January 13, 2017

To: Laurel Karabatsos, Mark Quierolo, Colleen Daywalt, and Susan Mathieu, Colorado Department of Health Care Policy and Financing

Cc: Gretchen Hammer, Medicaid Director, Colorado Department of Health Care Policy and Financing

From: All Kids Covered Coalition

RE: ACC Phase II Draft RAE RFP Comments and Recommendations

This memorandum provides comments and recommendations to the Department of Health Care Policy and Financing regarding the Draft RAE RFP for Phase II of the Accountable Care Collaborative (ACC) from members of the All Kids Covered Coalition. As members of the All Kids Covered Coalition, we are committed to ensuring that the next phase of the ACC improves the health care system for children and families. The following comments and recommendations reflect this commitment, and also align with the following key priorities of this coalition for Phase II of the ACC:

- Ensure that the system offers incentives for developmental and behavioral health screenings and appropriate follow-up care, including referral and treatment
- Ensure that all new Medicaid clients are connected with appropriate medical and non-medical services
- Ensure that RAEs and Health Team Members are held accountable for the quality of care provided to children during their most sensitive periods, and are given incentives to improve that care
- Recognize the importance of integrated physical and behavioral health care for kids
- Provide care that is appropriate to culture, language and ability and support the sustainability of trusted local resources
- Ensure secure and reliable sharing of data across systems that support the health and well-being of children
- Provide additional services and a higher level of care for Colorado children during sensitive periods

Overall Impressions

We would like to thank the Department for making strides towards some of our key priorities:

- Increasing access to behavioral health care for children and families by removing six visits from the Behavioral Health capitation (that is defined by covered diagnosis)
- Better coordinating between behavioral health systems and physical health systems
- Acknowledging the key role the broader Community plays in the health of children and families and articulating a role for the RAE in investing in and supporting the Community
- Encouraging care that is appropriate to culture and language. We respectfully request that all references to cultural preference, competence, or humility be replaced with "responsiveness" because responsiveness implies an action on the part of providers and others in the health care system.
- Providing additional services and a higher level of care for Colorado children during the most sensitive periods including children and youth in foster care in addition to those at risk of out-of-home placement.

Medicaid is the single largest investment (in combined State and Federal dollars) that we make in the residents of Colorado and we are committed to partnering with the Department to help make those funds as impactful as possible. We and other child and family advocates and experts have a number of specific comments on the RFP language to help improve the $9 billion Medicaid system for children and families through 2025. The most important changes we are suggesting are:

- Remove EPSDT early intervention and prevention services from the behavioral health capitation and have it offered Fee-for-Service within the State Plan
- Ensure RFP language clearly allows the RAE to invest in the non-medical Community because non-medical services play a critical role in the health of children and families on Medicaid.
- Strengthen the Alternative Payment Methodology criteria to maximize the impact of that payment change
- Give the State Program Improvement Advisory Committee control over the Flexible Funding pool to ensure it is allocated in a way that corresponds with community priorities
- Make the Wraparound services a required component of the contract

While we focus most of our energy in on areas where we seek changes, we would also like to thank the Department for the thoughtful work and inclusive process that went into the development of this RFP. The RFP is well written and contains many components advocated for by child health experts that have potential to have a significant positive impact on Medicaid enrolled children and families. We specifically would like to thank the Department for:

- Requirements regarding translation and interpretation services that ensure members receive services and information in their language of choice.
- Requiring the RAE contract with providers who represent diverse racial and ethnic communities.
- Including criteria to include afterhours care and develop individual care plans for people with complex needs.
- Including robust measures for monitoring well-being, especially maternal depression screenings, dental visits, and developmental screenings.

- Focusing on youth taking psychotropic medications

We appreciate the effort that went into this document and are eager to support the Department in continuing to refine the program design.

RECOMMENDATION: STAFFING

PRIORITY Recommendation—Staffing: The scope and scale of the ACC is significant. We recognize the technical complexity and volume of work for the Department of Health Care Policy and Financing to effectively administer and oversee this program. We fully support Departmental requests for additional staffing and especially requests for staffing with the appropriate level of expertise. The functions the Department of Health Care Policy and Financing must perform in order to ensure Contractor accountability and that the program runs smoothly requires expert level staff, hiring this level of staff requires appropriate compensation. We support the Department in those requests.

RECOMMENDATION: WINNABLE BATTLES

Current Language: 2.1.21 "Colorado's 10 Winnable Battles – Public health and environmental priorities that have known, effective solutions focusing on healthier air, clean water, infectious disease prevention, injury prevention, mental health and substance use, obesity, oral health, safe food, tobacco and unintended pregnancy. The initiative is overseen by the Colorado Department of Public Health and Environment."

PRIORITY Recommendation—Winnable Battles: The RFP should clearly list the winnable battles for which the RAE is held accountable. We recommend that the RFP focus on the following strategies:

- **Increase the percent of mothers who are appropriately screened and treated for depression.**
- **Decrease untreated dental decay and decay experience in children.**
- **Increase access to and utilization of tobacco cessation services tailored for pregnant and postpartum women.**
- **Increase use of long-acting, reversible contraceptive methods.**

In general, we recommend that many of the aspirational goals in the RFP be narrowed, prioritized and defined. We recognize that the capacity of both our providers and the RAEs is finite and by prioritizing we will be more likely to be successful in all endeavors.

Rationale: There are many strategies listed in the Winnable Battles documents and the RAEs will not have the resources to focus on all of them. Providing more clarity on priorities and expectations will ensure that the RAEs dedicate their efforts where they can effectively intervene and make the largest difference for children and families. The strategies we have highlighted above are within the scope of work of the RAEs and have strong evidence supporting their effectiveness at improving the health of children and families.

RECOMMENDATION: COMMUNITY GOAL

Current Language: 3.2.3.3 "It differs from a capitated managed care program by investing directly in Community infrastructure to support care teams and Care Coordination."

Recommendation—Community Goal: We are deeply grateful for the inclusion of a Community section. We recommend removing from 3.2.3.3., "to support care teams and care coordination" from the program's description so that the sentence reads "It differs from a capitated managed care program by investing directly in Community infrastructure."

