Challenges and Findings

Network Adequacy Document Review for Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Gilpin, and Jefferson counties. (RAE 3, 5, 6, 7)

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COMBINE is a non-partisan small donor political committee supporting the Medicaid behavioral health workforce. COMBINE reviewed the network adequacy reports posted by Dept of HCPF in February 2021. These reports are generated by the RAEs and then provided to HCPF, who then post to the website.

The heart of Medicaid mental healthcare is the workforce. Ultimately whether the program will serve the members or not is based on provider participation.

There are many key metrics to measure the success of Medicaid mental healthcare, and different ways of measuring success. Provider count is an important metric, particularly when policy changes can lead to increases and decreases in participation. Importantly, member count can be divided by provider count to produce a ratio that can be used for comparison with other parts of the state and country.

COMBINE investigated two hypotheses using this data. First, a 20% cut to reimbursement reduced the number of providers willing to participate, and second, Colorado Access restricts care by prohibiting pre-licensure counselors providing service, creating inequity versus other parts of the state.

The questions for this set of data are how did provider counts change after the 20% cut to reimbursement rates in January of 2020 in RAE 6 and 7? And what's the difference in member/provider ratios between regions managed by Colorado Access and other regions?

What about member/provider ratios?

Members per provider statistics allow for comparison and also a sense of ease or difficulty accessing care. If the number is high, then access to care is harder. For comparison here's research on these ratios from around the country [1]

> "In Massachusetts, there is a mental health provider for every 180 residents, which marks the best ratio in the nation. On the other end of the spectrum is Alabama, which has the nation's worst ratio at 1,100 residents for every one mental health provider. Texas, West Virginia, Georgia, Arizona, Tennessee, Mississippi and Iowa are the others states that have ratios of 700:1 or worse."

Member/Provider ratios for selected states (best, worst)

Massachusetts	1:180
Oregon	1:210
District of Columbia	1:220
Maine	1:220
Vermont	1:230
Alaska	1:260
Arizona	1:790
Georgia	1:790
West Virginia	1:830
Texas	1:960
Alabama	1:1100

What is the Member/Provider ratio required by Medicaid mental healthcare contracts in Colorado?

Currently the RAEs are required to operate a network with 1 provider for every 1800 members.[2]

> 9.4.11.4. Adult mental health providers: One (1) practitioner per eighteen hundred (1,800) adult Members.

RAEs may meet this 1 counselor per 1800 people easier than if the ratio was more aligned with national standards, claiming network adequacy without measuring up to other parts of the country.

What's required in these reports?

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[1] https://ct.counseling.org/2019/10/maldistribution-mental-health-care-in-america/, retrieved Feb 16, 2021
[2] https://www.colorado.gov/hcpf/health-first-colorado-managed-care-contracts, retrieved Feb 16, 2021

The reports are known as “deliverables” in the contract [3] between each RAE and HCPF. The contracts require reporting, and describe what’s to be reported. Generally, deliverables are to be high quality, as in:

> 3.7.3. Contractor shall employ an internal quality control process to ensure that all Deliverables are complete, accurate, easy to understand and of high quality. Contractor shall provide Deliverables that, at a minimum, are responsive to the specific requirements for that Deliverable, organized into a logical order, contain accurate spelling and grammar, are formatted uniformly, and contain accurate information and correct calculations. Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing Deliverables for reference as directed by the Department.

The annual plan is described here:

