deter small practices from participating in insurance networks. Specific recommendations aimed at federal agencies are listed below, under the overarching goals of the report.

**GOAL 1: GROW THE PIE**

Bolster state and federal efforts to promote and ease entry into Medicare, Medicaid, and the Marketplace along the behavioral health care workforce continuum by reducing credentialing, enrollment, and licensing barriers and by focusing training programs and telehealth support where public insurance beneficiary access gaps are greatest.

- **RECOMMENDATION 1: CMS and SAMHSA should restructure current workforce and training mechanisms and their funding to better incentivize robust training environments that support career choices that will more directly impact care for Medicare and Medicaid beneficiaries.**

  - The CMS and SAMHSA restructure of the current workforce and training mechanisms should have two interrelated priorities. First, a focus on the providers serving populations with highest need for greater access to behavioral health provision in Medicaid such as rural, child/adolescent, and racial/ethnic minoritized populations. Second, a focus on workforce demographic diversity,
modeled after and aligned with existing Health Resources and Services Administration (HRSA) programs that have successfully grown and diversified the behavioral health care workforce in underserved areas.

- CMS should predicate ongoing funding of the workforce training with consistent reporting of post–trainee career trajectories to facilitate institutional comparisons among grantees and ultimately provide a mechanism for greater accountability between CMS funding of training and the rate at which trained providers serve Medicare and Medicaid beneficiaries.

- **RECOMMENDATION 4:** The Department of Health and Human Services (HHS) and its agencies should develop a uniform strategy to promote and adopt evidence–based approaches to reduce multi–state licensure barriers as a mechanism to expand access to behavioral health providers in Medicare, Medicaid, and the Marketplace.

  - HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments and its National Center for Interstate Compacts, the relevant national professional associations, and states to create and adopt interstate compacts for those behavioral health care professions not currently covered in an occupational interstate compact. Provisions for telehealth across state and jurisdictional lines should be included.

  - HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments and its National Center for Interstate Compacts, the relevant national professional associations, and states to ensure that states join existing occupational interstate compacts.

  - HRSA should incentivize states by including language in its request for proposals grantmaking process to join existing occupational licensure interstate compacts.

  - HHS should encourage states to review existing occupational professional interstate compacts to allow for the provision of telehealth across state and jurisdictional lines.

**GOAL 2: MAKE PARTICIPATION WORTHWHILE**

Strengthen support structures for behavioral health care providers and alleviate administrative and financial impediments to participation.

- **RECOMMENDATION 5:** CMS should use its authority to adopt policies and issue rules and guidance, and to monitor managed care plan access standards to quickly reduce provider administrative burdens and related adverse patient impacts associated with low–value prior authorization and other medical usage review instruments applied to behavioral health care services.

  - CMS should use its authority to identify and, to the fullest extent possible, disallow low–value prior authorization practices within Medicare plans. CMS should provide states with technical assistance to similarly eliminate and monitor for low–value prior authorization practices within Medicaid managed care.

  - CMS should adopt policies and the standards that require or incentivize insurers to focus behavioral health prior authorization only where high–cost waste and misuse are evident. These policies and rules should articulate clear responsibilities and guidelines for the mechanisms of rigorous regulatory oversight of insurer prior authorization review activities by state and federal agencies.

- **RECOMMENDATION 6:** CMS should provide guidance on setting Medicare and Medicaid fee–for–service reimbursement rates to ensure adequate access to a full continuum of behavioral health care services, which includes accounting for the actual
costs of care and adjusting for past and current undervaluation of work efforts of behavioral health care providers. To address this undervaluation, CMS should continue to revisit and revise the resource-based relative value scale (RBRVS).

- CMS should conduct an updated cost study to remedy the acknowledged bias in the current RBRVS formulation. Improving the formulation of the Medicare fee schedule may also help to influence Medicaid fee-for-service rates.

