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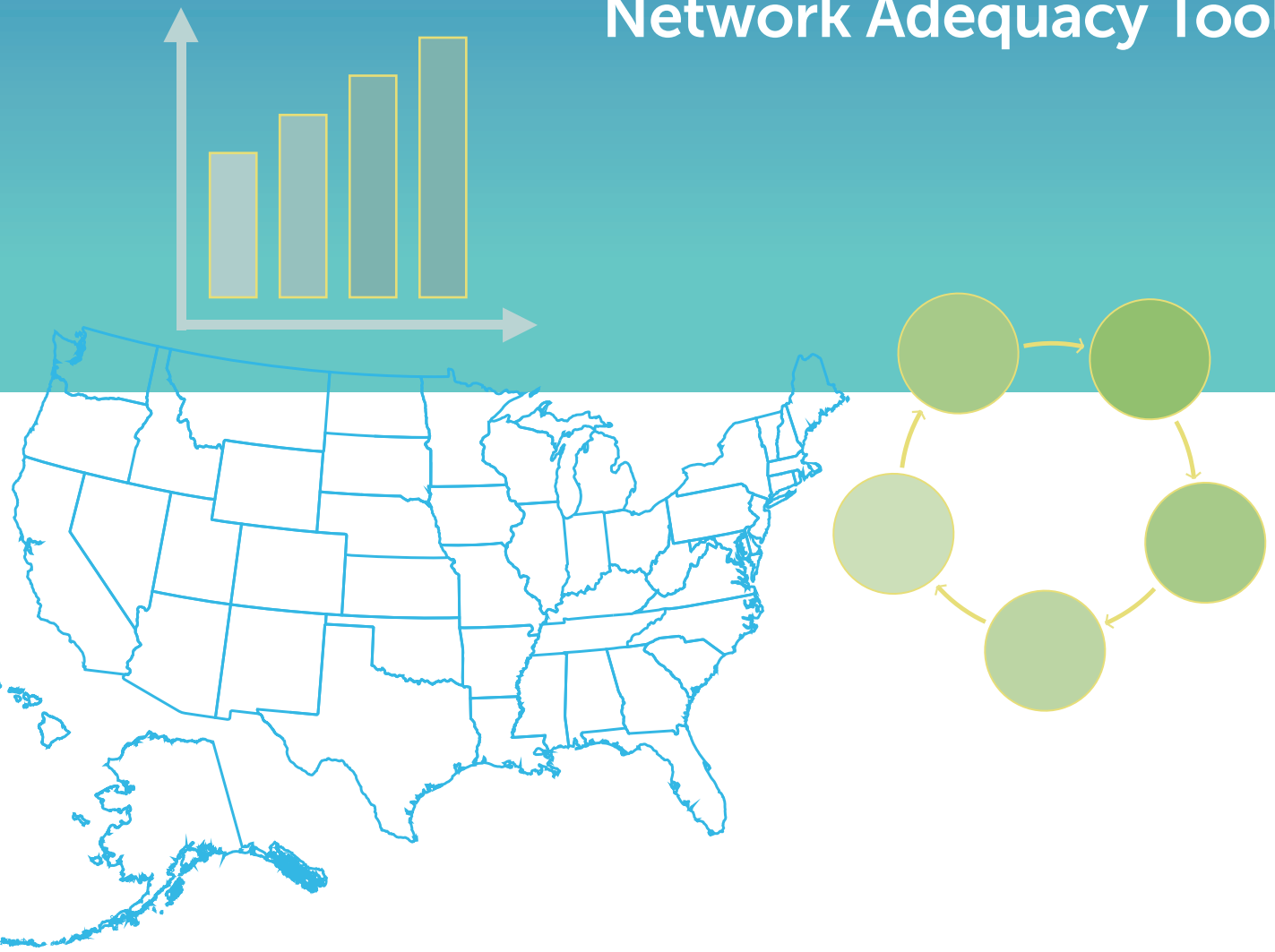
Promoting Access in Medicaid and CHIP Managed Care:

Behavioral Health Provider Network Adequacy Toolkit



CMS
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Promoting Access in Medicaid and CHIP Managed Care:

Behavioral Health Provider Network Adequacy Toolkit

May 2021

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Contents

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Section I:

Background, Purpose, and Organization

A. Background and context

Recent increases in substance use, as well as repercussions of the COVID-19 pandemic, have underscored the importance of behavioral health services that treat substance use and mental health disorders. Drug overdose deaths tripled between 2009 and 2016, driven by opioid use and opioid use disorders (OUDs) (Hedegaard et al. 2017). More recently, early indicators have suggested that the COVID-19 pandemic has negatively affected many people's mental health (Panchal et al. 2020).

Section at a glance

Section I provides background information about behavioral health services, the role of the Medicaid program and managed care in the delivery of behavioral health services, and the federal regulations pertaining to provider network adequacy requirements in Medicaid managed care. The section describes the purpose of this toolkit, data sources, methods, and the selection of strategies for inclusion in the toolkit, followed by an overview of each section of the toolkit.

Medicaid plays a critical role in the financing and delivery of behavioral health services. In 2015, Medicaid was the primary source of health coverage for 26 percent of adults with serious mental illness and 17 percent of adults with substance use disorders (SUDs) (Zur et al. 2017). The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that Medicaid paid for 24 percent of the $156 billion in national spending on mental health treatment, and 25 percent of the $56 billion spent on SUD treatment in 2015 (SAMHSA 2019).

State Medicaid agencies have increasingly covered behavioral health services through comprehensive managed care plans rather than paying for them on a fee-for-service (FFS) basis or covering them through limited-benefit managed care plans, sometimes called behavioral health organizations (BHOs)[1]. In 2018, nearly 10 percent of all Medicaid beneficiaries were enrolled in BHOs, down from enrollment of 17 percent in 2013 (CMS 2020). Meanwhile, the percentage of Medicaid enrollees who receive behavioral health services through comprehensive managed care organizations (MCOs) has grown from 56 percent in 2013 to 70 percent in 2018 (CMS 2020; CMS 2015). In addition, as more states adopt managed care as the primary delivery system in Medicaid, managed care plans are playing a growing role in delivering behavioral health services through networks of contracted providers, such as physicians, psychologists, nurses, specialty community

[1] The Centers for Medicare & Medicaid Services (CMS) uses the term "managed care plan" to encompass all types of managed care entities defined at 42 CFR 438.2, including comprehensive plan types like managed care organizations and health insuring organizations, as well as limited-benefit plan types like prepaid inpatient health plans, prepaid ambulatory health plans, nonemergency medical transportation, primary care case management (PCCM), and PCCM entities.

behavioral health centers, inpatient psychiatric units, and community-based organizations (CMS 2020). The expanded role that Medicaid managed care plans play in delivering behavioral health services—and the greater demand for such services among Medicaid beneficiaries—raises the importance of access to these critical services through robust provider networks.

Federal regulations established requirements for provider network adequacy in Medicaid managed care, particularly the 2020 Medicaid and CHIP Managed Care Final Rule and the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA). Both the final rule and the MHPAEA include regulations and guidance on states' and managed care plans' obligations related to behavioral health providers. Specifically, states and managed care plans with contracts that include coverage for behavioral health services must do the following:

- **Develop quantitative network adequacy standards for behavioral health providers.** States must develop standards for behavioral health providers (42 C.F.R. §§ 438.68(b)(1)(iii) and 457.1218) separately for adult and child behavioral health providers. Examples of quantitative standards that states can use include minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (such as extended evening or weekend hours); and combinations of these quantitative measures.
- **Ensure timely access to services.** Managed care plans must demonstrate that their networks include sufficient behavioral health providers to ensure timely access to covered services (42 C.F.R. §§ 438.206 and 457.1230(a)). States must also ensure that services covered under managed care contracts are available to enrollees, 24 hours a day, seven days a week, when medically necessary (42 C.F.R. §§ 438.206(c)(1)(iii) and 457.1230(a)).
- **Ensure provider accessibility.** Plans must maintain a network of providers able to offer physical access, reasonable accommodations, and accessible equipment for those with disabilities, including mental disabilities (42 C.F.R. §§ 438.206(c)(3) and 457.1230(a)). In the behavioral health context, reasonable accommodations may include flexible scheduling policies and availability of services in alternative settings, such as in an individual's home or through telehealth modalities.