9.5. Network Adequacy Plan and Report
9.5.1. The Contractor shall create a single Network Adequacy Plan that contains, at a minimum, the following information for both its PCMP and Behavioral Health Network.
9.5.1.1. How the Contractor will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract for all Members, including those with limited English proficiency and Members with physical or mental disabilities.
9.5.1.2. How the Contractor will ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
9.5.1.3. Number of Network Providers by provider type and areas of expertise particularly:
9.5.1.3.1. Adult primary care providers.
9.5.1.3.2. Pediatric primary care providers.
9.5.1.3.3. OB/GYN.
9.5.1.3.4. Adult mental health providers.
9.5.1.3.5. Pediatric mental health providers.
9.5.1.3.6. Substance use disorder providers.
9.5.1.3.7. Psychiatrists.
9.5.1.3.8. Child psychiatrists.
9.5.1.3.9. Psychiatric prescribers.
9.5.1.3.10. Family planning providers.
9.5.1.4. Number of Network Providers accepting new Medicaid Members by provider type.
9.5.1.5. Geographic location of providers in relationship to where Medicaid Members live.
9.5.1.6. Cultural and language expertise of providers.
9.5.1.7. Number of providers offering after-hours and weekend appointment availability to Medicaid Members.
9.5.1.8. Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the Department to ensure standards are being met and maintained across the Contractor’s provider network.

[3] Ibid.

9.5.1.9. Case load for behavioral health providers.
9.5.1.10. Number of behavioral health providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region.
9.5.1.11. A description of how the Contractor's network of providers and other Community resources meet the needs of the Member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.
9.5.2. The Contractor shall submit the Network Adequacy Plan to the Department.
9.5.2.1. DELIVERABLE: Network Adequacy Plan
9.5.2.2. DUE: Annually, on July 31.

The quarterly report is also described as:

9.5.3. The Contractor shall create a Network Report to the Department on a quarterly basis. The Network Report shall contain, at a minimum, the following information:
9.5.3.1. Percent of PCMPs accepting new Medicaid Members.
9.5.3.2. Percent of behavioral health providers accepting new Medicaid Members.
9.5.3.3. Percent of PCMPs offering after-hours appointment availability to Medicaid Members.
9.5.3.4. Percent of behavioral health providers offering after-hours appointments.
9.5.3.5. Performance meeting timeliness standards.
9.5.3.6. Number of behavioral health provider single-case agreements used.
9.5.3.7. New providers contracted during the quarter.
9.5.3.8. Providers that left the Contractor's network during the quarter.
9.5.3.9. Additional information, as requested by the Department.
9.5.4. The Contractor shall submit the Network Report to the Department.
9.5.4.1. DELIVERABLE: Network Report
9.5.4.2. DUE: Quarterly, on the last Business Day of July, October, January, and April.

Delayed data.

COMBINE has monitored the HCPF Deliverables[4] web page since the first RAE reports were posted. Reports were quarterly as appropriate for a time. However, after October of 2019, also around the time providers were notified of the 20% cut, the site was no longer updated.

In January of 2021, additional documents were posted. There is more data to come, as the current document set is incomplete.

Document naming conventions.

HCPF provides three types of documents: annual plans, quarterly reports, and spreadsheets with provider rosters. Herein those documents are referred to by their fiscal year and quarter

[4] Retrieved February 16, 2021
https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-deliverables

and type. “1819 Q1” refers to the first quarter report for fiscal year 2018-2019. The annual plans are referred to by year, as in “1819 Plan”. Spreadsheets are called by year and quarter plus “sheet” as in “1920 Q2 sheet”.

Analysis challenge - Confusing document dates.

Several (RAE 5, 6, 7) quarterly reports from 1819 Q1, Q2, and Q3 state “April 24, 2018” and “March 29, 2018” as report dates. These dates are before the reporting periods, as Q1 18-19 begins July 2018. One document, RAE 6 1819 Q1, has two different dates on different pages of the document.

Analysis challenge - Provider count versus Available Provider count

HCPF contracted the RAEs to provide “Number of Network Providers accepting new Medicaid Members” and compliance with this contract obligation varies.

For example, RAE 5 (Denver - Colorado Access) 1819 Q1, Q2, Q3, and Q4 reports offer no count for providers accepting new clients. However, in 1819 Q1 sheet (a spreadsheet), the number of providers accepting new clients can be derived.

The reported numbers are 690, 729, 822, and 831 in respective 1819 quarters. The provider count for available providers is 354, 378, 452, and 510.

Analysis challenge - Count methodology change from 18-19 to 19-20.

Some RAEs (RAE 6 and 7, Anthem and RAE 3, Colorado Access) switched methods for counting and reporting provider numbers in the 2nd quarter of 19-20. The 20% cut to rates was announced around this time, in November of 2019, and then took effect January of 2020.

