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

States

The National Academies of Sciences, Engineering, and Medicine report *Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans* addresses gaps in access to care for those with mental health and substance use disorders. This is critical considering about 20 percent of all Americans live with a behavioral health condition, but only half of this population receives treatment—negatively affecting individuals, families, and society at large.

With recognition that the nation’s current behavioral health care system is fragmented, overly complex, and difficult to navigate for care providers and for patients, the following goals and recommendations are designed to assist states in facilitating increased participation of behavioral health care providers in Medicare, Medicaid, and Marketplace programs.

The recommendations also focus heavily on building the supply and increasing the diversity of a behavioral health care workforce that is more likely to serve public programs; increasing workforce capacity to better meet the needs of publicly insured populations; supporting and sustaining care providers currently participating in Medicare, Medicaid, and Marketplace plans; and developing innovative payment and clinical care models that optimize behavioral health provider retention, satisfaction, and efficacy in fully serving their clients.

**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 2:** The Centers for Medicare & Medicaid Services (CMS) should use its regulatory authorities over Medicare (including Medicare Advantage), and provide assistance to state Medicaid programs, and Marketplace plans to streamline behavioral health provider credentialing and enrollment processes.
  - CMS should develop guidance for states on funding mechanisms and provide models for developing, implementing, and operating a single state-wide platform for care provider credentialing and enrollment. For instance, states could use available funding mechanisms to upgrade their Medicaid Management Information System provider enrollment modules, creating a single, state-wide platform for Medicaid, its managed care organizations (MCOs), or other Medicaid payers to use for credentialing, enrollment, renewals, and licensure checks.
CMS should allow states to include connectivity to state and federal licensing entities as part of the allowable costs of implementing the system.

CMS should encourage states to accept Medicare credentialing and enrollment for Medicaid purposes, and Medicare should reciprocate.

CMS should work with states to modify Medicare’s and Medicaid’s enrollment systems and processes to check ex parte information sources before requiring additional information from behavioral health care providers for initial enrollment or renewal as a care provider. This would allow behavioral health care providers to keep their enrollment information current in either a state Medicaid or a state Medicare system, and it would facilitate more rapid initial enrollment.

Whenever possible, CMS should impose time limits on the credentialing process, or support enforcement if there are existing time limits, employing a centralized database to streamline this process. CMS should encourage state regulators to do the same.

**RECOMMENDATION 3:** CMS should develop an agile and flexible interagency strategy to set guidelines for coverage and payment for telehealth for behavioral health needs across settings, modalities, and care providers. This strategy should include:

- Efforts to establish coverage consistency of telehealth across states in order to simplify cross-state telehealth health care provider engagement.

**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.

The Health Resources and Services Administration 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 is 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 7: CMS should use its regulatory and incentive structures to ensure prompt payment and eliminate inappropriate claims denials of behavioral health care services.**

To adequately enforce prompt pay laws and regulations, CMS should use its monitoring authority over state Medicaid programs and state Marketplace plans to ensure that plans are in compliance with prompt pay laws. Specifically, state Medicaid agency single audits should include monitoring of prompt payment of Medicaid managed care plan behavioral health claims. State insurance regulators should include similar monitoring of prompt payment in Marketplace Plans.

CMS, in consultation with state Medicaid officials, should ensure that Medicare and Medicaid provider claims are not rejected or denied for non–substantive reasons (such as using Dr. instead of Drive in an address). This may necessitate updating claims payment systems, manuals, managed care contracts, or other actions to ensure that payments are received in a timely manner following claims submission. Medicare and Medicaid payers should be required to provide regular training opportunities for behavioral health care providers on billing and claims submission and clear, accurate, and up-to-date instructions to participating care providers.

**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 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. It will also require addressing beneficiary barriers
to seeking, receiving, and benefitting from services.

- CMS and the Substance Abuse and Mental Health Services Administration (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.

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