What are behavioral health services?

Behavioral health services encompass mental health and substance use disorder (SUD) services and include a range of prevention, intervention, treatment, and recovery support services designed to improve the health of people with mental illnesses and SUDs.

Why are they important? Individuals who do not receive needed behavioral health services may experience a range of negative health, social, and economic outcomes, including exacerbated health issues, job loss, and involvement with the criminal justice system (GAO 2017).

Who provides them? Behavioral health providers include providers of mental health (or psychiatric) services, SUD services, and treatment for people who have co-occurring mental health and SUDs.

- **Mental health providers** include psychiatrists, psychologists, therapists, counselors, case managers, community health workers, peer support staff, and clinicians such as pharmacists, nurses, and physician assistants with a specialty in psychiatry.
- **SUD providers** include counselors, case managers, community health workers, recovery specialists (peer recovery coaches), and clinicians (physicians, advanced practice nurses, physician assistants, registered nurses, pharmacists) with specialties in addiction medicine or SUD or generalists (such as primary care providers) with a waiver pursuant to the Drug Addiction Treatment Act (DATA) of 2000.

- **Allow access to out-of-network providers.** If a plan's network cannot provide all covered services, it must cover services by providers not in the network in an adequate and timely manner (42 C.F.R. §§ 438.206(b)(4) and 457.1230(a)). Because many areas of the country have acute shortages of behavioral health providers (HRSA 2020), and a sizable share of providers do not participate in Medicaid managed care provider networks (GAO 2017), states should consider the need for out-of-network providers (Lipson et al. 2017).
- **Document the plans' capacity to serve all enrollees.** The final rule also requires states, through their contracts with managed care plans, to obtain assurances and supporting documentation that the plans have the capacity to serve all enrollees in each service area and comply with all other state access standards (42 C.F.R. §§ 438.207 and 457.1230(b)).
- **Adhere to MHPAEA regulations on treatment limitations.** Provisions in the MHPAEA also apply to provider network adequacy requirements in Medicaid managed care (42 C.F.R. § 438 subpart K and § 457.1201(l)). The MHPAEA final regulation prohibits plans from imposing nonquantitative treatment limitations—defined as "non-numerical limits on the scope or duration of benefits for treatment"—if the limitations apply to mental health and SUD benefits disproportionately in comparison with medical care benefits. Under MHPAEA, differences in the standards applied to behavioral health providers and medical care providers for admission to a provider network could be prohibited. Similarly, reimbursement rates that limit the availability of behavioral health benefits in ways that create disparity with medical benefits could also be prohibited (Lipson et al. 2017).

Challenges in ensuring adequate networks and access. Despite efforts to comply with these federal requirements, managed care plans face many obstacles to establishing and maintaining adequate behavioral health provider networks. Obstacles include the following:

- **Shortage of behavioral health providers.** There were more than 4,500 mental health professional shortage areas in the United States as of April 2017, containing about 109 million people, or roughly a third of the American population (HRSA 2017). Over half of these shortage areas were in rural or partially rural locations (GAO 2017). Recent estimates project shortages of more than 10,000 full-time equivalents for psychiatrists, psychologists, and mental health and SUD counselors and social workers by 2025 (HRSA 2016). This projection may be an underestimate, given the current opioid crisis and the COVID-19 public health emergency. These workforce shortages demonstrate a critical need for more providers who are qualified to diagnose and treat mental health disorders and SUDs.
- **Low Medicaid reimbursement rates.** Medicaid reimbursement rates are typically lower than other payers' rates, which can deter behavioral health providers from participating in Medicaid (Maclean et al. 2018).
- **Requirements for providers participating in Medicaid managed care.** Providers may perceive the credentialing, reporting, or billing requirements of Medicaid managed care plans to be a deterrent to their participation in plan networks (Maclean et al. 2018; Isett et al. 2009). Lack of standardized credentialing processes and variation in reporting requirements across managed care plans may present additional obstacles.

B. Purpose and contents of the toolkit

This toolkit aims to help state Medicaid agencies and the managed care plans with which they contract meet the network adequacy requirements for behavioral health care providers. Numerous state Medicaid agencies have developed innovative approaches to strengthen their behavioral health workforce and improve access to services within Medicaid managed care. This toolkit highlights promising practices and strategies implemented by state Medicaid agencies and managed care plans. Although many strategies that are effective for Medicaid managed care may apply to CHIP, the toolkit does not specifically address behavioral health network adequacy for children and adolescents covered by CHIP.

Sources and methods

The toolkit draws on multiple sources and methods, including a document review, discussions with state Medicaid and behavioral health agency staff, and a virtual forum series. To identify state strategies, Mathematica reviewed state Medicaid managed care manuals, websites, and other resources provided by state Medicaid agency staff. We also consulted with internal and external experts to identify additional state strategies and resources that have strengthened behavioral health networks in managed care.

Mathematica obtained detailed information about state strategies for establishing strong behavioral health provider networks through the aforementioned individual discussions with staff from ten states and with two national experts. Through these discussions, we learned about the state context in which the strategies were developed, the factors that led to the successful implementation of these strategies, and considerations for other states that may be interested in implementing similar strategies.

In partnership with the Centers for Medicare & Medicaid Services (CMS) and state Medicaid teams, between March and July 2020, Mathematica hosted a forum series featuring state Medicaid staff and national experts. The series covered a range of topics related to behavioral health provider networks in Medicaid managed care: (1) incorporating behavioral health into Medicaid managed care through specialty behavioral health plans and comprehensive managed care contracts; (2) developing, expanding, and supporting the mental health and substance use treatment workforces and their participation in Medicaid; (3) increasing access to care through telehealth; and (4) monitoring network adequacy in Medicaid managed care. The insights and promising practices highlighted in these sessions are included in the toolkit.

Throughout the toolkit, we use parenthetical citations to cite information drawn from reviews of state managed care contracts or other print sources. Reference lists for these sources are at the end of each section. Information on state practices presented without a parenthetical citation was drawn from interviews and webinar forums conducted in 2020.

Selection of strategies

The toolkit describes promising state strategies and approaches to monitoring the compliance of managed care plans with state and federal regulations and assuring access to behavioral health services covered through Medicaid managed care. Mathematica considered a strategy or practice effective if it met the following criteria: (1) one or more states described how the strategy

was implemented and integrated as a routine business practice; (2) the strategy has potential for adaptation or adoption by states with different infrastructure and resources; and (3) the strategy is consistent with the intent of the behavioral health network adequacy requirements. The toolkit is not, however, an exhaustive list of strategies or options. State officials should consult with CMS to determine whether their proposed approaches—including strategies not described in the toolkit—comply with federal rules.

C. Organization of the toolkit

The remainder of this toolkit is organized into four sections:

- Section II describes the operational considerations for incorporating behavioral health services into comprehensive managed care arrangements, including strategies to support behavioral health providers during transitions from FFS or grant funding streams to managed care. It also presents a brief overview of how states fund and oversee behavioral health services.
- Section III focuses on strategies to increase behavioral health network capacity through the existing workforce, such as strategies to expand access through places of service (telehealth, for example).
- Section IV describes strategies to expand the behavioral health workforce and their participation in Medicaid managed care, including workforce pipeline initiatives, expanding the use and reimbursement for paraprofessionals offering behavioral health services, and strategies to increase workforce retention.
- Section V addresses oversight and monitoring strategies to assess managed care plan compliance with state network standards and encourage innovation to improve behavioral health networks and their performance.

