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Colorado Coalition of Adoptive Families (COCAF)
Comments on Accountable Care Collaborative (ACC) Phase II DRAFT RFP
Submitted January 13, 2017 (In Format Requested by HCPF)

1) Overall Comments/General Impressions

The Colorado Coalition of Adoptive Families – COCAF – appreciates the chance to comment on the *Regional Accountable Entity for the Accountable Care Collaborative DRAFT RFP* (November 4, 2016). We are hopeful that the integration of physical and mental health services will result in more time-efficient and effective service provisions for Members.

Our general comments are listed below, and discussed in greater depth in the appropriate Sections of the RFP.

1. Currently, there is almost no mention or discussion of the Child Mental Health Treatment Act (CMHTA), a critical service for some youth/children Members that is to be incorporated under mental health services as part of this RFP. The BHO administration of the CMHTA under the current program has had significant issues, and the process is not transparent; the process will not improve, and the Contractors will not be appropriately held accountable, without clearly outlining the requirements of this Act in this document.

   The RPF must be expanded – under ALL appropriate Sections – to include regulatory references and a detailed summary of the requirements of the Act, and the responsibilities of the Contractor in meeting these requirements. The discussion should also include detailed descriptions of:
   - The Appeals Process;
   - The role of the Ombudsman for Medicaid Managed Care; and
   - The Department's legal ability to oversee and correct inappropriate Contractor actions without a Member having to address those actions through a Fair Hearing.

2. We agree with and request that the proposed Wraparound Program be incorporated as part of this RFP. The provision of services to children and youth with significant mental health issues in a community setting is a critical area of need, and *should* be part of the Behavioral Health Benefit. If the Program is administered effectively, it can help meet one of the criteria of the Program in minimizing more restrictive levels of placement, and services would be provided much more cost effectively. In addition, this will hopefully facilitate positive interaction with DHS.

   We request that the Wraparound Program be included as part of this RFP, and that the document be expanded to include discussions and requirements under appropriate Sections. This service should be provided as any other service included in this RFP; the Contractor should not be required to receive approval from the Department prior to identifying members and providing Wraparound services.

3. We do not believe that the other two optional programs discussed in the Draft RFP – the Pre-Admission Screening and Resident Review (PASRR), and Brokering of Case Management – should be included under this Contract. Effective administration of physical and behavioral health programs separately is already a complex undertaking; integration of the two, under a completely new program, will clearly result in outcomes and issues that will need to be evaluated and prior to inclusion of additional program areas.
   Historically, it is much more difficult to access appropriate levels of mental health services vs. physical health services (hence the passage of mental health parity requirements in multiple federal legislation). We would be concerned that including the PASRR and Case Management Services might negatively impact provision of mental health services (inclusion of Wraparound Services in this RFP is different, in that the Services clearly fall under Behavioral Health Benefits).

4. We feel that inclusion and implementation of the Wraparound Program under Phase II of the ACC is a necessary and appropriate service for youth and children with significant mental health conditions; community-based services are clearly more family-focused and are provided in a healthier environment than care provision in more restrictive environments. However, in some cases, despite provision of appropriate and timely wraparound services, a child/youth may qualify for and need a more restrictive placement to address their mental health needs, for example, residential care.

   Residential services are clearly a provided service under Section **2.1.2**. However, as with CMHTA, this service is rarely discussed within this document, and is excluded in several sections where it clearly should be included. This omission will impact RAE management, and provision of this level of care to Members. Under the current BHO-managed contracts, it is already very difficult for Members to access Medically Necessary residential care, and often involves multiple levels of appeals.

   Please expand the discussions in the RFP to:
   - Incorporate discussions of residential services in appropriate Sections
   - Discuss how provision of this service could impact a Contractor's financial metrics, and how best to handle this issue

   We are concerned that without the creation of some form of a 'safety net', Members will continue to have difficulty accessing this level of care in a timely and effective manner.

   We request that the Department create a committee to address this issue.

5. The RFP includes terms throughout the document that are used in making decisions/determinations, but that are not defined. We have identified these in the specific sections, and request that they be added to Section **2.1.2**, or better defined in the text.