There are provider counts by county until 1920 Q2 when aggregated counts are offered, which are totals for the RAEs and not county by county provider counts. This increases the difficulty of comparisons quarter to quarter and year to year.

Analysis challenge - Inclusion of “Other Counties” in provider counts.

County by county data over time is what’s needed to understand network access and impacts of policy changes. Provider count comparisons over time are undermined by this change in reporting.

For example RAE 7 (Colorado Springs, Anthem) reports these provider numbers for adult mental health care providers in FY1819 by quarter: 491, 523, 552, and 606. Then, in a January 2020 report, the RAE reports 2,032 providers. In the next quarter they report 4,639 providers, essentially by including all providers statewide in their network.

Analysis challenge - Different data in Quarterly Reports vs Annual Plans.

We expect data in annual plans, due July 31 annually, to be the same as the Q4 report, also due at that time. However the reports provide different values for the same statistic.

For example, RAE 7 (Anthem Colorado Springs) reports 516 providers in the Plan, while reporting 606 providers in the Q4 report.
RAE 6 (Anthem, Boulder) reports 240 providers for Boulder County in their 2021 Plan, and 4,764 providers in their Q4 report, dated the same day.

Analysis challenge - Very large provider counts at facilities.

Irregularly, provider rolls are published as spreadsheets. RAE 3 (Adams, Arapahoe, Douglas - Colorado Access) provides such data for 1819 Q1, 2, and 4. Q3 shows physical medical providers rather than behavioral health. RAE 6 and 7 (Anthem) provides 1920 Q2 and Q3, and no others (as of Feb 16 2021).

Within these spreadsheets there are often presentations of individual providers and also facility providers. What confounds analysis is very large provider counts at single facilities.

For example RAE 6 1920 Q3 sheet shows 1929 providers at “Bruce Randolph Middle School-School Based Clinic”.

Analysis challenge - RAEs do not know how many providers they manage.

Operators of Medicaid behavioral healthcare clinics throughout the Front Range area routinely report that the RAEs do not ask for accurate counts of providers. While the contracted provider is queried quarterly about “accepting new clients”, the pre-licensure therapists, sub contracted licensed therapists, and university interns are not included in the count.

Analysis challenge - large redactions.

Several documents have large black squares over what appear to be maps displaying provider locations. This is not explained.

For example see RAE 7 FY1920 Plan, at the end of the document.