Additional resources

States are also encouraged to refer to the 2017 Medicaid managed care network adequacy toolkit for additional resources on implementing network adequacy requirements.

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Section II:

Operational considerations for transitioning behavioral health services into Medicaid managed care

A. Brief overview of the behavioral health service delivery system

Multiple agencies are responsible for funding and delivering behavioral health services. Medicaid agencies fund services for eligible populations, and they are responsible for the oversight of Medicaid managed care plans. Medicaid is partially funded by state revenue, with matching funds from the federal government. In addition, state mental health agencies are responsible for providing comprehensive mental health services for all state residents. They often receive a portion of their funding from Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grants. Certain state agencies or departments responsible for funding and overseeing SUD prevention and treatment services in the state often receive funding from SAMHSA Substance Abuse Prevention and Treatment Block Grants. Although SUD authorities have often operated as standalone agencies or departments with their own policies and procedures, they are increasingly merging with mental health agencies (SAMHSA 2017).

Section at a glance

Supporting the participation of behavioral health providers that contract with Medicaid managed care plans is a critical step in establishing and maintaining strong behavioral health provider networks. Section II is a brief overview of behavioral health service delivery systems, both in FFS and managed care arrangements. It also describes alternative ways in which states cover behavioral health services through Medicaid managed care. For those states switching behavioral health services from FFS or grant funding streams to managed care, the section discusses strategies to support behavioral health providers' successful transition.

State agency structure, and the authority and roles of each agency in funding and overseeing behavioral health services, vary by state. In some states, Medicaid, mental health, and SUD authorities are housed in distinct agencies, whereas other states have integrated oversight for some or all authorities. In Massachusetts, the Medicaid agency (MassHealth), the state authority for substance use disorders (Department of Public Health, Bureau of Substance Addiction Services), and the state authority for mental health (the Department of Mental Health) are distinct agencies or programs within a coordinated Executive Office of Health and Human Services (EOHHS) secretariat. However, in Arizona the same agency that administers Medicaid—the Arizona Health Care Cost Containment System (AHCCCS)—is charged with oversight of mental health and SUD services. The varying configurations of these authorities across states partly reflect differences in funding for behavioral health services. In turn, the degree to which behavioral health services are coordinated affects how states can best support behavioral

health service providers through transitions from grant-based programs or FFS to Medicaid managed care.

Behavioral health care providers often piece together funding from multiple sources. Within Medicaid, states have several options for the delivery and payment of behavioral health care services (see Exhibit). Many states use a combination of delivery arrangements for different populations (for example, children, adults, or seniors and people with disabilities) or for different types of services. Inpatient mental health services might be covered through an MCO, for example, whereas outpatient mental health services might be covered through FFS arrangements (Gifford et al. 2019). Although managed care for physical health benefits grew substantially in recent decades (Wagnerman et al. 2016), adoption of managed care arrangements for behavioral health services has been more gradual both across and within states. In addition, behavioral health providers—especially community mental or behavioral health centers—have long relied on grant or program funding and have less experience with managed care or FFS reimbursements.

Key terms for delivery and contracting arrangements for Medicaid behavioral health services

- In a **FFS** delivery system, providers bill for each behavioral health service rendered, and the state reimburses them directly.
- **MCO** contracts can include, or **carve in**, behavioral health services along with physical health services. MCOs can either manage directly or subcontract the management of behavioral health services.
- **Behavioral health carve-outs** exist when Medicaid managed care contracts cover medical and other services but exclude, or carve out, behavioral health benefits. Behavioral health services are then covered through a separate, limited-benefit managed care plan or rendered by providers on a FFS basis.
- **Specialty behavioral health plans** are designed for people with serious mental illnesses or severe mental health conditions. In some cases, these are prepaid inpatient health plans in that they only cover behavioral health services, while medical and other services are either covered through separate managed care plans or FFS. In other cases, specialty behavioral health plans are MCOs and cover medical and other services, but the plan delivers and coordinates services in a way that is sensitive to enrollees with behavioral health needs.

B. Transitioning behavioral health services from grant-funded programs to managed care

In the past 10 years, state Medicaid agencies have increasingly relied on comprehensive MCOs for integrated, whole-person care covering medical and behavioral health services. Even so, many states do not cover the full range of behavioral health services through one type of managed care plan. For example, as of 2019, 23 states included specialty outpatient mental health services in their comprehensive managed care arrangements, and 29 states included outpatient SUD services (Gifford et al. 2019). However, inpatient mental health and SUD services are covered through different arrangements. Including the full range of behavioral health services through MCOs can help reduce care fragmentation by enabling states and their managed care plans to provide a coordinated, whole-person approach to care across medical and behavioral services (Kenny et al. 2018). Care coordination can provide smooth transitions across care settings while centralizing accountability for the costs and quality of care (Soper 2016).

As states transition behavioral health benefits from grant-funded programs to managed care, behavioral health providers have experienced challenges, such as decreased revenue and increased administrative responsibilities associated with working with multiple plans with unique

requirements and administrative processes. Behavioral health providers who lack experience with managed care reimbursement processes and methods are likely to have high numbers of claim denials and delays in payments for services during the transition period. Some states expressed concern that payment delays could affect small behavioral health practices—that is, those with a small number of clinicians and fewer financial reserves—more acutely than larger practices.

States that have transitioned behavioral health from grant-funded streams into managed care have developed strategies to support providers and enable their participation in Medicaid managed care. States emphasized education and technical assistance for providers, partnering with managed care plans, and close monitoring of these efforts to resolve problems. Below we share practices for consideration by states planning to shift, or in the early stages of shifting, behavioral health services from grant or program funding into Medicaid managed care arrangements.

Tips to support provider reimbursement during a transition to managed care

- Have a good understanding of how providers are paid before the transition, especially those that are not paid on an FFS basis. "It's very, very important to understand the financial impact on providers."
- States might need to help managed care plans and providers translate and resolve reimbursement issues. For example, it was difficult for managed care plans to come up with rates to cover costs for community mental health centers that were accustomed to grant funding. "We had to provide a lot of detail to help managed care plans translate what a community mental health center did under a program to a billable code."

Education and technical assistance for behavioral health providers

- **Providing information and guidance.** Behavioral health providers, especially those accustomed to grant funding, need information, guidance, and technical assistance to understand reporting systems, billing processes, and business or practice models to succeed in the managed care environment. Behavioral health authorities can provide funding for education and technical assistance to providers using block grant funds, and Medicaid agencies can ensure that training and assistance is focused on the capacities needed to participate in Medicaid managed care provider networks.
- **Provider symposiums and learning collaborative forums** offer opportunities to educate providers and increase readiness to participate in managed care provider networks. By aiding providers in making the leap to managed care, states set the stage for the strongest possible behavioral health provider networks.
- **Listening forums** help state Medicaid staff learn about the needs of providers and build trust between providers and the state. This trust can boost provider buy-in and engagement in the transition process. Engaging with statewide provider associations can be an effective avenue for states to reach providers.
- **Consumer-led forums** in different regions offer an opportunity not only for consumer education but also consumer input on the transition process. Engaging consumers can help forestall access barriers and ensure that when strong behavioral health provider networks are estab-

lished, consumers will know how to maintain existing care arrangements with current providers or how to switch to different providers, if necessary.

Collaboration with managed care plans

- **Communicating with plans.** The relationships between the state and managed care plans are important to the process. In states that already have some managed care, adding behavioral health services to the scope of contractors that cover physical health services could be a way for states to capitalize on relationships with existing plans. Tennessee reflected that states might be able to resolve some of the inevitable challenges more quickly when working with known partners than when trying to address problems while also establishing relationships with new contacts.
- **Aligning service definitions.** In states with separate community behavioral health and Medicaid programs, state agencies can collaborate to align service definitions across their programs. This alignment can reduce the administrative burden for providers who deliver services under both programs, which in turn encourages providers to remain in the network. In addition, having the same service definitions across programs can minimize service disruption and improve continuity of care for people with behavioral health needs who transition on and off Medicaid.
- **Establishing common requirements and standard policies.** Providers face challenges meeting different credentialing requirements across multiple managed care plans and complying with different billing and prior authorization processes and policies. Establishing common standards for prior authorization policies and billing forms can reduce barriers to provider reimbursement and mitigate the risk that small behavioral health providers will be unable to meet multiple, conflicting requirements. Using a centralized credentialing vendor organization can also help apply the requirements and policies consistently.
- **Setting clear expectations.** States can include provisions in managed care contracts to require that managed care entities support providers during and after the transition. This support can be as basic as establishing a provider relations contact line to help providers with billing problems, such as claim denials. If the problems are widespread, agency staff can get involved to resolve issues, but clear contract language can provide additional leverage.