Rationale: Community, per the Department's definition, is the sphere of services beyond healthcare that has the majority of impact on health. Care teams and coordination are within the health neighborhood so this statement is confusing. We support RAE investment in community infrastructure and supports (including the social determinants of health) and believe removing this statement will allow for more innovation and more strategic investments in the broader Community.

RECOMMENDATION: COORDINATION WITH DEPARTMENT OF EDUCATION

Current Language: 3.3.10 "In order to maximize impact and minimize redundancies, the Program will focus on greater coordination with the Colorado Departments of Human Services, Public Health and Environment, and Corrections,..."

Recommendation—Coordination with Department of Education: We recommend adding the Department of Education to the list of Colorado state agencies with whom the RAE should coordinate in section 3.3.10.

Rationale: The Department of Education is core to a child's continuum of services and community of care. We would also like to note that for this coordination to be effective, it requires state leadership in addition to the RAE's investment of time and resources.

RECOMMENDATION: ORAL HEALTH AND PERSON AND FAMILY-CENTEREDNESS

Current Language: 3.3.11.1 "Members will have their medical and behavioral health care needs met and receive Community supports in a seamless way."

Recommendation—Oral Health and Person and Family-Centeredness: We recommend revising 3.3.3.11.1. to add oral health and language to emphasize that services should be person and family-centered. The sentence should read, "Members will have their medical, behavioral, and oral health care needs met and will receive Community supports in a person and family-centered way."

Rationale: Oral health is not implicit in the statement "medical and behavioral" and is crucial for whole person health. Stipulating that care must be person and family-centered is more encompassing and inclusive than "seamless" as a key goal for the program.

RECOMMENDATION: CONTINUUM OF SERVICES

Current Language: 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."

Recommendation—Continuum of Services: We recommend replacing the sentence at 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," with "This iteration of the Accountable Care Collaborative Program will include efforts to improve the coordination and delivery of a fully coordinated continuum of services for individuals and their families, including but not limited to:"

Rationale: Children and their families require a broader continuum of services than the current ACC supports, both for the child and the whole family. ACC Phase II should clearly articulate this goal. Further, adding the language "including, but not limited to" recognizes that there are other populations that may require special services and attention over the course of the contract.

RECOMMENDATION: CAPTURE EPSDT BENEFITS FOR CHILDREN AS REQUIRED COMPONENT OF RAE CONTRACTS

Recommendation—Ensuring continuation of EPSDT Services for children in Colorado's Medicaid program. We recommend including the following language as a contract requirement.

Contractors are required to ensure the provision of the full range of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services--comprehensive and medically necessary services needed to correct and ameliorate health conditions, including the following screening, diagnostic, and treatment services:

- **Screening Services**
- **Comprehensive health and developmental history**
- **Comprehensive unclothed physical exam**
- **Appropriate immunizations (according to the Advisory Committee on Immunization Practices)**
- **Laboratory tests (including lead toxicity screening)**
- **Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)**
- **Vision Services**
- **Dental Services**
- **Hearing Services**
- **Other Necessary Health Care Services**
- **Diagnostic Services**
- **Treatment**

Rationale: The shifting federal health policy landscape indicates that it may be important to ensure that EPSDT services remain a part of state contracts through 2025 in order to ensure appropriate medical care for children in the Medicaid program.

Contractor's General Requirements

RECOMMENDATION: DELIVERABLES

PRIORITY Recommendation—Deliverables: We recommend that all deliverables in section 5.1.6. (especially population health strategy) be posted online in their entirety, with confidential patient information removed, within thirty days of the Department's receipt in order to support transparency and the advisory process. Reports should be structured in ways that are easily understood by members, network providers, stakeholders, and the public at large.

Rationale: Publicly sharing deliverables will ensure that the program is transparent and that advocates can effectively assist the Department in monitoring the program.

RECOMMENDATION: RAE COMMUNICATION

Current Language: 5.1.8.2.4.9. The contractor shall not engage in any non-routine communication with any Member, any provider, the media or the public without the prior written consent of the Department.

Recommendation—RAE Communication: We recommend removing 5.1.8.2.4.9.

Rationale: RAE collaboration and coordination with members, providers and other stakeholders is core to their role. We do not want to inhibit the RAEs ability to communicate because that could impair their ability to collaborate and be effective in serving Medicaid enrollees. RAEs will be leaders in their communities and so have an important role to play as leaders in conversations about health. These non-routine conversations and messages will be important to improving the health of Medicaid enrollees.

RECOMMENDATION: PROVIDER DIRECTORY

Current Language: 5.5.3.7.1.6 "Provider directories and contact information, including the names, locations, telephone numbers, and non-English languages spoken by current contracted providers, as well as identification of providers that are not accepting new Medicaid Members."

Recommendation—Provider Directory: We recommend that the provider directory be up to date, interactive, and accessible and include provider type.

Rationale: Provider type is a crucial piece of information to ensure that the contacted provider will serve the client's need. Provider lists in PDF or other formats are difficult for clients to utilize. A dynamic and searchable provider directory that enables a client to filter the list and find a provider that is close, will take new members, and is appropriate for their age/gender and other needs is an important mechanism for supporting access.

Personnel

RECOMMENDATION: EXPERTISE

Current Language: 5.2.12

- Program Officer
- Chief Financial Officer
- Chief Clinical Officer
- Quality Improvement Director
- Health Information Technology and Data Director
- Utilization Management Director

PRIORITY Recommendation-Key Personnel Expertise: At least one of the Chief Clinical Officer, Quality Improvement Director, or Utilization Management Director must have behavioral health expertise and at least one of the Chief Clinical Officer, Quality Improvement Director, or Utilization Management Director must have pediatric expertise.

Rationale: Since the bulk of the dollars in the contract are dedicated to behavioral health, it is crucial that the leadership group include deep behavioral health expertise. Since more than 500,000 children are enrolled in the program, making up the largest demographic of Colorado Medicaid enrollees, and the needs of children and youth are fundamentally different than the needs of adults, pediatric expertise in key positions of the leadership group is necessary to ensure that the programs serve both. Ideally, expertise in pediatric behavioral health would also exist within the leadership team.