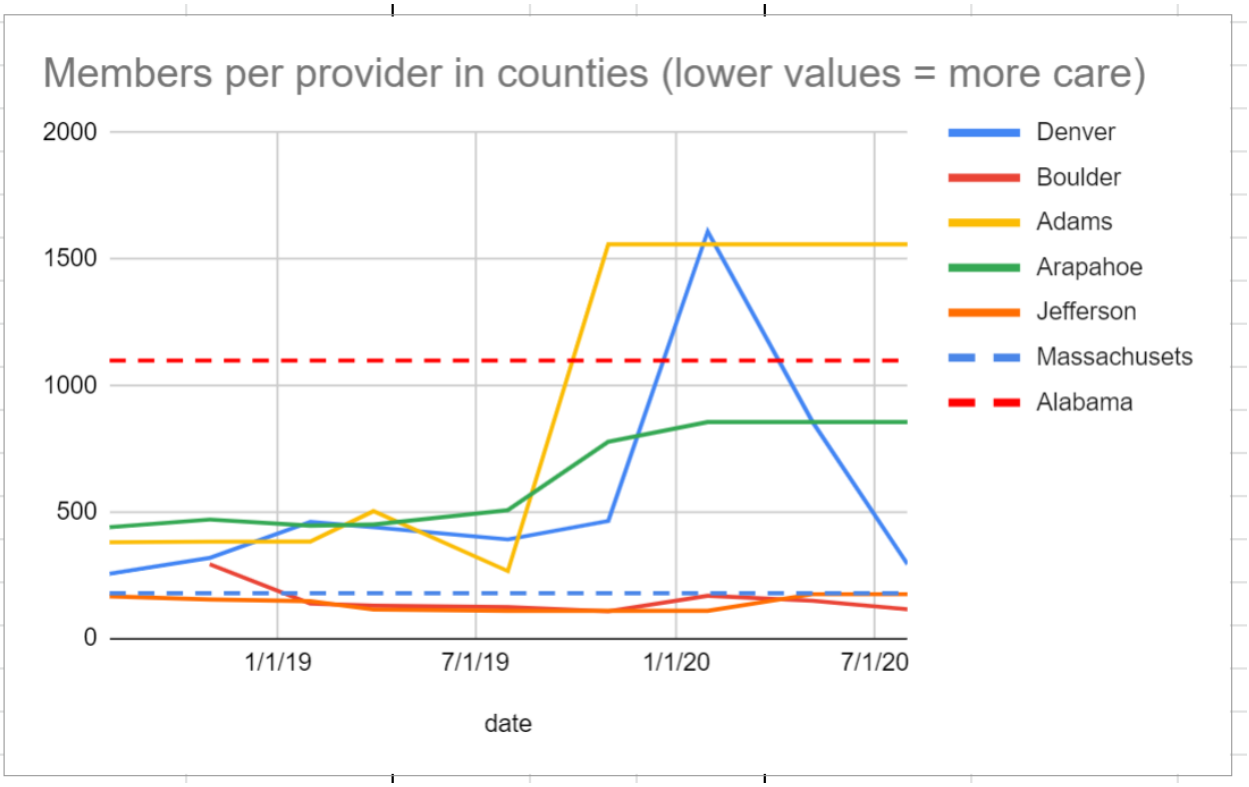
Evidence for Hypotheses?

Did provider counts drop after the 20% cut was announced around November 2019?

RAE 7 (El Paso, Teller, Park) Jan 2020 reports 741, then April 2020 reports 672 (1920 Q3 sheet, derived). They also report 919 providers in July of 2020 (2021 Plan) and 4,902 providers November 2020 (2021 Q1 report).

RAE 6 (Boulder, Jefferson, Broomfield, Gilpin, Clear Creek) shows 364 providers in Boulder County (10/19 in 1920 Q1) and then 240 providers for Boulder in July of 2020 (2021 Plan).

How about Members/Provider ratios for Denver, Arapahoe, and Adams versus other regions?



There are several assumptions made for this graph, due to unreported data. For instance, RAE 3 (Colorado Access) stopped producing provider counts by county 1920 Q2 (There is no Q3 report).

RAE 5 (Colorado Access - Denver) provider counts were derived from FY1819 and FY1920 spreadsheets which show a large drop in providers 1920 Q2, from 855 to 559, then a large gain in 1920 Q3 (559 to 781).

The vertical space between the RAE 6 counties (Anthem, orange and red Jefferson and Boulder lines) and the RAE 3 and 5 (Colorado Access, yellow, blue, and green Adams, Denver, and Arapahoe lines) indicates a gap between service access in Denver/Aurora and the west metro

(Boulder, Jefferson). The policy that prohibits pre-licensure counseling in Denver/Aurora contributes to this gap.

Recommendations

RAEs could provide timely county by county provider counts, not provide other county or statewide counts, use consistent methodology so counts are comparable, and disaggregate provider counts for 'accepting new clients' or 'not', as well as disaggregate by race, LGBT+, HH/D, gender, and other counselor provided demographics.

RAEs could provide provider and facility rosters each quarter rather than sporadically.

Counting providers is an easy problem to solve in 2021, through technology such as email and forms. Contracted providers could be asked weekly to simply update their provider count (including pre-licensure counselors) and which providers are available for clients. This process is happening for SUD clinic and inpatient bed availability and could be extended to Medicaid outpatient counseling.

When impactful policy changes occur, such as 20% cuts to reimbursement, or new prior authorization policies or other policies that add to administrative burdens, HCPF could track the impact of those changes.

The state could increase the required ratio of providers to members from 1 to 1,800 to a standard that would compare (favorably) with other states.