Oct 10 2020, Andrew Rose, text for legislation andrewroselpc@boulderemotionalwellness.org

Details for title changes for each of the asks.

#1. Network Adequacy Statistics plus fines for ignoring the law.

#2 Network Adequacy; Provider Ratios

#3 and #7) Prelicensure work and licensed work under a supervisor.

#4 : Prior Authorization rules, Extend HB 19-1211 to Title 25.5.

#5 Timely Credentialing : Extend SB21-126 to Title 25.5

#6 Continuity of care for graduating healthcare providers:

The asks

#1. Network Adequacy Statistics plus fines for ignoring the law.

See 25.5-5-410

https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=9737&fileName=10%20CCR%202505-10

Amend Section 25.5-5-410 to include (4)(a) In addition to any other data collection and reporting requirements, each managed care organization shall submit the following types of data to the state department or its agent, on a quarterly basis, disaggregated by county:

PCMPs accepting new Medicaid Members;
Behavioral health providers accepting new Medicaid Members;
Behavioral health providers accepting new Medicaid Members under the age of 13;
PCMPs offering after-hours appointment availability to Medicaid Members;
Behavioral health providers offering after-hours availability to Medicaid Members;
Behavioral health providers offering after-hours availability to Medicaid Members under the age of 13;
Performance meeting time and distance standards;
Number of behavioral health provider single-case agreements used;
New providers contracted during the quarter;
Providers that left the network during the quarter

(4)(b) MCEs will be fined $1000 per each day after 30 days after the reporting quarter while reports are undelivered or are incomplete.

#2 Network Adequacy; Provider Ratios

Note that DOI (Commercial) sets the ratio at 1:1000 for Colorado
See
https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=9696&fileName=3%20CCR%20702-4%20Series%204-2
Page 475 in section 4-2-53 where network adequacy is defined for commercial at 1:1000

Modify 25.5-5-406.1 (1)(h)

"(h) The MCE shall meet the network adequacy standards, as established by the state department, describing the maximum time and distance an enrolled member is expected to travel in order to access the provider types covered under the state contract;"

To
(h) … "as established by the state department and minimally providing 1 Mental health, behavioral health and substance use disorder care provider per 1000 adult members and 1 Mental health, behavioral health and substance use disorder care provider per 500 children under 13 years of age,

#3 and #7) Prelicensure work and licensed work under a supervisor.

Note that the medical side has explicit protection for pre-licensure work: 25.5-4-402.5. "Providers--state university teaching hospitals" For Parity compliance, pre-licensure work on the behavioral health site deserves protection.

For Medicaid:

Amend Section 25.5-5-406.1 - Required features of statewide managed care system to include

(1) (u) Each MCE must reimburse for care provided by pre-licensure or licensed providers who operate under supervision of a qualified licensed supervisor, when the care is billed through the supervisor's license and NPI number.

For commercial:

Amend
§ 10-16-107.7. Nondiscrimination against providers.

"(1) A carrier offering an individual or group health benefit plan in this state shall not discriminate with respect to participation under the plan or coverage against any provider who is acting within the scope of his or her license or certification under applicable state law."

To read

(1) A carrier offering an individual or group health benefit plan in this state shall not discriminate with respect to participation under the plan or coverage against any provider who is acting within the scope of his or her license or certification under applicable state law. A carrier must reimburse for behavioral healthcare provided by pre-licensure or licensed providers who operate under supervision of a qualified licensed supervisor, when the care is billed through the supervisor's license and NPI number.

OR Amend § 10-16-139. Access to care--rules

(5) Access to behavioral health professionals. A health benefit plan that is delivered, issued, renewed, or reinstated in this state on or after January 1, 2021, that provides coverage for behavioral healthcare services shall not prohibit the provision of services by qualified pre-licensure or licensed professionals who operate under supervision of a qualified licensed supervisor, when the care is billed through the supervisor's license and NPI number.