The *ACC Phase II Draft Request for Proposals Comments Form* is not designed to allow comments on Sections 1-4; however, there are certain issues covered in these sections that we have concerns with or questions on, and that further lay groundwork for Sections 5-8. We have therefore included these comments in the General Section, below:

1. **"3.2.4.1** The Community Behavioral Health Services Program is a statewide program that provides comprehensive mental health and substance use disorder services to individuals enrolled in Medicaid. The program is operated under a federal 1915(b) waiver and administered by capitated managed care entities known as Behavioral Health Organizations (BHOs). Under this waiver, BHOs provide State Plan services (available to all Medicaid Members) as well as certain community-based services, known as 1915(b)(3) or "alternative" services. These services include respite, clubhouse/drop-in services, Assertive Community Treatment, and other non-medical services, all of which are provided in the least restrictive and most cost-effective manner in order to best use available funding." [Emphasis added]

   *This summary is not consistent with the definition provided in Section **2.1.2**, which states: "1915(b)(3) Services – Alternative, non-State Plan Services described in 42 C.F.R. § 440 and provided under the Departments 1915(b)(3) waiver such as: intensive case management, Assertive Community Treatment (ACT), respite care, vocational services, clubhouses and drop-in center services, recovery services, educational and skills training courses, prevention/early intervention and residential services.*" [Emphasis added]

   *The definition provided in Section **2.1.2** is comprehensive, and includes residential services, which is clearly not a community-based service. The exclusion of residential services from this section is consistent with the lack of referral to this service throughout the RFP (except for Sections **5.12.5.7.1.5 and 5.12.6.5**). Please either refer to Section 2.1.2 when discussing "alternative" services, or include the full spectrum of services.*

2. **"3.2.4.4.3** Increased coordination of care for specialty populations, including children, adolescents and their families who are involved in the Child Welfare system."

   Please provide a greater description of/name of program referenced above (is this referring to Creative Solutions meetings?)

3. **"3.3.12.2** Once a Client is enrolled in the Program, the Department will conduct a brief Health Needs Survey through PEAK and/or the Department's Enrollment Broker."

   Will the client be able to receive services prior to completing a Health Needs Survey?
   Is there a length of time specified within which the Health Needs Survey must be administered?
   Would it be more efficient to have the Contractor, rather than the Department, conduct the Survey?

4. **"3.3.12.4** The next iteration of the Accountable Care Collaborative Program will include efforts to improve the coordination and delivery of services for special populations: children involved with the child welfare system, individuals transitioning out of institutions and correctional facilities, and children at risk for out-of-home placement."

   *Provision of effective and timely mental health services is critical for these populations; improvement of the coordination and delivery of services for these three groups **must** be*

included in this iteration of the ACC Program. Please modify the language and the scope of the RFP to reflect this.

Additionally, many children who were adopted or have been placed with kin, have experienced trauma and are dealing with mental illnesses that can result in significant and long-term mental health needs. Currently, children/youth do not appear to be identified as 'adopted or kinship placement" during mental health evaluation. It would be very beneficial – both from a cost and service provision point-of-view – to request this information as part of an intact interview.
We request that these data be collected for all Members.

5. **"3.3.13.2** The Department will retain capitation for behavioral health services..."

   Has there been any recent evaluations to determine whether a 'capitated' mental health program is the best model for children with severe trauma & mental illness?
   Will the new data collection system (BIDM) be used to assess this model?

6. **"3.3.13.3** The Department expects greater focus on innovative place-based community behavioral health education, skills training, and promotion of well-being across life stages and functional status. The RAE will be responsible for maintaining a comprehensive statewide network of specialty behavioral health providers capable of delivering the full range of covered services to support Members in improving their mental health and life outcomes. This includes providing services in multiple community-based settings, vocational services, clubhouse and drop-in centers, prevention and early intervention activities, support for Members transitioning to a new system of care or care environment."

   *Again, we agree with the need for, and appreciate the focus on community-based mental health services. However, there will always be a population of Members who cannot maintain safely in the community, even after receiving intensive community-based services. As stated in Section **2.1.2**, alternative, non-State Plan Services provided under the Department's 1915(b)(3) waiver includes residential services.*

   It is not appropriate to continue to ignore this level of care throughout the RFP. This does not provide appropriate direction for the RAEs, and –without this direction – can present a barrier to Members to access this level of service.

   Please include direction within appropriate sections of the RFP on residential-level care.

7. **"3.3.15.3** ... The RAE will assume comprehensive risk and take full responsibility for optimizing the mental health of Members and for providing and arranging for all covered inpatient and outpatient behavioral health services."

   Please clarify whether 'comprehensive risk' includes 'financial risk'.