- Within Medicaid fee-for-service, CMS should encourage state Medicaid agencies to adopt regular rate reviews to adjust for inflation and account for market forces that could be discouraging behavioral health providers from enrolling in Medicaid fee-for-service. CMS should encourage consideration of rate differentials in underserved areas where there is an inadequate workforce within Medicaid and ensure proposed rates are sufficient to support access to behavioral health providers consistent with the general population. CMS should provide comparison rate and provider access information to states for Medicare, Medicare Advantage, Marketplace, and private plans to assist states in developing access monitoring review plans for behavioral health services that better determine whether state payment rates are sufficient to ensure access to care for beneficiaries at least comparable to the general population.

- **RECOMMENDATION 7:** CMS should use its regulatory and incentive structures to ensure prompt payment and eliminate inappropriate claims denials of behavioral health care services.

- **RECOMMENDATION 7-3:** CMS should develop a common set of behavioral health diagnostic codes that qualify for reimbursement. CMS, through its federal authority, and Medicaid and insurance regulators, through their state authority, would hold responsibility for enforcing compliance.

- **RECOMMENDATION 7-4:** CMS should develop policies that address the findings of HHS’s Office of Inspector General report related to Medicare Advantage plans’ inappropriate payment denials for services provided that meet Medicare coverage rules and medical assistance organizations’ billing rules.

**GOAL 3: OPTIMIZE PERFORMANCE AND ACCOUNTABILITY.**

Improve opportunities for care providers to increase care delivery capacity and to provide more person-centered care, while strengthening managed care organization (MCO) accountability for access and care delivery and provider accountability for performance.

- **RECOMMENDATION 8:** CMS should develop behavioral health care access outcome standards, along with significant financial penalties and bonuses, for MCOs participating in Medicare. CMS should work with states to develop similar standards and financial models to incentivize behavioral health care access in Medicaid managed care.

  - Both Medicare and Medicaid increasingly rely on third-party MCOs to deliver health care services to beneficiaries. CMS should work with states to establish an outcome-based behavioral health care access standard for payment, which can be adopted widely in a contract model.

  - CMS should convene Medicare and state Medicaid leadership to develop a model managed care contract for behavioral health services that establishes quality metrics for access, measuring the MCO’s delivery of timely, appropriate behavioral health care services to enrollees, and that is enforced through financial incentives (e.g., penalties and bonuses). In establishing quality metrics, CMS and states should recognize that meeting access outcome standards will require MCOs to build a full continuum of behavioral health providers and services, culturally aligned with the beneficiary population, and establish bi-directional integration of behavioral and physical health.
will also require addressing beneficiary barriers to seeking, receiving, and benefitting from services.

- CMS and SAMHSA should implement a technical assistance function to support states and MCOs (Medicare Advantage and Medicaid MCOs) in implementing these access measures and to help plans adopt additional efforts to support and build the behavioral health workforce and improve beneficiary access to care.

- SAMHSA should work with states to align state grant funds to supplement managed care investments in building the continuum of care providers and services needed for MCOs to meet quality metrics for access.

- **RECOMMENDATION 9: CMS should invest in the development of improved quality and risk adjustment measures for behavioral health care.** These measures should improve the measurement of performance of care toward desired goals of care—and be linked to payment. These measures should carefully consider the administrative measurement burden that would fall on care providers.

- CMS should lead in the development of new performance metrics. CMS should coordinate with states and MCOs to agree on a limited set of measures that apply across Medicare, Medicaid, and Marketplace. Measures should offer insight into whole-person health by considering social (e.g., educational attainment, employment levels, housing stability) and emotional (e.g., quality of life, loneliness, self-efficacy) needs. Without this emphasis, value-based models in behavioral health run the risk of perpetuating disparities and leaving vulnerable populations behind.

- CMS and states should work with MCOs and CMS–supported value-based payment programs to incentivize care providers based on these newly developed measures. These efforts should include sunsetting legacy measures and aligning measures across insurance segments to reduce the burden to care providers participating in these programs.

- CMS should create targeted financial support for practice transformation costs, recognizing that behavioral health care providers need technical assistance for developing new operations, reporting, billing, and health record systems.

- In its development of new measures, CMS should also consider modifying the existing measures for behavioral health risk adjustment.

To access the full report and supporting materials, visit www.nationalacademies.org/expanding-behavioral-health-access.