#4 : Prior Authorization rules, Extend HB 19-1211 to Title 25.5.

Introduce a new section to 25.5-4 called “25.5-4-108. Prior authorization for health care services
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disclosures and notice - determination deadlines - criteria - limits and
exceptions - definitions - rules.
“

Enter text of HB19-1211 with these changes:

Where HB19-1211 refers to “10-16-112.5”, substitute “25-4-108”

Where HB19-1211 refers to “carrier”, substitute “any managed care system”

Delete Section 2 (B) “this does not apply to… “

#5 Timely Credentialing : Extend SB21-126 to Title 25.5

New title:
Was "Timely Credentialing Of Physicians By Insurers.
Concerning credentialing of physicians as participating physicians in health coverage plan provider networks, and, in connection therewith, making an appropriation."

Now:

"Timely Credentialing Of Health Care Providers By Insurers.
Concerning credentialing of health care providers as participating health care providers in health coverage plan provider networks"

Create 25.5-5-406.1 (1) (v ?) "Required features of statewide managed care system"
to include text of SB21-126 with these changes:

Change 10-16-705.7. to 25.5-5-406.1(1)(v)

Change "physician" to "health care provider"

Add to Definitions that "Carrier" include Managed Care Entities contracted by the state department.

Add to Definitions that "Health Care Professional" is any person licensed by the state to provide health care.

Section 2 Appropriations could give HCPF some $ for oversight. (?)

#6 Continuity of care for graduating healthcare providers:

Amend 12-245-208(1) - Provisional license - fees (in Mental Health Practice Act)

(1) (a) The board may issue a provisional license to an applicant who has completed a post-graduate degree that meets the educational requirements for licensure in section 12-245-304, 12-245-404, 12-245-504, 12-245-604, or 12-245-804, as applicable, and who is working in a residential child care facility as defined in section 26-6-102(33) under the supervision of a licensee.

Add :
(b) The board must issue a provisional license to an applicant who will complete a post-graduate degree that meets the educational requirements for licensure in section 12-245-304, 12-245-404, 12-245-504, 12-245-604, or 12-245-804, as applicable, after the board certifies that the degree requirements satisfy the educational requirements and upon receipt of a completed application that includes confirmation by a universit official that the applicant is likely to graduate.

The asks

1) There is no oversight without statistics. HCPF and the RAE managed care orgs are obligated to report the # of providers every quarter. These reports have become useless and there is no way to tell if policy changes attract or repel providers. For instance CDPHE is about to spring a $2500 licensing fee on _every_ group clinic, a fee we never had to pay before. Without accurate statistics, we can't see the impact. The reports HAD county counts and then they disappeared. The evidence is in front of everyone on HCPF website (google "HCPF deliverables"). WORSE, there are missing financial reports. How can we know if our $ is being spent properly on care without these public reports being accurate?

Ask #1. Simple legislation mandating what's in those reports. There must be county by county counts of providers that are available to see clients.

2) The provider to member ratio in these Medicaid contracts between HCPF and Anthem, United Health, and Colorado Access are set entirely to low. These contracts ask the MCOs to provide 1 counselor for every 1800 people. According to KFF (Kaiser Family Foundation) reporting, the lowest provider ratio in the states is 1:1100 people (Alabama). Massachussets is highest at 1:180.

Ask #2. Provider ratio must increase. Pick a number, but please make it better than Alabama. If the managed care orgs cannot get these providers to come into their networks, they need to figure how and why and do something about it. They are getting millions$ from Colorado, they have the money to attract providers, but they easily satisfy this very very low provider member ratio so they just let the network degrade.

3) The "baby boomer cliff" is starting to impact the workforce as experienced leaders retire. We need work opportunities for early career therapists. They must be supervised properly and those supervisors need incentives to do that, as it's a lot of work and a lot of risk (I know this personally). There is currently a hodge-podge as Aetna, CIGNA, Friday, and Medicaid (Anthem, UHC) allow prelicensure care, while other carriers will not (notably Colorado Access, Anthem commercial, and UHC commercial).

