishing a data sharing agreement and a clear workflow for NHP and BHASO Care

Coordinators to collaborate when a Member transitions between these entities. This includes sharing documentation, conducting warm hand-offs, connecting Members to previously known staff, and ensuring that the same level of care is provided at the receiving entity. When a Medicaid member is disenrolled from Medicaid and has ongoing behavioral health needs, NHP Care Coordinators ensure that the Member is connected to the BHASO before closing NHP services. The NHP Care Coordinator shares the Comprehensive Care Plan and supports the Member's engagement with BHASO services.

Child Welfare

NHP has ongoing collaborative relationships with current Region 2 county child welfare offices, and NHP continues to deepen these connections and build relationships with counties new to the RAE in ACC Phase 3. These relationships allow NHP and child welfare teams to coordinate preventive care, specialty care, and intensive behavioral health services for children and youth involved in the system.

Care Coordinators communicate proactively with child welfare staff, as well as provide them with NHP's referral form and Care Coordination phone line. This allows child welfare teams to promptly notify NHP of youth who become involved in child welfare so that prevention programs and medically necessary services can be enacted quickly.

NHP Care Coordinators monitor and coordinate preventive care for all youth in foster care, and they remain available and known to families to support additional needs. They also provide ongoing Care Coordination to youth in CO-SOC, and support youth emancipating from foster care. See more details in this policy under "Interventions." NHP reports on Care Coordination activities to child welfare and collaborates with their teams to avoid duplication and facilitate integrated care.

Justice System

NHP works with the Colorado Department of Corrections (CDOC), Division of Youth Services (DYS), Colorado Judicial Branch, and jails in Region 2 to establish processes for working together. This includes participating in workgroups created by the Department or other state agencies.

NHP uses these relationships and data feeds, such as the list from CDOC, to identify Medicaid-eligible individuals being released from carceral settings who may be assigned to Region 2. Upon identification, Care Coordinators provide support to help stabilize Members in the community and address their needs. See more details in this policy under "Interventions."

VI. Enforcement

All Staff, including employees, delegated entities, and subcontractors, are expected to comply with this policy. Any violations may result in corrective or disciplinary action, up to and including termination of employment or contract, in accordance with NHP's personnel policies and applicable laws and regulations.

VII. Distribution

This policy is to be distributed to all NHP Staff and to all individuals, providers, or entities providing Care Coordination on behalf of NHP and through a subcontracted agreement.

Policy Revision History

Version	Date	Description	Approved By
01.1	07/01/2021		Jennifer Hale-Coulson
01.2	07/01/2022		Jennifer Hale-Coulson
01.3	07/01/2023		Jennifer Hale-Coulson
01.4	07/01/2024		Jennifer Hale-Coulson
01.5	07/01/2025	Revisions made to align with ACC Phase 3 Contract.	Jennifer Hale-Coulson