Regional Accountable Entity: Member Enrollment and Attribution

<u>Recommendation—Reduce Churn</u>: We note the importance of continuous enrollment in the Medicaid program, especially among children, in order to ensure consistent access to care, continuity of care, and a provider's ability to manage a client's care effectively. We recognize and appreciate the Department's ongoing efforts to work with providers to ensure that they are able to provide continuous comprehensive care for their clients.

Member Engagement

RECOMMENDATION: HEALTH NEEDS SURVEY

Current Language: 5.5.5 "The Department has developed a Health Needs Survey to be completed by Clients during enrollment to capture some basic information about a Member's individual needs. The Health Needs Survey is a brief set of questions capturing important and time-sensitive health information (Appendix H Health Needs Survey) that shall be used by the Contractor to inform Member outreach and Care Coordination activities."

PRIORITY Recommendation—Health Needs Survey Timing: We recommend the health needs survey occurs post-enrollment.

Rationale: While we understand the operational opportunity and potential complications of doing the screening later in the process, the risks of deterring people from applying for Medicaid are significant. We are also concerned that urgent needs identified at the time of application by an eligibility technician or through the PEAK application process will not be responded to within an appropriate timeframe. The questions within the Health Needs Survey may also go beyond what is legally allowed by the Centers for Medicare & Medicaid Services to be required on a Medicaid application, and exceed what is allowable for other assistance programs incorporated within the PEAK application (e.g. SNAP, Colorado Works, and subsidies through Connect for Health Colorado). Additionally, we are concerned with how individuals who are not deemed eligible for Medicaid but who have identified needs will be connected to necessary resources, services, and supports. Finally, because the majority of Coloradans eligible for Medicaid are already enrolled in the program, conducting the Health Needs Survey at the time of application will not capture the health needs of the majority of people enrolled with the RAE.

PRIORITY Recommendation—Health Needs Survey Design: We recommend that the Health Needs Survey be a requirement of the RAE and be family and child oriented. We recommend that the screening be a triage tool to identify how quickly clients require outreach and by whom. Determining whether a child-bearing age female enrollee is pregnant or in the first year postpartum should be a priority of the survey, in order to facilitate rapid referral to appropriate health services and community resources. Specifically, we recommend that Question 4 in Appendix H be asked of ALL child-bearing age female clients, and that it be followed by a question that reads as follows: "Have you given birth in the last 12 months?" We recommend strategies for soliciting information from families so that heads of household do not have to provide duplicative information (e.g., family-level information) on each individual application but that the information of individual parents (for example) remains confidential.

We recommend that the community-level results of Health Needs Surveys be explicitly tied to the actions proposed in the population health strategy.

Rationale: Identifying behavioral health, physical health, and social needs of pregnant women and women in the first year postpartum should be a priority upon enrollment. Regional Accountable Entities should be responsible for the screening and for referring women to appropriate resources based upon screening results.

RECOMMENDATION: HEALTHY COMMUNITIES

Current Language: 5.5.6.2 “The Contractor shall collaborate with Healthy Communities contractors in the Contractor’s Region for onboarding Members to Medicaid and the Program. Healthy Communities will have contracted responsibilities to onboard Members to Medicaid and the Program through outreach, navigation support of Medicaid benefits, and education on preventive services, particularly services for children and families.”

Recommendation—Healthy Communities: Are Healthy Communities onboarding all members rather than just kids and families? We recommend that the state delineate roles and responsibilities so that it is clear what those roles and responsibilities are statewide. We also recommend that Healthy Communities remain focused on children and their families, which is their area of expertise.

Rationale: Clear delineation of roles and responsibilities will allow for reasonable apportionment of funds and ensure that services are not duplicative but complimentary.

Grievance and Appeals

NO RECOMMENDATION

Network Development and Access

RECOMMENDATION: ACCESS TO CARE STRATEGIES

Current Language: 5.7.1.5 "The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds."

Recommendations—Telehealth: We recommend that the RAE consider telehealth broadly as a strategy to reduce barriers to access to the healthcare system. We recommend deleting the following sentence (5.7.1.5), The Contractor "May use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers…" and adding, "The contractor should include the development of a broad telehealth capacity (including psychiatric and other consultation services for providers and direct to client phone, email and other communications to replace in person visits when clinically appropriate) within the network as a way to build capacity and reduce barriers to accessing care."

Rationale: For Medicaid enrollees, especially children and families, with many competing demands on their time, money and energy, accessing a provider by phone or email is an important part of health care reform. For providers, access to psychiatric and other specialty providers through phone or video consultation makes these services more readily available for clients in all parts of the state.

RECOMMENDATION: PCMP CRITERIA

Current Language: 5.7.2.1.8 Criteria for a PCMP, "Has adopted and regularly uses universal screening tools including behavioral health screenings, uniform protocols, and guidelines/decision trees/algorithms to support Members in accessing necessary treatments."

PRIORITY Recommendation—PCMP Criteria: We recommend that the PCMP network requirement for providers to use universal screening tools should explicitly call out developmental screenings for children under age six.

Rationale: Developmental Screening is a fundamental part of high quality care for pediatrics and periodic screenings using a standardized tool are included in best practice guidelines. Early detection of developmental delays helps children receive the interventions they need to ensure their healthy development.

RECOMMENDATION: THIRD PARTY CREDENTIALING FOR THE STATEWIDE BEHAVIORAL HEALTH NETWORK

Current Language: 5.7.3.1 "The Contractor shall establish and maintain a statewide network of behavioral health providers that spans inpatient, outpatient, laboratory, and all other covered mental health and substance use disorder services."

Recommendation—BH Network Administration: We recommend that a third party entity conduct the credentialing and governance for one statewide network of behavioral health providers (rather than a

different statewide network for each RAE). This would mean that clinicians would have to be credentialed only once in order to provide behavioral health capitated services in any region.