Monitoring the transition process

- **Frequent check-ins.** States reported that frequent calls with stakeholders during the transition were critically important. These calls encouraged communication and helped states identify systemic issues facing providers as soon as they arose and enabled relevant players to problem solve on the spot. **Washington State** held daily phone calls open to all stakeholders for the first month of implementation. These calls reduced the chance that early problems would spiral into crises and impact providers' financial position or damage trust between providers and plans. Trust and financial stability enable plans and providers to work together to create strong provider networks.
- **Listening tour.** After moving to cover behavioral health services through MCOs, **Tennessee's** Medicaid staff visited every Community Mental Health Center in the state to express in person that the state valued these behavioral health providers. This helped Medicaid staff gain a better understanding of how the transition was playing out at the local level, build trust, and ensure

that providers knew they could reach out to Medicaid staff if they were having trouble with an MCO or if an MCO was unresponsive.

- **Mediating when necessary.** Regardless of the amount of planning preceding the transition process, Medicaid agencies may need to take a hands-on role when issues arise between plans and providers, such as billing, prior authorization, or other reimbursement-related policies or processes. One state described its role in this process as leveraging relationships with both parties to work through problems. Close monitoring, in turn, enables states to know when it is necessary to become involved.
- **Setting up an early warning system.** Washington State collected data monthly from providers to examine how claims processing and payment was working and to give providers an opportunity to share concerns.

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Section III:

Strategies to increase capacity for delivering behavioral health using the existing workforce

A. Strengthening network adequacy in Medicaid managed care through collaborative care and team-based care models

Several provisions in the federal Medicaid regulations are intended to support the coordination and integration of physical and behavioral health services for managed care enrollees and promote information sharing through technology (Edwards 2017). For example, 42 C.F.R. § 438.208(b) requires MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans to designate a person or entity responsible for coordinating the services received by the enrollee. This provision further requires managed care plans to coordinate services between settings of care, with Medicaid services the enrollee may receive outside of the managed care plan, and with services from community and social support providers. In the past, separate financing structures for physical and behavioral health care have posed challenges to integrated care for state Medicaid agencies (Edwards 2017). Recently, some states have shifted to integrated financing, whereby states contract with managed care plans for integrated primary and behavioral health services. Integrated services have the potential to help decrease fragmentation of care, reduce costs, and improve health outcomes for Medicaid enrollees.

Section at a glance

Section III covers the strategies that states and managed care plans can implement to take full advantage of the existing behavioral health workforce. These strategies include leveraging the physical health workforce to provide behavioral health services within their professional capacity, integrating physical and behavioral health services, and implementing telehealth and other technologies to reach rural and frontier areas. The section also presents examples showing how several states leverage their managed care contracts to integrate and enhance care, as well as links to additional resources on integrating care and contracting with behavioral health providers.

Collaborative care and team-based care models that draw on the physical health workforce have the potential to deliver selected types of behavioral health care services and support. Training and collaborating with physicians, nurses, community health centers, and other medical care providers can free up capacity among behavioral health specialists to focus on enrollees with complex or higher levels of behavioral health care needs. Through collaborative care, with the support of care managers and consulting specialists, primary care providers offer treatment for mild to moderate behavioral health conditions. For example:

- **Screening, brief intervention, and referral to treatment (SBIRT)** is an evidence-based practice to identify and provide early intervention for persons with or at risk of SUDs (SAMHSA 2011). Within minimal training, primary care providers can implement this 15-minute intervention into clinical practice. SBIRT allows primary care providers to identify enrollees who may need a higher level of care. This care delivery model necessitates having a network of behavioral health specialists for referral partnerships.
- **Consultation services** is another way states can increase provider capacity to deliver behavioral health services. For example, in the hub-and-spoke model, specialists (hubs) provide remote or referral consultations for primary care providers (spokes) who prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 (Brooklyn and Sigmon 2017).

The Agency for Healthcare Research and Quality defines **integrated care** as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost effective approach to provide patient-centered care for a defined population." (AHRQ n.d.)

States can encourage or require managed care plans to educate their network providers on the availability and use of integrated services through clauses in contracts. For example, **Washington's** integrated managed care contract has the following provision:

The Contractor shall develop and deliver ongoing training for network providers. The training objective is to strengthen the knowledge, skill, and expertise of all parties to improve integrated care delivery as it relates to outreach and engagement, screening and assessment, appropriate referral and delivery of person-centered, recovery-oriented care (WSHCA 2021, p. 198).

Additional resources

- Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States identifies strategies that states can use to leverage the procurement process and contracts with managed care plans and thus respond to the behavioral health needs of enrollees. This toolkit offers design options for states to consider, along with sample request for proposals (RFPs) and contracts.
- How States are Using Comprehensive Medicaid Managed Care to Improve Primary Care provides information on how Medicaid managed care contracts can be used to strengthen primary care.
- Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements provides information on creating managed care RFPs that support integrated care with an array of providers.

The contract also specifies that training requirements for primary care providers include "screening for behavioral health conditions using developmentally, age appropriate screening tools" and "brief intervention and referral to treatment for enrollees aged 13 years and older" (WSHCA 2021, p. 199).

Care coordination through case management and enrollee navigation is another way to increase behavioral health capacity. Care coordination service providers work across provider types and community-based organizations to coordinate care and reduce duplicative services. These teams can enhance provider capacity by assisting with medication management, connect-

ing enrollees to community-based resources, and facilitating information sharing among providers. Two examples, the collaborative care model and co-location of primary and behavioral health services, are described next.

	The **collaborative care model** is an evidence-based approach for integrating behavioral health services into the primary care setting. This model uses two key services to enhance routine primary care: (1) care management for enrollees receiving behavioral health treatment, and (2) regular psychiatric inter-specialty consultation to the primary care team, particularly regarding enrollees whose conditions are not improving (Unützer et al. 2013). Although different types of staff can deliver case management and navigation services, organizations often rely on community health workers, nurses, or social workers (HRSA 2019). With the enrollee's consent, case managers or navigators make referrals, coordinate care among providers and specialists, and manage the exchange of information between providers.
	**Co-location of services** occurs when physical and behavioral health care providers are located in the same building, although they typically have separate information systems and funding streams. Co-location enables providers to streamline referrals through warm handoffs, and, in some cases, collaborate on care plans for enrollees (Rural Health Information Hub n.d.). As with the collaborative care model, co-location of services breaks down barriers between primary care providers and specialists, and relies on midlevel staff to provide coordination and navigation services.

States will need to determine the level of behavioral health integration that best fits their current provider market and the needs of enrollees. For example, a state may opt to provide a flexible definition of integration in requests for proposals (RFPs) and contracts for managed care plans, thus allowing individual plans to define and implement integration models that are responsive to enrollee needs. Although the specifics of care integration are left up to the managed care plan, **Oregon's** managed care contract states:

> The Contractor shall ensure the following elements of Care Integration: outpatient behavioral health treatment shall be integrated into a person-centered care delivery system and coordinate with the physical health care services by Contractor and by Contractor's transformed health system (OHA 2019).