Additionally, this again raises concerns about Members who need more restrictive services/care then can be provided by community services. Members in BHOs already have great difficulty in accessing residential care under the current system. Some of the issues that families of children who were adopted have experienced include:

- *BHO requiring that family agree to community services multiple times, even when the services have not modified the child's needs (and despite calls to police and hospitalizations);*
- *Refusal of the BHO to pay for the child's residential placement, even when the hospital temporarily caring for the child refused to return the child home due to safety concerns, and the hospital shouldered costs*
- *Families being told incorrect information, including that the BHO does not agree with RTC-level care*
- *Families not being provided appropriate information on Appeals*
- *BHO changing the definition of medical necessity while under contract and not informing HCPF or Members of change*

It's difficult to believe that the attempts of some BHOs to minimize access to residential care in those cases where it is medically necessary – in some cases where an independent review from the OBH disagreed with the BHO's decision, and recommended RTC-level care – is not related to the need to control/mitigate costs under the capitated mental health program. We are concerned that Members are not provided this level of care in an appropriate and timely manner because of the cost concerns.

Without clear guidance from HCPF on how RAEs are to absorb these type of costs, Members and their families will continue to be discouraged from accessing this level of care.

*We are requesting that HCPF clearly address this with respect to the requirements of the RAEs to meet specified metrics (**3.3.15.3.1** Capitation Rate Setting, Section **5.14**, etc.). We are also concerned that – without some form of financial safety net – an "incentive program that will enable RAEs to earn up to a 4% incentive on top of their capitation for achieving key performance targets" (**3.3.15.3.2**), will further incentivize RAEs to minimize access to medically necessary residential care.*

2) **5.1 Contractor's General Requirements**
3) **5.2 Personnel**
4) **5.3 Regional Accountable Entity**
5) **5.4 Member Enrollment and Attribution**
6) **5.5 Member Engagement**
7) **5.6 Grievances and Appeals**

1. "**5.6** Grievances and Appeals"

This section completely excludes any discussion on the Child Mental Health Treatment Act (CMHTA) Appeals Process. This process is obscure and complicated under the current BHO

system; it MUST be accurately summarized in a separate section under 5.6 for Contractors to appropriately serve Members accessing the CMHTA.

The following complaints have been documented under the current BHO contract:

- *Family never informed of the option for a CMHTA independent review.*
  Because the family was not informed, they missed the deadline to request the review (Catch-22)
- *Face-to-face interview was never conducted with Member, despite requirement under CMHTA*
- *BHO changed definition of Medical Necessity* ***during contract period*** *– did not inform either Department, or Members.*
  When the Department was informed of this action, they did not take action against the BHO; instead, the Department indicated that the issue would have to resolved by a Member-initiated Fair Hearing.
- *BHO denial of services was not valid, based on family's completion of all actions previously recommended by BHO. The BHO also blamed parent for child's illness, despite the parent following all BHO recommendations, child's mental health diagnosis, and no indication by any other provider of concerns regarding the parent (BHO position: "… decompensations are primarily environmental in nature.")*
- *Referral of a mentally-ill child to DHS (BHO's stated position for denial of provision of service: "If the patient's mental health diagnosis has not improved through the wide range of intensive mental health treatment services that have already provided, there is not a reasonable expectation that further residential treatment services would cure, correct, reduce, or ameliorate the effects of his mental health diagnoses.")*
- *BHO denying payment for RTC-level care despite the refusal of the Hospital to return the child home from inpatient hospitalization due to safety concerns (even after Hospital request to BHO for Doctor-to-Doctor Review)*
- *Family not receiving written confirmation of BHO denials of appeal*
- *BHO reversing denial only after Department conducts Creative Solutions Meetings*

We request that the Appeals Process, to be documented as part of this RFP, will clarify the Department's role in overseeing Contractor actions that are not consistent with the CMHTA. It is not appropriate for the Member to have to pursue an Administrative Fair Hearing decision against a Contractor action, when that action is not consistent with the CMHTA.

2. "**5.6.7.13.1** The Contractor shall allow a Member to request a State Fair Hearing. The Member must exhaust the Contractor Appeal process before requesting a State Fair Hearing. The Member has one hundred and twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing."

   This does not appear to be consistent with the current appeals process, which allows a Member to file for a State Fair Hearing at the same time as following the Contractor Appeals process. Given how time-critical service provision can be in a mental health crisis, it does not appear to be appropriate to prevent a Member from filing an Appeal under both processes concurrently.

   Please provide the legal standing for prohibiting that both appeals occur concurrently, or modify the above text to allow this to occur.

3. "**5.6.8** Ombudsman for Medicaid Managed Care"

   The role of the Ombudsman is not clear under the current BHO contract, especially with respect to the Office's role in supporting Members at Fair Hearings. Please clarify what actions the Ombudsman is allowed to conduct when a Member files for a Fair Hearing (for instance, can the Ombudsman advocate for the Member at the Hearing?).