Rationale: The goal of this change is to ensure an adequate network and avoid potential conflicts of interest. Having a third party entity perform credentialing would achieve the following:

- **Reduce administrative burden on providers in contracting with multiple RAEs**
- **Remove conflicts of interest related to expanding the behavioral health network**
- **Remove potential negative consequences of having different RAE behavioral health networks**
- **Would ensure that the behavioral health network is adequate by ensuring that there is one broad statewide network.**

RECOMMENDATION: DEFINE BEHAVIORAL HEALTH PROVIDER

Current Language: 5.7.4.10 "The Contractor's behavioral health network shall have a sufficient number of providers so that each Member has their choice of at least two (2) behavioral health providers within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger."

Recommendation—Definition of BH Provider: We recommend that the term "behavioral health provider" be defined to clarify that the requirement of two behavioral health providers does not refer to individual clinicians or teams, but rather entirely separate brick and mortar entities so that access requirements are more clearly understood.

Rationale: Many clients and families want a choice other than the local CMHC. Clarification of this term would ensure that these criteria would give clients that meaningful choice in selecting a qualified behavioral health service.

RECOMMENDATION: PROVIDER RATIOS

Current Language: 5.7.4.11 "Adult primary care providers: One (1) practitioner per eighteen hundred (1,800) adult Members. Mid-level adult primary care providers: One (1) practitioner per twelve hundred (1,200) adult Members. Pediatric primary care providers: One (1) PCMP Provider per twenty-five five hundred (2,500) child Members. Mental Health Providers: One (1) practitioner per fifteen hundred (1,500) Members."

Recommendation—Network Access: The standard for children's primary care to provider ratio (in 4.7.4.11.) should be revised from 2,500 to 1,200. At a minimum, the standard should be equal for children and adults. The ratios of necessary mental health providers should be broken out by child and adult. In addition, network adequacy should also include consideration of people who have to utilize non-traditional modes of transportation or public transportation. RAEs should do an initial analysis of accessibility based on public transportation. We know the Medicaid population has higher mental health needs than the general population. In order to assure access to care for 25% of the pediatric population, we recommend a ratio of pediatric mental health providers to child enrollees of one practitioner per twelve hundred (1,200) twelve hundred members.

Rationale: The Pediatric Primary Care ratio is not adequate. Children have many more primary care visits than adults. Children's mental health needs differ from those of adults and providers of mental health services to children should be trained to provide those services. The driving distance standards fail to acknowledge accessibility for many Medicaid clients who do not have vehicles.

RECOMMENDATION: ACCESS STANDARDS

Current Language: 5.7.4.13.5.2 "Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days of a Member's request. Administrative intake appointments or group intake processes are not considered a treatment appointment for non-urgent, symptomatic care."

Recommendation—Appropriate BH Follow-up: We recommend that 5.7.4.13.5.2. should also include, "and follow-up appointments at clinically optimal and indicated intervals." We appreciate the change in language that group or intake appointments are not considered adequate engagement with the system and want to be sure that follow-up and ongoing care is provided in a timely fashion.

Rationale: We appreciate the clarification that intake appointments do not fulfill the criteria for a first appointment. However, we are concerned that the first appointment will be made in a timely fashion and then, like now, the following appointments will be delayed due to insufficient numbers of clinicians.

RECOMMENDATION: NETWORK ADEQUACY REPORTING

Current Language: 5.7.5 "The Contractor shall submit a Network Report to the Department on a quarterly basis."

Recommendation—Network Adequacy Reporting: For all network access reporting, we recommend pediatric data and access should be separate from adult data and access in order to determine network adequacy for each population.

We also recommend that the network adequacy plan should include reporting on the race and ethnicity of the provider to determine whether the contractor is meeting the goals of 5.7.1.3.

Health Neighborhood and Community

NO RECOMMENDATION

Population Health Management and Care Coordination

RECOMMENDATION: RAE DIRECTORY

Current Language: 5.8.4.5 "The Contractor shall have and maintain a centralized regional resource directory listing all Community resources available to Members and share the information with providers and Members."'

PRIORITY Recommendation—RAE Directory: We recommend adding the following language, "The RAE directory should include resources to support women and families who are experiencing pregnancy-related depression and anxiety, including the Postpartum Support International phone number and website, and other community resources."

Rationale: There is a wealth of evidence, including from Harvard University's Center on the Developing Child and the American Academy of Pediatrics, around the long-term negative impact of pregnancy-related depression and anxiety on child health and development. The effects of maternal depression are linked to "reductions in young children's behavioral, cognitive, and social and emotional functioning." Children raised by clinically depressed mothers are at risk for later mental health problems, social adjustment difficulties, and difficulties in school. One study also found that women suffering from maternal depression had health care costs that were 90 percent higher than those of non-depressed women. Identifying women with pregnancy-related depression and anxiety and quickly connecting them with care can have a long-term positive impact on Medicaid enrollees. Babies of mothers who are treated for pregnancy-related mood issues have better health and developmental outcomes, are more likely to attend well-child visits, and have decreased emergency and urgent care utilization. These resources and supports should be accessible and available to women during pregnancy, at infant well-child visits, and at post-partum follow-up visits.

RECOMMENDATION: CARE COORDINATION DEFINITION

Current Language: 2.1.12 Care Coordination – The deliberate organization of Client care activities between two or more participants (including the Client and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional LTSS supports, oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs

Recommendation—Care Coordination Definition: We recommend revising the 2.1.12. definition of care coordination so that it is more client centric and better addresses the function of care coordination as it relates to whole person needs. The sentence should read, "Care Coordination – A consumer-directed, team approach to the integration of care, services and support for optimizing health and social outcomes. Care coordination must be done in collaboration with the Client to identify needs and viable solutions, create a care plan and then execute the care plan. A care plan may include physical health care, behavioral health care, functional LTSS supports, oral health, specialty care, housing supports, school participation, food resources, employment supports, transportation

options, and other medical and community services. Care coordination must allow a Client to change care coordinators upon request."