Other states may take a more prescriptive approach and define activities that managed care plans must support in order to facilitate integration of services. **Tennessee's** statewide contract with managed care plans has provisions for coordination and collaboration for members with behavioral health needs. It states:

> The Contractor shall be responsible for providing a full continuum of physical health, behavioral health, and long-term services and supports. The Contractor shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term services and supports provider (TennCare 2020).

The contract also lists specific integration elements. For example, managed care plans in **Tennessee** must develop policies that include "screening for behavioral health needs . . . [and] referral to physical health and behavioral health providers" (TennCare 2020).

In 2018, **Arizona** consolidated responsibility for physical and behavioral health services under the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency (Bachrach, Boozang, and Davis 2017). This made it easier for the agency to require managed care plans to cover primary and behavioral health care integration, and to coordinate services between the two. The state seeks to ensures care integration through contract language; excerpts are in Exhibit III.1. Additionally, the state implemented integrated payment evaluation and management codes to incentivize care integration (AZ 2019).

Similarly, **Washington** phased in coverage of behavioral health services for adults and children through MCOs (Kelly et al. 2019). In 2016, Washington State began regionalized Medicaid purchasing to provide Medicaid enrollees with the full continuum of physical and behavioral health services through managed care. The state established integrated managed care contracts for additional regions in subsequent years. As of May 2001, the state has five contracts with MCOs to provide services under this integrated program. See the contract language in Exhibit III.1.

North Carolina has covered behavioral health care in Medicaid through managed care under a 1915 (b)(c) waiver in selected counties since 2005 and statewide since 2013. Under new 1115(a) waiver authority, North Carolina will change its primary FFS model to an integrated managed care model, integrating physical health, behavioral health, pharmacy, long-term services and supports, and unmet health-related resource needs in a single plan. As part of this transition, the state is developing two integrated managed care plans. Standard Plans will provide coverage for most beneficiaries, beginning July 2021, while Behavioral Health/Intellectual Developmental Disability Tailored Plans will support people with moderate to severe behavioral health needs, intellectual and developmental disabilities, and traumatic brain injuries, beginning in July 2022.

Exhibit III.1. Examples of RFP, contract, and provider manual language	
	**Arizona contract:** "The contractors shall implement validated behavioral health screening tools for Primary Care Providers (PCPs) to utilize for all adults to determine if further assessment for behavioral health services is necessary," thus increasing the capacity of primary care providers to screen for behavioral health conditions (AHCCCS 2019, p.92).
	**Washington RFP:** "The Apparent Successful Bidder(s) will be responsible for maintaining a comprehensive network of mental health and SUD providers, capable of delivering the full range of covered services to support enrollees in improving their mental health, substance use, and life outcomes. This includes providing services in multiple community-based settings and clubhouse and drop-in centers, and providing vocational services, prevention and early intervention activities, support for enrollees transitioning to a new system of care or care environment, and other services that empower enrollees to reach their full potential" (WSHCA 2020, p.5).
	**North Carolina Behavioral Health Intellectual/Developmental Disability Tailored Plan:** **"**The BH I/DD Tailored Plan shall meet annual requirements established by the Department for the percentage of members actively engaged in Provider-based Tailored Care Management approaches, meaning members who are receiving at least one (1) of the following six (6) core Health Home services in that month: i. Comprehensive care management; ii. Care coordination: iii. Health promotion; iv. Comprehensive transitional care/follow-up; v. Individual and family supports; or vi. Referral to community and social support services" (NCDHHS 2020, p.126).

B. Telehealth and expanded places of services to increase network capacity

States and managed care plans can also increase behavioral health network adequacy by expanding the modes and places of service that are allowed. For example, services can be provided virtually rather than in person, and patients can be seen at their home or at a location other than the provider's office. These options are particularly important in the context of the COVID-19 public health emergency, when provider offices are restricting in-person visits. Such arrangements can also make it easier to fulfill network adequacy standards for Medicaid members who live in rural areas, where behavioral health providers are in short supply and meeting quantitative network adequacy standards is difficult. Although it remains to be seen whether temporary waivers of rules that permitted greater use of telehealth will continue after the COVID-19 public health emergency, states have latitude to allow this mode of delivery at any time, and doing so can be a particularly effective way to increase access to behavioral health services.

Telehealth services for behavioral health include assessment, treatment, medication management and monitoring, education, and care collaboration. Emerging research shows that telehealth for behavioral health services is effective across a variety of behavioral health conditions. There is evidence that clients adapt to telehealth and establish rapport with telehealth providers, and both clients and clinicians report satisfaction after telehealth visits (Perle and Nierenberg 2013). Behavioral health providers may also see benefits from telehealth visits, including lower no-show rates from clients.

Although telehealth is a promising way to expand access to behavioral health services and improve network adequacy, barriers still remain, among them the perception that in-person services are more effective than those provided virtually, as well as reimbursement rates for telehealth services that are lower than those for in-person visits. Yet states and managed care plans have developed strategies to address these problems:

- **Colorado** allows services to be provided through in-person or remote interactions and stipulates that telehealth services must be reimbursed at the same rate as in-person services.
- **Arizona** enhanced access to services by approving use of "store-and-forward" technologies, which allows for the electronic transmission of medical information through secure email communications (Center for Connected Health Policy n.d.). Asynchronous technologies, such as store-and-forward, can also support clinical decision making for providers, thus increasing efficiency (Center for Connected Health Policy n.d.).
- **Florida** has a provision in its managed care plan contract requiring plans to submit annual network development plans to demonstrate how they are developing, maintaining, and monitoring appropriate provider networks. The annual network development plan must include a description of the covered services, including "the extent to which the Managed Care Plan utilizes telemedicine services to resolve network gaps" (Florida Agency for Health Care Administration n.d.).

In addition to adopting telehealth technologies, states can expand the places of service where behavioral health services are delivered. For example, **Arizona** designates schools as a place of service and funds initiatives to bring behavioral health providers into the school setting (AHCCCS n.d.a).

C. Expanding service availability in rural and remote areas

Ensuring that enrollees have access to behavioral health services in rural and remote areas is particularly challenging, but financial incentives can help recruit providers to deliver services in remote areas. For example, **Arizona** has used its Targeted Investments Program, authorized under 42 C.F.R. 438.6(c) and the state's Section 1115 Medicaid Demonstration Waiver, to promote the integration and coordination of physical and behavioral health care for Medicaid beneficiaries (AHCCCS n.d.b). One initiative under the Targeted Investments Program is a differential adjusted payment program to increase services in hard-to-reach areas, such as tribal lands. Through this program, managed care plans provide a rate increase to eligible Medicaid providers for all claims and encounters with AHCCCS across the state.

States, managed care plans, and providers are also promoting the use of technology to increase enrollee access to care and improve services. Some examples of technologies that can be used to reach rural and remote enrollees are as follows:

- **Opioid use disorder treatment:** Boulder Care, a digital clinic, offers long-term support and medical treatment for opioid use disorders. The digital clinic and remote care teams partner with pharmacies to deliver buprenorphine to client homes and use chat and video messages to provide remote support (Hostetter and Klein 2019). Emerging research has demonstrated that at-home initiation of medication-assisted treatment can be as effective as in-person care (Martin et al. 2018).
- **Clinical decision support:** Determining the appropriate level of care for an enrollee and then locating an appropriate referral can be challenging for providers, particularly those unfamiliar with behavioral health conditions (Hostetter and Klein 2019). New technology provides clinical decision-making support to help providers assess a client's acuity and specific needs. One such platform then generates a list of recommended facilities and allows for digital referrals. In states that have implemented the platform, over half of all referrals are made in less than 30 minutes (Hostetter and Klein 2019).
- **Therapeutic services:** Technology can also serve as an alternative or complement to traditional talk therapy by allowing enrollees to engage in remote therapy, education, and coaching. For example, some managed care plans and Medicaid programs have begun to incorporate digital tools designed specifically for behavioral health self-care, which is one way to engage enrollees who have unmet behavioral health needs (Abhulimen and Hirsch 2018; Hostetter and Klein 2019). Digital behavioral health tools can match enrollees with interactive resources based on cognitive behavioral therapy, motivational interviewing, and other evidence-based counseling approaches (Hostetter and Klein 2019).

