Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans

About 20 percent of all Americans live with a behavioral health condition such as a mental health or substance use disorder, but only half of this population receives treatment—with direct consequences that include poor physical health outcomes, increased health care costs, and reduced quality of life and life span. Barriers to obtaining behavioral health treatment include inadequate insurance coverage, fragmented health care delivery, and less qualified and diverse behavioral health care providers than are necessary, both overall and in certain geographic areas. These pervasive barriers to treatment are most evident in populations receiving Medicare, Medicaid, and Marketplace insurance plans. These populations are both disproportionately likely to suffer from behavioral health conditions and more likely to be older adults, adults with disabilities, low-income individuals, and racial and ethnic minorities. Workforce issues are a major barrier to treatment for these populations, in part because challenges around adequate and prompt payment and appropriate training present disincentives for clinicians to service them.

Therefore, the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) asked the National Academies of Sciences, Engineering, and Medicine to convene a committee to examine the current challenges in ensuring broad access to high-quality behavioral health care services through Medicare, Medicaid, and Marketplace programs and propose strategies to address those challenges. The National Academies appointed an interdisciplinary committee of experts to conduct this analysis, and the committee’s report, Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans, presents its conclusions and recommendations.
Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans outlines nine recommendations to improve behavioral health care provider participation in these programs, but acknowledges throughout the report that America’s behavioral health care system is not providing equitable, appropriate, or accessible care to those who need it, so systemic reforms—beyond the scope of this report, outside of the targeted populations, and including explicit integration of physical and behavioral health care—are needed. The report’s recommendations fall under three overarching goals to expand behavioral health care provider participation in Medicare, Medicaid, and Marketplace plans and improve the behavioral health care system writ large: ease provider entry into these programs; make entry into these programs worthwhile for providers; and once providers are operating within the programs, support opportunities to provide better care and hold providers accountable for the care they provide. The report also emphasizes the pressing need to increase the diversity of the behavioral health workforce, as less than 25 percent of all behavioral health care provider types identify as racial or ethnic minorities. The report underscores that the goal should be for all behavioral health care providers to be culturally competent, and not rely on the racial and ethnic minority providers to solve the problem of health disparities.

CURRENT STATE AND CHALLENGES WITHIN THE AMERICAN BEHAVIORAL HEALTH CARE SYSTEM
The American behavioral health care system—encompassing care for both mental health and substance use disorders—was assembled in parallel with the physical health care system, and as such, the two systems have not realized the same efficiencies and reforms. Issues of fragmentation and inadequate reimbursement were partially addressed with health parity acts passed by Congress in 1996 and 2008, but enforcement and compliance remain challenging and result in additional barriers to treatment. These issues impact both patients—who may not be able to understand or access their insurance’s behavioral health coverage or who must pay for treatment entirely out of pocket—and providers who receive significantly lower and delayed reimbursement rates from insurance versus out-of-pocket payment. The behavioral health care system is especially challenging for children and adolescents and their families to access, as providers who specialize in youth are often geographically distant from those who need them, experience extremely high caseloads, or are hesitant to or restricted in accepting Medicaid, the largest insurer of children in the United States.

Even though a large portion of Americans who experience behavioral health challenges are insured by Medicare, Medicaid, or Marketplace plans, participating in those programs has historically been burdensome for behavioral health care providers—including issues like lower reimbursement, caring for more complex patients, and adhering to restrictive administrative guidelines. The report’s recommendations aim to reduce those burdens and incentivize behavioral health care providers to provide high-quality and culturally appropriate behavioral health care to those who need it most.

GOAL 1: EASE PROVIDER ENTRY INTO MEDICARE, MEDICAID, AND MARKETPLACE PLANS
The committee recommends four areas of focus to ease provider entry into these programs:

- appropriately funding focused training to ensure that clinicians are prepared and incentivized to treat Medicare, Medicaid, and Marketplace populations (see Recommendation 1 in the report),
- streamlining credentialing (see Recommendation 2 in the report),
- leveraging existing telehealth approaches and adopting innovative methods of care without compromising quality, value, or equity (see Recommendation 3 in the report), and
- promoting and easing approaches to obtaining multi-state licensure (see Recommendation 4 in the report).