Rationale: We recommend changing this language to be more client-centered so that the clients have agency in the coordination of their own care. Additionally, the definition of Care Coordination noted several times in the RFP is very medically focused. The list of providers is comprised of all medical providers. We recommend clarifying that Care Coordination necessitates supporting clients in accessing the full range of services they require to optimize their outcomes.

RECOMMENDATION: CARE COORDINATION

PRIORITY Recommendation—Care Coordination for Developmental Delays and Pregnancy-related Depression: We recommend that the Contractor be incentivized to focus on care coordination activities for children who screen positive for a developmental delay and women who screen positive for pregnancy-related depression and anxiety, enabling these children and women to receive necessary treatment and support. These care coordination services should include referring affected children and women to medical and community resources, following-up with these families to determine whether they were able to access those resources, and informing the health care provider who documented the positive screen of the services the family or woman was offered and whether the family was able to access those resources.

RECOMMENDATION: POPULATION HEALTH MANAGEMENT

Recommendation—Population Health Management: We recommend that the population health management plan include prevention, early intervention and the full spectrum of population health management services. We recommend that the plan be required to be review by experts in the populations and strategies outlined. Evidence of that review could be a requirement of the proposal submission.

Provider Support and Practice Transformation

RECOMMENDATION: SCREENING TOOLS

Current Language: 5.10.5.2.3 "Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled. "

PRIORITY Recommendation—Screening Tools: We recommend specifically identifying that the RAE should maintain and provide a list of Medicaid-approved developmental screening tools and behavioral health screening tools for children under age 6 and pregnancy-related depression screening tools for pregnant and postpartum women to promote adherence to clinical best practice guidelines and that the RAE should support the use of these tools.

RECOMMENDATION: PROVIDER TRAINING

Current Language: 5.10.6 "The Contractor shall, at a minimum, develop trainings based on subject matter expertise and host forums for ongoing training regarding the Program and the services the Contractor offers."

PRIORITY Recommendation—Provider Training: Provider support should include training providers in delivering culturally responsive care and in best practices related to caring for children and families. These practices should include completing pregnancy-related depression screening multiple times during pregnancy and during the child's first year and screening for Adverse Childhood Experiences (ACEs) as well as other early childhood mental health competencies. The contractor should also provide guidance around documentation of screening results and appropriate billing procedures for each type of setting. In addition, we recommend that behavioral health providers working with young children have the Colorado Infant/Early Childhood Mental Health Endorsement.

Primary Care Alternative Payment Methodology

RECOMMENDATION: PREVENTATIVE BEHAVIORAL HEALTH VISIT

Current Language: See Appendix M

Recommendation—Preventive Behavioral Health Visits: We recommend that the highest tier of the Alternative Payment Methodology include preventive behavioral health visits for children.

Rationale: The preventive behavioral health visit should be linked with well-child visits (at least 2 per year in the first three years and annually beginning at age 4), provided in collaboration with physical health services, and include: 1) child behavioral health and family psychosocial screening and identification; 2) anticipatory guidance around development, behavior, relational health between the child and caregivers/parents; 3) identification and discussion of environmental influences on well-being; and 4) address identified needs, provide intervention, triage, and connect families to necessary resources. Behavioral health preventive care plans must be integrated with physical health care plans with care teams functioning collaboratively to support optimal health and well-being. This preventive visit could also identify clients who require care coordination/care management services.

QUESTIONS: ALTERNATIVE PAYMENT METHODOLOGY

1. **24 Hour EHR Access: Who is the access to? Providers? Or providers and clients? What does Asynchronous communication mean?**
2. **Please clarify what a shared care plan: patient is.**

PRIORITY Recommendation- Ensure Alternative Payment Methodology Tiers Maximize Potential for Improving Clinical Care:

- **The Criteria for Enhanced level should be revised:**
    1. **Health Neighborhood Care Coordination: Recommend moving hospital and ER follow up to Enhanced and away from Advanced.**
    2. **Behavioral Health Integration: Having Behavioral Health providers in health settings should be moved from Advanced to Enhanced.**
- **The criteria for the Advanced level should include**
    1. **Access to and continuity of care:**
        1. **Advanced practices should also be able to offer group prenatal care referrals to their clients. Group prenatal care has been shown to reduce low birthweight births and preterm births and is a promising practice to help reduce disparate infant mortality rates among non-white racial and ethnic groups**
    2. **Team Based Care: Team-based care should include lay health workers/non-traditional health workers/navigators etc.**
    3. **Care Management/Care Coordination: This should include an assessment of family needs and social needs (i.e. does the caregiver/parent have a medical home? Are all social needs met?)**

4. **Health Neighborhood: The practice must be engaging a community-based care coordination tool where information is shared across medical and social needs. In addition, practices must be supporting patients in accessing dental care.**
5. **Behavioral Health Integration: Co-location is not integration. Documentation in a single EHR and other metrics of meaningful integration must be met. This includes being able to capture behavioral health utilization from within the physical health practice.**
6. **Quality Improvement: The practice must be engaged in regular reportable quality improvement activities and demonstrate improvement in designated patient populations.**

Capitated Behavioral Health Benefit

RECOMMENDATION: HEALTH AND BEHAVIOR CODES

Recommendation—Health and Behavior Codes: We recommend that the health and behavior codes be added as a fee-for-service benefit. Addition of six behavioral health visits out of primary care does not replace the need for health and behavior codes to address behavioral health aspects of acute and chronic medical conditions.

Rationale: Health and behavior codes would enable clinicians to provide necessary counseling and treatment for medical conditions and diagnoses (e.g., weight management/obesity, asthma, congenital anomalies, developmental diagnoses, feeding disorders, sleep disorders) that can have long-term effects for healthcare costs and outcomes. These behavioral health interventions need to be delivered within health care settings by licensed behavioral health providers (or license-eligible trainees under the supervision of a licensed clinician) billing health and behavior codes on a medical diagnosis, not a mental health diagnosis. For example, counseling an adolescent on weight management is a high value activity that will result in significant long-term savings to many systems.

