October 11, 2023

Dear BHA,

Thank you and to other BHA staff for the excellent report, "Administrative Burden CCAR/DACODS Modernization at the BHA." It's apparent that a great deal of resources were applied to get stakeholder input and that the BHA is taking this challenge seriously.

https://docs.google.com/document/d/1f6shodjGmEewwc85Yd7FZ0VEJBAI4WkkDKNUTXawNVs/edit#heading=h.i4hl772rax8q

It is not my intention to throw the baby out with the bathwater, and I generally agree that the state needs statistics to monitor the system.

While patient volume, treatment length, changes in level of care, and outcome measures are key, COMBINE is aware that there is not a parallel effort to gather statistics about the workforce or how the workforce is managed by the RAEs and other organizations that contract and employ providers. That idea is outside of the scope of the effort before us and perhaps beyond the scope of the BHA itself. Pardon my digression.

Know that there are key statistics, namely the number and names of actual providers, that have been disregarded for years. The state simply does not know, and does not ask for, quantities or identities of rendering outpatient providers who are operating under supervision (candidate licenses and university interns). There is no effort to establish a baseline about the capacity of the workforce and therefore no real way to measure the impact of policy. It is our assumption, for lack of data, that pre-licensure supervised work is a significant portion of Medicaid outpatient care.

Until the state takes on the task of accurately describing and measuring the workforce, we are sceptical of other demands for statistics and reporting. We would like efforts by the state and by the workforce to be mutual, according to our abilities and resources.

COMBINE advocates versus situations that will cause independent outpatient providers to question Medicaid participation, and therefore safety net participation. Margins are tight, reimbursement is low, and expenses are high, so administrative burdens become important. Our clinics do not have administrative staff like CMHC centers do, as you know.

CCAR was always an obstacle to provider recruitment and it was an advance when RAEs, with HCPF support, agreed to not require CCARs. This reduced a serious barrier to recruitment.

In the following years, since then, the RAEs and HCPF have justified the decision by describing the information that is collected through the 1500/837P, which we submit for every clinical session. From page 8, I infer that the BHA understands this. All 837P data winds up in the CIVHC APCD database, as far as we know.

Regarding this document, we would like to see an acknowledgement that a tremendous amount of care has happened since 2019 through the RAEs without any CCAR tracking. Perhaps a paragraph about the RAE situation would be sufficient to acknowledge that a large part of the mental health care system (over 1/2 of outpatient care) has not participated in CCARs for years. HCPF, RAEs, or CIVHC should be able to produce statistics if necessary.

Medicaid and the independent provider network would most likely be moot in this conversation, except for the growing pressure from consumer advocates for our clinics to be licensed by the BHA, which will mean these CCAR policies become our policies (unless there is an exemption). Our larger clinics (e.g., mine, Boulder Emotional Wellness) are already licensed as Community Mental Health Clinics, and more clinics are seeking that licensure.

We request that CCAR is not required for non-SUD outpatient care, as this is essentially the status quo, and data collection happens through 1500/837P.

We appreciate this mention of a consequence of the current system : "Disincentivizing new providers from entering the public behavioral health workforce due to the high and inequitable administrative burden they experience when compared to the private sector."

If data is sought beyond what is collected in the 837P/1500, non-intrusive outcome measures will require creativity and nuance, and will differ at different levels of care and for different types of care. Previous to this career, I was a high school special education teacher in a political environment that wanted to tie my compensation (in part) to my students' academic gains, measured by multiple choice, machine scored exams. This was of course a threat to special education teachers in underfunded environments with students who would react to standardized testing.

COMBINE stands ready to participate and assist in designing processes where quality and safety can be measured and monitored in a fair way, with as little administrative burden as possible, and we are glad to see the commitment to an open process by the BHA. I am reminded of Dr. Medlock's assertion that asking clients a single question, "would you recommend this provider to a family member," is a reliable and valid measure.

In conclusion, I very much appreciate the nod to pragmatism represented here, "At the end of the engagement process we should be left with only data entries that we can solidly defend."

In kind regards,

Andrew Rose, Policy Committee Chair, COMBINE, combinebh.org