Appropriately Funded and Focused Training
CMS and SAMHSA provide dependable, ongoing funding to support behavioral health provider training. However,
there is currently no requirement that those benefiting from taxpayer-funded training treat those supported by taxpayer-funded insurance programs—and much of this funding supports delivery sites or institutions rather than individual members of the workforce.

The report recommends a restructuring of these training mechanisms and funding to incentivize career trajectories that serve Medicare, Medicaid, and Marketplace populations (see Recommendation 1 in the report) and that these new mechanisms should be modeled on existing Health Resources and Services Administration programs that have shown to increase access to care for all Medicaid beneficiaries (see Recommendation 1-1 in the report). The report also recommends that behavioral health trainees be able to bill for services under the supervision of a licensed care provider—advancing parity between physical and behavioral health providers, as this is already possible for physician trainees (see Recommendation 1-3 in the report).

Streamlining Credentialing
Receiving the necessary licensure and credentialing to practice behavioral health is often a confusing and duplicative matrix of individual state and scope-of-practice laws and guidelines. Behavioral health care professionals often do not have the administrative support that physical health professionals do—especially those operating individual small clinics—so when coupled with lengthy and differing credentialing processes between insurance carriers and managed care companies, these requirements provide strong disincentives for providers to participate in public insurance plans.

The report recommends that CMS support and promote single state-wide platforms for credentialing and enrollment (see Recommendation 2-1 in the report), allow for data sharing between state and federal licensing agencies (see Recommendation 2-2 in the report), and allow enrollment in Medicare credentialing to carry over to Medicaid and vice versa (see Recommendation 2-3 in the report).

GOAL 2: MAKE PROVIDER ENTRY INTO MEDICARE, MEDICAID, AND MARKETPLACE PLANS WORTHWHILE
Once providers are working within Medicare, Medicaid, and Marketplace plans, the committee believes that the following three priority areas will help ensure that they will find their work worthwhile:

• reforming prior authorization practices and reducing associated administrative burden (see Recommendation 5 in the report),
• ensuring adequate and fair reimbursement (see Recommendation 6 in the report), and
• ensuring prompt payment for services rendered (see Recommendation 7 in the report).

Reforming Prior Authorization Practices and Reducing Administrative Burden
The need to lower costs and fund public insurance programs have driven the use of prior authorizations and other cost-containment tools, especially within managed care programs. However, data show that there are services and treatments for which the use of prior authorizations provides little cost savings. Broadly requiring prior authorizations places an undue administrative burden on behavioral health providers and may serve as a significant disincentive from participating in Medicare, Medicaid, and Marketplace plans.

Therefore, the report recommends that CMS monitor managed care plan access standards to reduce provider administrative burden (see Recommendation 5 in the report) and identify and disallow low-value prior authorization processes, working with states to do the same (see Recommendation 5-1 in the report).

GOAL 3: ONCE PROVIDERS ARE OPERATING IN MEDICARE, MEDICAID, AND MARKETPLACE PLANS, SUPPORT OPPORTUNITIES TO PROVIDE BETTER CARE AND HOLD PROVIDERS ACCOUNTABLE
Lastly, once providers are operating within these programs, it is vital to ensure the efficiency and effectiveness of managed care plans (see
Recommendation 8 in the report) and accountability for provider performance toward desired goals (see Recommendation 9 in the report) so that once behavioral health care specialists are available, patients are receiving the care they need.

There is no “silver bullet” to overcome these challenges—improving behavioral health care in America will require a coordinated, multi-faceted effort. This effort, however, is both overdue and necessary to provide effective, person-centered, and culturally competent care to all, as well as to care for the clinicians who are providing much-needed treatment to their neighbors and members of their community. Ensuring that Medicare, Medicaid, and Marketplace programs sustain and support the clinicians who participate in them is one important component for reforming the behavioral health care system to one that serves patients and clinicians alike.

To learn more about this report, visit www.nationalacademies.org/expanding-behavioral-health-access.