RECOMMENDATION: SIX BEHAVIORAL HEALTH VISITS

Current Language: 3.3.13.2.2 "The Department will increase access to low acuity behavioral health interventions by encouraging the delivery of behavioral health within primary care settings. Low acuity behavioral health treatment delivered in primary care settings may be reimbursed Fee-for-Service for up to six (6) sessions per episode of care. These sessions will not require a covered behavioral health diagnosis. Additional sessions will require authorization from the RAE for reimbursement through the Capitated Behavioral Health Benefit."

PRIORITY Recommendation—Six Behavioral Health Visits:

We strongly support the availability of six behavioral health sessions without a covered behavioral health diagnosis as this is the primary way that the draft RFP contemplates expanding access to behavioral health services in the next iteration of the ACC program. This program change is especially important for children who may not yet have a covered diagnosis but could benefit from behavioral health services. Allowing these six behavioral health visits in primary care settings will dramatically improve access to these services for Medicaid clients. We are confident that with care coordination and data support provided by the RAEs, information from these visits will be able to be shared across health care providers as necessary and appropriate while protecting patient privacy.

We recommend eliminating the "low-acuity" terminology because it is subjective and unclear. Further, we support the delivery of the right type of care in the appropriate setting and think that any issue that can be treated in a primary care setting over a defined period of time should be allowed to be treated in these visits, regardless as to the acuity of the issue. A client could have an acute but short-term need that could be met by these services.

We also recommend specifying that these visits allow for dyadic visits for a caregiver and baby together when mother demonstrates symptoms of depression or anxiety.

We also recommend that the six behavioral health psychotherapy sessions be provided by a licensed behavioral health clinician (or license-eligible trainees under the supervision of a licensed clinician).

Therefore, we recommend adjusting the language as follows: "The Department will increase access to behavioral health interventions by encouraging the delivery of behavioral health within primary care settings by a license-eligible behavioral health practitioner. Behavioral health treatment, including dyadic behavioral health intervention for infants and young children with their parents present, delivered in primary care settings may be reimbursed Fee-for-Service for up to six (6) sessions per episode of care. These sessions will not require a covered behavioral health diagnosis. Additional sessions will require authorization from the RAE for reimbursement through the Capitated Behavioral Health Benefit."

We appreciate the wording that the six visits limit will be per episode of care. We would like to clarify that the episode is determined by the treating provider. We also recommend revising Appendix N so that the reference to six visits per fiscal year is removed.

RECOMMENDATION: PRIMARY DIAGNOSIS

Current Language: 5.12.5.6.2 The Contractor's responsibility for all inpatient hospital services is based on the primary diagnosis that requires inpatient level of care and is being managed within the treatment plan of the Member.

Recommendation—Primary Diagnosis: The RFP describes a Medicaid delivery system that continues to rely on covered diagnoses; which features a primary diagnosis requirement very similar to the current system. Without a change to this requirement, children will continue to be denied services they need whenever their primary diagnoses are physical in nature— including those diagnoses related to autism, Substance Use Disorders (SUD), or developmental/intellectual disabilities. It would be best if the Regional Accountable Entities (RAEs) have a requirement to cover behavioral health services in all settings, irrespective of whether other diagnoses are present.

Rationale: Without a change, this continues to perpetuate many of the same issues that Medicaid clients are currently experiencing. The reasons are twofold. First if the BHO determines a lower level of care is appropriate, but that level of care isn't immediately available, the BHO may make the child wait until the lower level of care is available, rather than approving access to the higher level of care that is available immediately. Second, because BHOs often make treatment decisions, rather than a rendering provider, patient treatment and placement beyond stabilization and screenings often has to wait until the managed care organization weighs in. This can mean many hours in an ER or other situations (e.g., returning home and waiting for an "opening" in the approved level of care) that are not ideal for a client.

RECOMMENDATION: OUT OF NETWORK SERVICES

Current Language: 5.12.6.9 "If the Contractor is unable to provide covered behavioral health services to a particular Member within its network, the Contractor shall adequately and timely provide the covered services out-of-network at no cost to the Member."

Recommendation—Out of Network Access Requirements: We recommend removing the "adequately and timely language" at 5.12.6.9. and adding, "ensure provision of the service by a qualified clinician while meeting the same standards of timeliness as required of in-network providers" so the section reads, "If the Contractor is unable to provide covered behavioral health services to a particular Member within its network, the Contractor shall ensure provision of the service by a qualified clinician while meeting the same standards of timeliness as required of in-network providers at no cost to the Member."

Rationale: Limits to the network should not be a reason for failure to meet the timeliness standards. It is up to the Contractor to ensure network adequacy and approve access to care when the network does not meet a Member's needs.

RECOMMENDATION: PREVENTION/EARLY INTERVENTION

Current Language: 5.12.5.7.1 "The Contractor shall provide or arrange for the following 1915(b)(3) Waiver services to Members in at least the scope, amount and duration proposed in the Uniform Service Coding Standards (USCS) Manual. All 1915(b)(3) services provided to children/youth from age 0 to 21, except for respite and vocational rehabilitation, are included in the State Plan as Expanded EPSDT services: Vocational Services, Intensive Case Management, Prevention/Early Intervention, Clubhouse and Drop-in Centers, Residential, Assertive Community Treatment, Recovery Services, Respite Services.

PRIORITY Recommendation—Move BH Prevention/Early Intervention to Fee For Service: We recommend the State remove Early Intervention and Prevention from the behavioral health capitation and offer it as a state plan service, in addition to the six visits discussed above, and define the behavioral health early intervention and prevention services required.