Ask #3. All carriers must cover services provided by supervised pre-licensure clinicians.

4) Prior authorization (which we understand can be a way to manage overuse) was an absolute debacle in 2021. Anthem created a new program for all outpatient counseling in March of 2021, increasing our administrative costs dramatically. Our clinic had to hire help to do the paperwork. Then Anthem CANCELLED the program in September of 2021. Providers quit over the paperwork. Anthem approved nearly every request, but only for 13 weeks, creating an enormous paper drag. Prior authorization protections are already in Colorado law, but only for commercial insurance.

Ask #4. Extend prior auth rules already given to commercial providers to Medicaid. Extend HB 19-1211 to Title 25.5.

5) Contracting timelines dissuade participation. The moment a trained clinician expresses interest in Medicaid is rare. The first thing they find out is "hurry up and wait" for a contract. First there is weeks for "HCPF Validation." Then there are MONTHS of waiting for a contract from the Medicaid MCOs (Anthem, UHC, Colorado Access). Some are better than others.

Ask #5. Contracting time regulation as was created for physicians last session. See SB21-126.

INTO THE WEEDS. Here are some more abstract but very necessary fixes.

Continuity of care is interrupted by current red-tape. We need to support providers as they grow through their career. They need to continue caring for the clients they have as they change licensure status.

DORA has established a pathway for almost-graduating counseling grad students to obtain the "LPCC" (candidate counseling credential), allowing them to practice under supervision after graduation, however they only seem to have done this for Naropa.

Ask #6. DORA must allow all counseling programs (that meet CACREP equivalency) to have their students apply for LPCC before graduation. CACREP is the national accreditation group for counseling.

Currently insurers are requiring LPCs to have "their own contract" with the MCO. This is a nightmare for training centers and clinics when an LPCC finally gets their LPC. Essentially the clinician needs to stop work with their clients while they wait for contracts (which take a long time).

Ask #7. Carriers must allow LPCs to be supervised by LPCs while they wait for contracts, so they can continue to provide care for their clients.

Currently when a clinician leaves a workplace, where they have been seeing clients, and that workplace has been receiving $ for their work, there are two big problems. First, clients should have the right to continue seeing the clinician. Some Centers require the client to continue with the Center rather than the clinician. This interrupts care and is clinically inappropriate. The second problem is even though the clinician's work has been billed for, and the clinician is known to the insurance company, the carrier insists on a new contract.

Ask #8. Centers are prohibited from enacting policies that prevent clients from going with their therapist. If a client wants to follow a clinician, there should be no impediment.
Ask #9. If a licensed provider is known to a carrier, through their work at a group practice, the carrier must reimburse for work while the provider is waiting for a contract.

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Clawbacks are when the carrier decides to reimburse less than owed in order to 'clawback' some previously paid $. This system needs regulation as many other states have done. Carriers have 'retroactively disenrolled' members (going back as far as two years) and then simply reduced payouts in order to clawback money. WORSE, when the providers showed that they had verified eligibility, the carrier never paid back the $. (2007 reference https://www.cga.ct.gov/2007/rpt/2007-R-0205.htm)

Ask #10. Carriers are prohibited from "retroactively disenrolling" a member. Carrier may not clawback payments older than 18 months.

Colorado created some nice language with HB19-1269 (Parity) however the Parity law has become inconsequential. The only thing required is an annual report on Parity concerns, which HCPF is now producing in-house. So the department that is supposed to be regulated is regulating itself. Nobody can hold HCPF or Anthem, etc accountable and they just do what they want.

Ask #11. Amend HB19-1269 to provide for a "private right of action" so that if a carrier is violating parity (see MHPAEA), a provider or member has the right to file a motion in a district court.