   Additionally, I have been informed that fair hearings conducted on a CMHTA issue are ONLY documented and reported annually to the Department IF the family has contact with the Ombuds Office, and the Office is aware of the hearing. It is clear that this form of reporting would under-report fair hearing requests and outcomes. It would further be detrimental in evaluating overall Contractor metrics, and would prevent the Department from identifying any systemic issues associated with the RAE.

   Please clarify how fair hearing data are captured annually for reports to the Department. IF the process requires that the utilization and awareness of the Ombuds Office, ***we are requesting that this process be changed to require that the Contractor report all fair hearing requests/outcomes****.*

8) 5.7 Network Development and Access Standards
9) 5.8 Health Neighborhood and Community
10) 5.9 Population Health Management and Care Coordination
11) 5.10 Provider Support and Practice Transformation
12) 5.11 Primary Care Alternative Payment Methodology (Primary Care APM)
13) 5.12 Capitated Behavioral Health Benefit

1. *The Child Mental Health Treatment Act (CMHTA) is mentioned only three times in the document, and only in sections discussing reporting obligations.*

   Children and youth Members under the existing BHO program already have difficulty in accessing services mandated under the CMHTA, and having those services provided under the specified time lines. This RFP ***must*** *be expanded to include an in-depth summary of CMHTA, and all RAE obligations to meet CMHTA requirements (as specified in CRS 27-67-101), including the Appeals Process.*

2. 5.12.5.7.3 – Appendix N

   Why is Pervasive Developmental Disorder and excluded diagnosis?

14) 5.13 Data, Analytics and Claims Processing Systems
15) 5.14 Outcomes, Quality Assessment and Performance Improvement Program

1. **"5.14.4.9.1.1.3** The Contractor's rate may be set higher than the actuarially certified point estimate if the Contractor has met the base performance standards and has also met or

exceeded performance on additional performance metrics point estimate. Current performance measures that must be met for the higher rate payment include:

5.14.4.9.1.1.3.1 **Mental health engagement**"

*Please define the term **Mental health engagement.***

2. **"5.14.4.9.1.2.2** In order to qualify the Behavioral Health Incentive Payment, the Contractor shall have ninety percent (90%) accuracy for all Encounter Data submitted to the Department."

   *Please define **Encounter Data** in Section 2.0.*

3. "5.14.4.9.1.2.3 Once qualified, the Contractor may earn a Behavioral Health Incentive Payment based on annual performance goals in one or more aspirational performance measures identified through a collaborative process." [Emphasis added]

   *These metrics **must** be quantified as part of the RFP. Please define the terms "annual performance goals" and "aspirational performance measures identified through a collaborative process" in Section 2.0, or replace this text with a detailed summary of what would qualify a Contractor for a Behavioral Health Incentive Payment.*

4. "**5.14.5.3.5** The Contractor shall share CAHPS survey results and data with their provider network."

   For transparency, non-identifying CAHPS results and data should also be made available to the public (advocates, Members, legislature, etc.) on the RAE website.

5. "**5.14.5.6.1** The Contractor shall develop a corrective action plan when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is reported."

   The determinants required to develop a corrective action plan are too vague. Please clearly define the terms 'pattern of complaints', 'decreasing Member satisfaction', and 'serious complaint' within Section 2.0 or in this section.

6. "**5.14.6** Mechanisms to Detect Overutilization and Underutilization of Services"

   Please define "overutilization criteria" and "underutilization criteria" in Section 2.0.

7. "**5.14.7.1** The Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or providers, or concerns discovered by the Contractor. Member complaints about care are not considered QOC concerns and should be processed as Grievances, unless the Department instructs otherwise."

Under what circumstances would the Department instruct that a Member complaint be investigated as a QOC concern vs. a Grievance? Has this been done before under the current BHO contract?

8. "**5.14.7.2.5** Refer QOC issues to the Contractor's peer review committee, when appropriate."

   Please remove the term 'when appropriate'; ALL QOCs should be referred to the peer review committee.

9. "**5.14.7.2.10** The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that the Contractor took to investigate the concern and the outcome of the review as determined by the Contractor." [Emphasis added]

   Please delete the term 'upon request'. It's possible that the Department would not even be aware of a QOC concern that they otherwise would request information for. ALL QOC concerns should be forwarded to the Department.

10. "**5.14.7.2.11** Notwithstanding any other provision of this Contract, the Contractor may not disclose any information that is confidential by law. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at 24-72-203, C.R.S., the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to 24-72-204(6)(a), C.R.S. to prohibit disclosure."