These services include activities such as:

1) **Screening, identification, triage, intervention, and referral when concerns or delays are identified using standardized screening protocols; Specifically, postpartum depression screening, developmental screenings, ACES and MCHATS should be reimbursed in the frequency that is clinically recommended and at appropriate reimbursement levels.**
2) **Health promotion services that support the development of nurturing relationships between caregivers/parents and children, provide anticipatory guidance and support around typical developmental issues, and help address psychosocial complexity before it impacts well-being;**
3) **Prevention efforts that provide a higher level of services and supports to families identified as being at risk or vulnerable because of child, family, or environmental factors that could negatively impact development; and**

4) **Early childhood behavioral health intervention services provided by a qualified workforce of behavioral health professionals for those families identified as having complex needs and/or with identified adversity and behavioral health needs.**
5) **Proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive behavioral health. Services include behavioral health screenings; educational programs promoting safe and stable families; senior workshops related to aging disorders; and parenting skills classes.**

Rationale: Early Intervention and Prevention services for children are not presently being offered adequately, and the proposed RFP does not change the offering. In addition, the focus on the provision of high-acuity services in the next iteration of the capitation makes the future network potentially even less effective at Prevention and Early Intervention. Prevention and Early Intervention services may be better provided by providers outside of the specialty behavioral health network since this work requires specialization and training beyond the scope of what licensed behavioral health professionals are required to have and the services are often delivered in community settings including primary care, early care and education, social service programs (e.g., WIC offices), and homes (e.g., home visiting). This should include opening H codes as a fee-for-service billing mechanism to allow for assessment of need/suitability for services, psycho-education and counseling around health and well-being, group-based service delivery, and community engagement, all without requiring a behavioral health diagnosis.

Data, Analytics and Claims Processing Systems

RECOMMENDATION: CARE COORDINATION TOOL

Current Language: 5.13.2.1.1 "The Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. The Contractor shall make it available for use by providers and care coordinators not currently using another tool."

Recommendation—Care Coordination Tool: We recommend that preference be given to bidders that provide a plan for or are positioned to move in the direction of universal interoperability with regard to the collection and sharing of information across medical and non-medical systems, including oral health care providers, EPSDT, Early Intervention Colorado, home visitation programs, school-based health clinics, the Colorado Department of Education, Colorado Department of Human Services, Colorado Department of Public Health and Environment, the immunization registry, and child care and early learning settings.

The care coordination tool should potentially be accessible to clients as well as healthcare providers.

Further, we recommend that screening outcomes and referrals to additional services should be captured in a care coordination tool so that necessary information is shared with all members of a client's health team to reduce unnecessary and duplicative screenings.

Rationale: We support the proposal for a care coordination tool that allows for the collection and sharing of information across systems, and recognize that such a tool must be interoperable with electronic medical records and other systems in order to function in a way that is useful across provider types. If the function of this tool is to enhance care coordination (rather than just track it) then it must be able to transmit information in order to support the delivery of care.

Outcomes, Quality Assessment and Performance Improvement Program

RECOMMENDATION: KEY PERFORMANCE INDICATOR EVALUATION

Recommendation—KPI Evolution: The current contract reads such that the KPIs would remain the same over the course of the contract. If the program is successful, ability to improve on some of the KPIs will likely plateau before seven years. After a reasonable period of percentage improvement, measures should become discrete benchmarks. Maintenance of benchmarks should be a prerequisite for future payment incentives. We recommend the following language, "Reimbursement to be based on percent improvement until a benchmark is met. At that time, those KPIs will become a prerequisite or gate for receiving any incentive payment and new KPIs will be added."

A percent improvement for seven years does not allow for the possibility that some peak performance is reached. Keeping the KPIs static until 2025 does not allow the state to adjust for new priorities.

RECOMMENDATION: NUMBER OF KEY PERFORMANCE INDICATORS

Current Language: 5.14.4.8.1.1.1 The Contractor shall work to improve performance for up to nine Key Performance Indicators (KPIs) in order to earn performance payments. The KPIs will consist of eight (8) measures defined by the Department, plus one (1) measure that the RAE can choose from a list of options offered by the Department.

Recommendation—Number and Types of KPIs: We recommend fewer than 9 KPIs to allow for focus on the part of the RAEs and providers. We recommend that as the Department evolves the measures, they continue to identify measures that are specific and unique (not composites of many measures) and that are developmentally-relevant and age appropriate.

Rationale: Too many measures dilutes focus. Clarity in measures and accessible goals bring both administrative efficiencies and clinical efficacy.

RECOMMENDATION: TYPES OF KEY PERFORMANCE INDICATORS

Recommendation—Types of KPIs: We recommend that KPIs for RAEs and providers should be aligned with the criteria for Alternative Payment Methodology tiers, to allow for focus on the part of the RAEs and providers.

Rationale: Too many sets of measures dilute focus. Clarity in measures and accessible goals bring both administrative efficiencies and clinical efficacy.

RECOMMENDATION: WELLNESS KPI SPECIFICITY

Current Language: 5.14.4.8.1.1.2.3 "Wellness visits – Members of all ages and populations with at least 90 days of continuous program enrollment that have had a well visit within a rolling twelve (12) month period."

PRIORITY Recommendation—Wellness KPI Definition: We recommend that the wellness visits measure KPI be more specific: Most adults and older children should be measured for visits, but for children under six, the indicator should be developmental screening, and for pregnant and postpartum women, the measure should be receipt of a depression screen.

Rationale: Developmental and depression screenings occur within the context of a wellness visit and so would capture both the presence of a wellness visit and the quality of that visit for these key populations. This also allows for a focus on pregnancy-related depression screening, in alignment with several other state initiatives. Children six months of age who had documentation of a maternal depression screening for the mother is a State Innovation Model (SIM) quality measure. The state's 2016-2020 Maternal and Child Health Needs Assessment identified women's mental health including pregnancy-related depression as a priority area. The state has also identified maternal depression as a component of one of Colorado's ten winnable battles: mental health and substance abuse. The U.S. Preventive Services Task Force recommends universal screening for depression in pregnant and postpartum women, noting that even studies of the effect of screening plus "minimal additional intervention" have shown reductions in postpartum depression at follow-up.

RECOMMENDATION: BEHAVIORAL HEALTH ENGAGEMENT

Current Language: 5.14.4.8.1.1.2.4 "Behavioral health engagement – Members engaged in behavioral health services delivered either in primary care settings or under the Capitated Behavioral Health Benefit within a twelve (12) month rolling period."

PRIORITY Recommendation—Behavioral Health Engagement KPI: Rather than behavioral health engagement, we recommend measuring age and stage appropriate behavioral health screening, specifically encouraging pregnant and postpartum women to receive a depression screen.