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Section IV:

Strategies to support and expand the behavioral health workforce and their participation in Medicaid managed care

A. Workforce development strategies to expand the supply of behavioral health providers

State officials, including governors, state executive agency leaders, and state legislators, as well as private sector workforce development coalitions, have spearheaded behavioral health workforce initiatives to promote interest in the field and recruit professionals. State Medicaid agencies can also support expansion of behavioral health provider networks through collaboration on workforce development initiatives and policy development.

Section at a glance

Section IV highlights workforce development strategies and managed care policies to expand the supply of behavioral health providers and increase their participation in Medicaid managed care provider networks.

Although this toolkit highlights strategies that states can use, federal initiatives to bolster the behavioral health workforce will likely be needed alongside state-driven efforts. State and federal programs intended to strengthen the behavioral health workforce should consider the disparities in provider supply across and within states when deciding how to allocate resources.

Initiatives to improve the pipeline of providers

State legislation can support the development of the behavioral health workforce by (1) creating entities, either internal or independent, to assess workforce needs and priorities; and (2) developing strategies to address critical shortages in the workforce. For example, in **Nebraska**, the Behavioral Health Workforce Act of 2009 established the Behavioral Health Education Center of Nebraska (BHECN) to address the shortage of behavioral health professionals throughout the state (see the text box for details on the center).

An example of state legislation supporting workforce development

In Nebraska, the Behavioral Health Workforce Act of 2009 established the Behavioral Health Education Center of Nebraska (BHECN) to address the shortage of behavioral health professionals throughout the state. BHECN is mandated to (1) establish priorities for workforce development in the state; (2) coordinate statewide initiatives and investments in programs focused on training, recruiting, and retaining behavioral health providers; and (3) collect, analyze, and report on behavioral health workforce data. Located on the campuses of the University of Nebraska Medical Center, the University of Nebraska at Kearney, and Chadron State College, BHECN is a partnership between state legislators, community partners, and academic institutions.

BHECN has developed a program to introduce students in high school, college, and professional schools to careers in behavioral health. The BHECN Ambassador Program distributes information to students on the pathways required to pursue licensed behavioral health careers. The program also offers funds for community groups to introduce behavioral health professions in their local communities.

Source: BHECN (2020).

State Medicaid agencies can partner with schools of higher education and residency programs to establish or expand educational opportunities in behavioral health specialties. Clinical training opportunities, such as internships and residency programs, can help attract and retain providers. BHECN partnered with 16 academic institutions in the state of Nebraska that provide graduate-level behavioral health education. Through these partnerships, BHECN (1) tracks the number of students who graduate from a behavioral health program and stay in Nebraska; (2) hosts future workforce interest groups; (3) holds annual seminars for graduate students in behavioral health academic programs for training and networking; (4) offers residency, internship, and training programs focused on behavioral health; and (5) provides education for community health workers and for paraprofessionals (BHECN 2020).

Partnerships with university medical schools can raise awareness, spark interest, encourage students to become behavioral health professionals, and draw others into the state for training opportunities. In partnership with the University of Nebraska Medical Center Munroe-Meyer Institute, the state of Nebraska has established 43 integrated behavioral health/primary care clinics across rural and underserved urban areas of Nebraska to help build the behavioral health workforce (BHECN 2020). Nebraska's Department of Health and Human Services has also focused on provider training to strengthen the workforce through Project ECHO (Extension for Community Healthcare Outcomes). Funded through the State Targeted Response to the Opioid Crisis grant from the Substance Abuse and Mental Health Services Administration, Project ECHO is a virtual consultation model that connects providers with addiction and pain management specialists (BHECN 2020).

Additional resources

Project ECHO (Extension for Community Healthcare Outcomes), a national program that started at the University of New Mexico Health Sciences Center, has increased access to specialty care, including behavioral health. The model provides training, telementoring, and ongoing support for community providers in rural and underserved areas (spokes) by expert teams at academic centers (hubs). The Behavioral Health and Addiction ECHO program trains and supports primary care providers and care coordinators at managed care plans in the assessment and management of substance use and mental health disorders.

National and state loan forgiveness programs draw providers to practice in health professional shortage areas. The National Health Service Corps (NHSC) Loan Repayment Program is a federal

initiative administered by the Health Resources and Services Administration, in which primary care and behavioral health care practitioners who work a minimum of two years in a Health Professional Shortage Area can receive loan repayment assistance (HRSA 2020). Providers in this program are eligible to receive up to $50,000 of their student loans forgiven for two years of either full- or part-time service (HRSA 2020). State-based loan repayment programs can supplement the national program by expanding the offer to more providers, to different clinicians, or to different locations than those that would qualify for the NHSC program. For example, Arizona expanded its State Loan Repayment Program in 2015 to include behavioral health providers. The Arizona program provides loan repayment assistance to behavioral health care providers who provide outpatient services in the state's designated Health Professional Shortage Areas. Under this program, Arizona behavioral health providers can be awarded up to $50,000 in the first two years of service, up to $25,000 in the third year, and $20,000 in the fourth year (ADHS n.d.).

Training and career pathways

State Medicaid agencies can amplify training efforts through cross-agency collaboration. Medicaid agencies can collaborate with behavioral health agencies and other agencies to organize provider trainings and competency development initiatives. Such programs build the skills and expertise of providers and expand the behavioral health services they are able to provide. **Nebraska's** Medicaid agency, the Division of Medicaid and Long-Term Care, collaborates with the state's Division of Behavioral Health to offer trainings to community-based behavioral health providers who also participate in Medicaid managed care. After a statewide behavioral health needs assessment highlighted several areas for improvements, the two agencies partnered to create several skill-enhancing opportunities for providers. One training offered behavioral health providers the opportunity to become certified in the Matrix Model, an intensive outpatient treatment model for SUD treatment. Another training effort is an ongoing multiyear initiative aimed at establishing a cohort of behavioral health providers with additional competencies for treating clients with co-occurring behavioral health conditions and cognitive impairment. The Division of Behavioral Health funded the trainings using discretionary grant funding, while the Medicaid agency worked with managed care plans to encourage provider participation. The trainings targeted practitioners who provide community mental health services (overseen by the Division of Behavioral Health), most of whom are also required to contract with all three state Medicaid managed care plans.

In **Massachusetts**, MassHealth, the state Medicaid agency, collaborated with the Department of Public Health when MassHealth added residential rehabilitation services (ASAM Level 3.1) to their benefits to ensure that requirements and performance specifications for the services were consistent with the requirements for the services through Department of Public Health contracts. The two agencies also collaborated on training and technical assistance opportunities for these services. The partnership was important because Medicaid managed care entities share a residential rehabilitation provider network with the Bureau of Substance Addition Services. These types of collaborations offer states the opportunity to maximize the impact of their resources and draw from the expertise of multiple agencies or governmental departments to identify provider network needs and create trainings to address them. The trainings and technical supports offer the opportunity to strengthen behavioral health provider networks by expanding the competencies of existing network providers.

Creating career ladders and pathways for provider advancement can also be valuable in expanding the competencies of existing network providers and promoting provider retention. **Arizona** has been intentional in creating opportunities for their behavioral health peer and family support workforce to specialize and advance. AHCCCS, the state's Medicaid agency, established the Peer and Family Career Academy to provide education and training and enable peer and family support staff to specialize in areas such as forensic peer and family support and opioid use disorder. The academy also offers peer and family support staff the opportunity to advance their careers by becoming peer supervisors. It is overseen by the Office of Individual and Family Affairs within AHCCCS, which is tasked with encouraging the use of peer and family support staff in the state's Medicaid managed care program, especially in, clinics providing integrated care.