   We believe that there are circumstances where entities should be allowed to request non-identifying/redacted information under CORA; for example, if trying to evaluate systemic issues within an RAE.
   Is the Department required by law to petition a court to prohibit disclosure of ***non-identifying/redacted information****? If not, please clarify this in the above text.*

11. "**5.14.9.4** Operational Learning Collaborative
    …
    5.14.9.4.1.11 Transitions of care, including hospital discharge and LTSS Members transitioning to the community"

    As previously stated, the RFP again excludes discussion of residential care in appropriate sections of the document. This will not lead to appropriate management for Members needing this level of care. Please insert text as appropriate within the RFP to include this service.

16) 5.15 Compliance

1. "**5.15.11.3** The Administrative Report shall contain all information regarding the Contractor's staffing, expenses and revenues relating to the Work, as directed by the Department for the period that the report covers. This information may include, but is not limited to, all of the following:

…
5.15.11.3.5 Administrative expenditures, such as payments to Subcontractors and Providers, broken out by source as directed by the Department."

Please include a specific Department category that incorporates all costs associated with Member Appeals (e.g., fair hearing preparation and participation, QOC concerns). This should be one of the metrics that determines whether a Contractor is providing appropriate care under the ACC.

17) 5.16 Start-up and Closeout Periods

18) SECTION 6.0 ADDITIONAL STATEMENT OF WORK ACTIVITIES

1. "**6.1.1** The Contractor shall perform the following activities as part of the Work when requested by the Department. The Contractor shall not perform any activities included in Section 6.0 without the Department issuing an option letter to add the funding associated with these activities." [Emphasis added]

   The Department needs to determine whether an activity will be included as part of the scope of the Phase II RFP, or not. Requiring that the Contractor be provided a letter and funding from the Department for each individual case is not cost- or time-inefficient, and will NOT benefit the targeted population in a timely manner. If an activity is to be included, procedures like those outlined for mental and physical health provision must be included in the RFP; otherwise, discussion of the activity should be excluded.

2. **Section 6.2** – ***We are in agreement with, and request that the Wraparound Program be incorporated as an activity under Phase II of the ACC.***

   In order to identify need and provide appropriate and timely services for children/youth with significant mental health conditions, collaboration between the Department and DHS is critical. Collaboration has not historically occurred in providing care for this population and their families, so we are hopeful that implementation of the Wraparound Program as part of Phase II will:

   1) increase cooperation between these two agencies;
   2) allow shared costs and service provision; and
   3) ultimately, provide better outcomes for these children and youth, and their families.

   *We again must point out that one of the primary goals of the Wraparound program is to, "… reduce potentially-preventable emergency room, inpatient, or residential child care facilities" (Section **6.2.1**).*
   This is our hope as well – we recognize that Members absolutely must be provided care in a community setting when appropriate – but there will be cases where the child/youth will need more restrictive care.

3. "**6.2.3.1** The Contractor shall administer the Wraparound Program for children and youth from birth to age twenty-one (21) who are assessed as likely to benefit from the Program and who meet all of the following Medical Necessity criteria" [Emphasis added]

   Please cite the source that states that a child/youth must meet ALL of the Medical Necessity criteria in order to qualify for the Wraparound Program.

4. "**6.2.3.1.3** The child or youth is taking multiple psychotropic medications outside of recommended guidelines and/or is identified as having a high likelihood of any of the following" [Emphasis added]

   *Why would children/youth who are taking multiple psychotropic meds, but that fall WITHIN recommended guidelines, not be eligible for Wraparound services, especially if the child/youth also qualifies under Sections **6.2.3.1.3.1**- **6.2.3.1.3.3**? Please modify the text to include this population.*

5. "6.2.8.1.5 Ensuring Wraparound Program enrollees receive timely access to Medically Necessary services covered under the Accountable Care Collaborative, such as outpatient behavioral health therapy and intensive in-home therapy."

   In those cases where enrollees in the Wraparound Program are identified as needing Medically Necessary residential services, those enrollees should also receive timely access to residential care. Please include this in the above text – do not exclude discussion of a 2.1.2 covered care from the RFP.

6. Sections **6.3** and **6.4** – We are not in agreement with inclusion of these two programs (LTSS Case Management Brokerage and PASRR) as part of Phase II of the Accountable Care Collaborative. Combining physical and mental health care under the same Care program is a significant undertaking; outcomes from the combined program must first be evaluated, and any concerns addressed, prior to expanding the obligations of the Contractor.

19) SECTION 7.0 COMPENSATION