Rationale: Since behavioral health engagement is already held to payment under the capitation, it makes sense to have "medical" portion of the funding tied to those indicators influenced by medical factors. As with the recommended measure above, this change would also allow for a focus on pregnancy-related depression screening, in alignment with several other state initiatives. Children six months of age who had documentation of a maternal depression screening for the mother is a State Innovation Model (SIM) quality measure. The state's 2016-2020 Maternal and Child Health Needs Assessment identified women's mental health including pregnancy-related depression as a priority area. The state has also identified maternal depression as a component of one of Colorado's ten winnable battles: mental health and substance abuse. The U.S. Preventive Services Task Force recommends universal screening for depression in pregnant and postpartum women, noting that even studies of the effect of screening plus "minimal additional intervention" have shown reductions in postpartum depression at follow-up.

RECOMMENDAITON: INFLUENZA VACCINE

Current Language: 5.14.4.8.1.3.1 "The Contractor is responsible for improving network performance on core health and cost measures that will be reported publicly on a quarterly basis."

Recommendation— Add Influenza Vaccine to Public Reporting Measures: We recommend adding the influenza vaccine to the list of public reporting measures.

Rationale: Influenza vaccine is not only important for the health of the child but also for the health of the family and peers. It can reduce ER visits and days missed from work and school.

RECOMMENDATION: BH PERFORMANCE MEASURES

Current Language: 5.14.4.9.1.1 "To be paid the base capitation rate (and not penalized) the RAE must meet standards for the following measures:

- Suicide risk assessment for major depressive disorder in children and adolescents
- Suicide risk assessment for major depressive disorder in adults
- Hospital readmissions at 7, 30, and 90 days
- Hospital readmissions at 180 days
- Adherence to antipsychotics for individuals with schizophrenia
- Penetration rates
- Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication
- Inpatient utilization
- Emergency department utilization for a mental health condition
- Follow-up appointments after emergency department visits for a mental health condition
- Follow-up appointments after emergency Department visits for a mental health condition or alcohol and other drug dependence"

5.14.4.9.1.1.3.1 "The Contractor's rate can be set higher if they meet or exceed the following metrics

- Mental health engagement
- Initiation of alcohol and other drug dependence treatment
- Engagement in alcohol and other drug dependence treatment
- Follow-up appointments with any practitioner within 7 and 30 days after hospital discharge for a mental health condition
- Follow-up appointments with a licensed behavioral health practitioner within 7 and 30 days after hospital discharge for a mental health condition"

Recommendation—BH Performance Measures: We recommend identifying measures that would better capture the performance of the system and more specifically focus on the needs of children such as the percent of positive behavioral screens receiving care, the percent of children engaged in behavioral health care who have also received appropriate physical health care, parent report of

school success (expulsions, suspensions, detentions, passing rates), time to intervention from referral, and time to BHO disposition and eligibility (determination of coverage).

Rationale: The current metrics do not measure some of the areas where the system has been less effective and does not focus on pediatric well-being or indicators of adequate care.

Start-Up and Close-out Periods

NO RECOMMENDATIONS

Additional Statement of Work Activities

RECOMMENDATION: WRAPAROUND

Current Language: 6.2.2 The Contractor's Wraparound Program shall consist of high-fidelity Wraparound Care Coordination and parent/caregiver peer support in alignment with the state's System of Care and the evidence-based model detailed within the book Building Systems of Care: A Primer (2010).

6.2.3.1.1 "Must meet diagnostic criteria for Serious Emotional Disturbance or Serious and Persistent Mental Illness, the disorder must substantially interfere with the youth's functioning, be taking multiple psychotropic medications, have a high likelihood of out of home placement, receive services from multiple providers or state agencies and voluntarily chooses to participate."

Proposed Reimbursement is $800 to $1,000

Recommendation—Wraparound: We strongly recommend the inclusion of the Wraparound Additional Statement of Work as a bidding requirement in order to ensure that contracted RAEs are able to take on this additional work. We recommend insuring that financial incentives for this component of the work align with the expected delivery of services and outcomes and that reimbursement is sufficient to support this additional work.

Compensation

RECOMMENDATION: ALLOCATION OF FLEXIBLE FUNDING POOL

Current Language: 3.3.15.4.2 "Flexible Funding Pool: This pool will be created from any monies not distributed for KPIs and will be used to reinforce and align evolving program goals."

PRIORITY Recommendation—Flexible Funding Pool: We recommend adding the following language: "The use of the Flexible Funding Pool funds will be approved by the Statewide Program Improvement Advisory Committee. The funds must be used to encourage innovative upstream interventions that address risk and protective factors as well as the social determinants of health."

Rationale: The State PIAC's authority over spending the flexible funds would ensure that these funds are used to strategically meet community needs.

RECOMMENDATION: ADMINISTRATIVE PAYMENTS

Current Language: 5.10.9.1 "The Contractor shall distribute, in aggregate, at least thirty percent (30%) of the Contractor's administrative PMPM payments received from the Department to their PCMP network **and Health Neighborhood."**

Recommendation—Administrative Payments: We recommend adding the following language: "At least some of those funds must be distributed to Health Neighborhood beyond PCMPs." We also recommend that the Department continue to seek ways to ensure that the funding in the Medicaid program is aligned with the areas where there is the greatest return on investment and that there continues to be increases in resources allocated to primary care (including primary behavioral health care) and decreases in investments in secondary and tertiary care.

Rationale: Currently specialists and other non-primary care providers are not financially tied to the ACC in any way. Distributing some funds to the broader health neighborhood is an important step to seeking their engagement.

Thank you for the opportunity to provide comments and recommendations regarding the Draft RAE RFP.

Sincerely,

All Kids Covered and the undersigned organizations

American Academy of Pediatrics - Colorado Chapter
Children's Hospital Colorado
Colorado Children's Campaign
Colorado Children's Healthcare Access Program
Colorado Coalition for the Medically Underserved
Colorado Consumer Health Initiative
Colorado Covering Kids and Families
Gary Community Investment Company
Piton Foundation
The Consortium