Other states, such as **California**, are working to establish career advancement pathways for entry-level behavioral health counselors and nurses (Coffman et al. 2018). Through partnerships with state universities and residency programs, for example, state Medicaid agencies and managed care plans can provide education and training opportunities for registered nurses to become nurse practitioners. These career advancement pathways can be structured to incentivize providers to serve Medicaid enrollees after they complete their training.

Creating mechanisms to ensure behavioral health providers in managed care networks are able to practice to the top of their licensure can maximize the reach of provider networks. States could explore using the full capabilities of advanced practice registered nurses and physician assistants to prescribe and manage enrollees' medications, which frees psychiatrists—who are in high demand in many states and regions—to focus on providing consultation, supervision, or specialized behavioral health services.

B. Development of managed care policies that support the behavioral health workforce

State agencies can promote policies that support and increase provider participation in Medicaid managed care. State agencies can collaborate to identify policies to increase participation in Medicaid managed care among community-based behavioral health providers who receive state behavioral health funding. For example, in **Nebraska**, providers who receive funding from the state behavioral health agency are required to contract with the state's managed care plans. In establishing its residential rehabilitation services as a Medicaid managed care benefit, **Massachusetts** required its plans to contract with all licensed and qualified providers statewide. States can also encourage or require managed care plans to establish common credentialing processes and policies to promote adequate training and core competencies for the behavioral health workforce.

Medicaid agencies can support the behavioral health workforce by advocating for expansion of scope of practice policies. Twenty-eight states and the District of Columbia grant nurse practitioners full practice authority, which allows them to diagnose, treat, and prescribe medications to patients without formal physician supervision (Spetz 2019). Enabling psychiatric-mental health nurse practitioners (PMHNPs) to practice autonomously reduces the burden of oversight on other behavioral health providers in high demand, particularly psychiatrists. It also allows more flexibility in how PMHNPs can practice, and it may reduce barriers for them to practice in rural areas, where coordinating physician oversight is more challenging. Training and recruiting PMHNPs is key to filling the gap created by shortages of psychiatrists in many states. A 2016

review of the scope of practice regulations for nurse practitioners suggested that states that provide nurse practitioners more authority see higher growth in the number of such nurses (Delaney 2017). State legislatures typically set the scope of practice statutes, and state authorities, such as licensing boards or commissions, interpret and implement the policies (Spetz 2019). Medicaid agencies can play an important role in advocating for policies that will support the growth of the PMHNP workforce and their participation in Medicaid managed care.

Key terms for the behavioral health workforce

- **Peer workers** (or peer support specialists, peer mentors, or coaches in mental health or recovery support specialists or recovery coaches in SUD) draw on their personal experiences of "recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency" (Myrick and del Vecchio 2016; U.S. DHHS 2015).
- **Consumer-operated services** (or consumer-run organizations, peer support programs, or peer service agencies) are "owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational approach" (U.S. DHHS 2011). Services or programs can offer drop-in centers, peer counseling, support groups, education, and social and recreational opportunities, among other services (U.S. DHHS 2011).
- **Family-run organizations**, which are organizations of families with children and youth with mental health conditions, promote family leadership in the development of policies and systems related to behavioral health services (Stroul 2015). Family-run organizations often require over 50 percent of the governing board and leaders to be parents or primary caregivers (Mendoza 2012).

Instituting licensing reciprocity is another way that states can encourage growth in their behavioral health workforces. Licensing requirements for behavioral health providers vary considerably by state. Differing requirements create significant barriers for states seeking to recruit out-of-state providers to build their workforce. A licensed provider in one state seeking to relocate to another state may have to complete additional training or practice under additional supervision for some period of time to receive full licensure in that state. Although some states offer transitional licenses, providers may have limited employment options until they have a completed license. States can reduce this burden by entering into reciprocity agreements with other states, joining interstate licensing compacts, or adopting requirements established by national organizations that develop standardized certifications and facilitate reciprocity for specific licensed provider types. For example, the International Certification and Reciprocity Consortium has established certification standards for SUD providers that many states have adopted (IC&RC n.d.). Reducing licensure barriers for behavioral health providers can serve as one part of a larger strategy to help states recruit behavioral health providers and build their workforce. During the COVID-19 public health emergency, State Medicaid agencies have waived requirements (through waivers under section 1135 of the Social Security Act) that health care providers be licensed in the state in which the services are delivered, if they have equivalent licensing in another state (CMS 2020).

States can allow and encourage managed care networks to include peer workers and community health workers. State Medicaid agencies can encourage the adoption or expanded use of behavioral health support services through managed care plans. For example, by allowing or requiring plans to reimburse services provided by peer support workers, or expanding the types of services that are reimbursable, states can alleviate demand on licensed behavioral health specialists and potentially improve coordination and beneficiary engagement. **Washington** reported that

matching peers with enrollees at a point of crisis was effective in supporting individuals who may not need as high a level of care as might be assumed. States can encourage plans to include providers in their network that have peer staff. For example, **Arizona** managed care contracts require plans to "maximize the use of existing behavioral and physical health infrastructure including peer and Family-Run Organizations" (AHCCCS 2019, p. 153). In addition, the state's Office of Individual and Family Affairs within the Medicaid agency focuses on peer and family support, and the state requires managed care plans to have similar offices.

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Section V:

Monitoring network adequacy, service availability, and enrollee access to behavioral health providers and services

A. Establishing network adequacy and service availability standards for behavioral health

Section at a glance

Section IV highlights workforce development strategies and managed care policies to expand the supply of behavioral health providers and increase their participation in Medicaid managed care provider networks.

Federal requirements. Managed care plans are responsible for contracting with a sufficient number of providers to serve plan enrollees and making sure those providers are available to enrollees, based on quantitative standards that states establish, a concept known as "network adequacy." Federal Medicaid regulations (42 C.F.R. §§ 438.68, 438.206, and 438.207) lay out network adequacy and access standards for all Medicaid managed care plans, which include behavioral health providers. The 2017 toolkit on network adequacy—see Lipson et al. (2017)—used the "5 A's of Access" that Penchansky and Thomas (1981) developed to outline key factors that influence access: availability, accessibility, accommodation, acceptability, and affordability. The toolkit proposes an additional dimension, realized access, which requires states to monitor the degree to which Medicaid managed care enrollees actually receive needed services in accordance with the standards (Lipson et al. 2017).

Federal regulations (42 C.F.R. § 438.66) also require state Medicaid agencies to operate a monitoring system that includes oversight of network adequacy and the availability of and access to services for all Medicaid managed care plans in the state. This system must include oversight of provider network management, compliance with provider directory requirements, network adequacy, and service availability standards. Such standards may relate to provider supply and capacity, appropriate use of service, timely access and proximity to services, physical accessibility, operating hours, translation services for non-English-language speakers, and communications and customer service.

State standards. States use a variety of network adequacy standards, such as provider-to-enrollee ratios, time and distance standards, and geographic access standards. Federal rules (42 C.F.R. § 438.68) require states to establish quantitative standards for seven provider types, one of which is behavioral health. These standards for behavioral health providers can vary by:

- **Geographic region:** Standards may differ for urban, rural, and frontier areas of a state.
- **Facility type:** Standards may differ by type of facility, for example, inpatient hospitals and outpatient clinics.
- **Provider type:** Standards may differ between mental health providers and SUD providers.

When designing network adequacy standards, states should consider the following principles:

- **Provider distribution:** Provider distribution can vary across a state, particularly for states that have both rural areas and urban centers. Standards that account for this distribution better reflect provider capacity, and specific areas may warrant exceptions, as specified in 42 C.F.R. § 438.68(d). For example, contracting with only a few providers in a rural area that has a shortage of providers may be acceptable, but contracting with only a few providers in urban areas is most likely not acceptable.
- **Community characteristics and patterns of care:** States should design standards that take into account different community characteristics, as well as patterns of care and the manner in which enrollees are likely to access care. For example, community characteristics may include limited public transportation options, or a need for providers who can communicate with enrollees who have limited English proficiency. Additionally, understanding and ensuring access to essential community providers, such as community mental health centers, federal qualified health centers, or tribal agencies, may be important to assure adequate behavioral health provider networks.

Exhibit V.1 lists examples from several states' network adequacy standards, as well as service access and availability standards, concerning behavioral health providers and services. A few highlights from the table follow:

- **Florida** requires that behavioral health providers in urban counties be located within 30 minutes' travel time of enrollees, or no more than 20 miles distant; for rural counties, the travel time must be within 60 minutes, or 45 miles distant. Plans must maintain a ratio of 1:1,500 psychiatrists to adult enrollees (Florida AHCA 2020).
- **Massachusetts** requires that Account Care Partnership Plan, MCO plans and the behavioral health vendor offer beneficiaries a choice of at least two network providers that provide behavioral health services (Massachusetts EOHHS 2020).
- **North Carolina** requirements include choice or access within 30 miles or 30 minutes for urban counties and 45 miles or 45 minutes in rural counties. Requirements are specified by service categories, including outpatient services, location-based services, community/mobile services, crisis services, inpatient services, specialized services, and waiver services. (North Carolina DHHS 2020).
- **Missouri** requires that 90 percent of enrollees in urban areas have access to an outpatient provider within 15 miles of their homes (Missouri Department of Social Services 2020).

Exhibit V.1. Behavioral health network adequacy and access and availability standards in seven state Medicaid managed care programs

	ARIZONA	FLORIDA	MASSACHUSETTS	MISSOURI	NEBRASKA	NORTH CAROLINA	WASHINGTON
Standard	(Arizona Health Care Cost Containment System)[a]	(Model Health Plan Contract)[b]	(MassHealth Managed Care)[c]	(MO HealthNet Managed Care)[d]	(Heritage Health)[e]	(BH I/DD Tailored Plan)[f]	(Apple Health Integrated Managed Care)[g]
Examples of travel time or distance standards for urban areas	Outpatient behavioral health providers: 15 minutes or 10 miles for 90% of enrollees	Psychiatrists: 30 minutes or 20 miles SUD treatment centers: 30 minutes or 20 miles	Outpatient services: 30 miles or 30 minutes Inpatient services: 60 miles or 60 minutes All other behavioral health services: 30 miles or 30 minutes	Psychiatrist: 15 miles Psychologist/other therapists: 10 miles Inpatient treatment facility: 25 miles	Outpatient providers: 30 miles	Outpatient behavioral health providers: 30 minutes or 30 miles for 95% of enrollees Partial hospitalization: 30 minutes or 30 miles for 95% of enrollees	Behavioral health professionals: 25 miles Outpatient behavioral health agency providers: 25 miles Service sites are accessible by public transportation within 90 minutes
Examples of travel time or distance standards for rural areas	Outpatient behavioral health providers: 60 miles for 90% of enrollees	Psychiatrists: 60 minutes or 45 miles SUD treatment centers: 60 minutes or 45 miles	Same as urban	Psychiatrist: 80 miles Psychologist/other therapists: 40 miles Inpatient treatment facility: 75 miles	Outpatient providers: Rural areas: 45 miles Frontier areas: 60 miles If requirements cannot be met, MCO must utilize telehealth options	Three outpatient behavioral health service providers within 45 minutes or 45 miles for 95% of enrollees Two providers of specialized services within 60 minutes or 60 miles for 95% of enrollees	Behavioral health professionals: 25 miles Outpatient behavioral health agency providers: 25 miles Rural Areas: 30 minutes Large Rural Geographic Areas: 90 minutes
Examples of wait time for receipt of service standards	Urgent need: within 24 hours Initial assessment: within 7 days of referral or request Non-urgent care: No later than 45 days, sooner if required by health condition	Urgent care: 48 hours Urgent care for services requiring prior authorization: 96 hours Post-discharge follow-up: 7 days Initial assessment: 14 calendar days	Emergency services: access 24/7 Urgent care: 48 hours Other behavioral health services: 14 days Post-discharge follow-up: outpatient services within 7 days and medication management within 14 days	Non-symptomatic routine care: 30 days Non-urgent symptomatic care: Lessor of 1 week or 5 business days Urgent care services: 24 hours Emergency services: 24/7	Not specified	After-hours access: 24/7 Community/mobile crisis services: 30 minutes Urgent care: 24 hours Routine care: 14 days	Non-symptomatic routine care: 30 days Non-urgent symptomatic care: 10 days Urgent care: 24 hours Emergency services: 24/7

	ARIZONA	FLORIDA	MASSACHUSETTS	MISSOURI	NEBRASKA	NORTH CAROLINA	WASHINGTON
Standard	(Arizona Health Care Cost Containment System)[a]	(Model Health Plan Contract)[b]	(MassHealth Managed Care)[c]	(MO HealthNet Managed Care)[d]	(Heritage Health)[e]	(BH I/DD Tailored Plan)[f]	(Apple Health Integrated Managed Care)[g]
Examples of provider number or choice standards	Not specified	Adult psychiatrist: ratio of 1:1,500 enrollees SUD treatment centers: 2 per county	Choice of at least two outpatient behavioral health specialists within 30-miles or 30 minutes	Not specified	Not specified	Outpatient behavioral health providers: 2 within the time and distance standard for 95% of enrollees	Not specified

[a] AHCCCS Contractor Operations Manual Policy 417 and Policy 436 (2020).

[b] Florida 2018–2023 Model Health Plan Contract (2020).

[c] Massachusetts Accountable Care Partnership Plans Contract (2020).

[d] MO HealthNet Managed Care, Request for Proposal: 2020.

[e] Nebraska Total Care Contract, (2021).

[f] BH I/DD Tailored Plan Request for Applications, Section VII. RFA Attachments (2020).

[g] Apple Health Integrated Managed Care Contract (2021).

Federal rules also require states to establish timely access standards (42 C.F.R. § 438.206(c)(1)). Access can be measured in terms of wait time to see a provider, which can differ depending on whether the visit is considered routine or urgent. For example:

- **Massachusetts** requires that enrollees have access to Emergency Behavioral Health services 24 hours a day, seven days a week and that providers must follow up with an enrollee within 24 hours of when the enrollee accesses emergency behavioral health services. By comparison, routine services must be rendered within 14 calendar days (Massachusetts EOHHS 2020).

Beyond establishing traditional access and availability standards, states can consider additional network adequacy standards that take into account other aspects of access to providers. For example, states could consider the following:

- **Provider willingness and capacity to accept new clients and provide specific services.** States could require managed care plans to assure that all, or a specified percentage of network providers accept new Medicaid clients. Simply measuring the number of providers with contracts could give a false reading of network adequacy if a large share of providers does not accept new clients.
- **Provider certification and scope-of-practice requirements.** Definitions and licensure standards for certain types of providers, such as SUD counselors, can be very broad. When provider definitions or scope of practice requirements do not indicate a specific level of training or ability to provide high-quality services, it is challenging to assess network capacity and adequacy. Clarifying the definitions of certain types of providers and evaluating licensure standards for them can improve the ability of states to identify and respond to provider and service gaps.
- **Characteristics of behavioral health providers and services.** Particularly important for integrated and team-based care, states could consider the range of providers needed for behavioral health services. For example, Assertive Community Treatment (ACT) programs rely on a team of different providers across service settings. States need to make sure that plans contract with all provider types involved in ACT to assure the services are appropriately provided. Additionally, states could use full-time equivalents rather than an absolute number of providers in a network to account for providers who may work part-time.

B. Demonstrating network adequacy

Federal regulations require that states obtain documentation from managed care plans attesting that the plans have the capacity to serve all enrollees and comply with all state access standards, per 42 C.F.R. §§ 438.68, 438.206, and 438.207. To ensure that states can obtain the documentation they need for effective oversight, state contracts with managed care plans should (1) clearly spell out network standards and access requirements, and (2) specify the data that plans must submit to document compliance with these standards.

Additional resources

See CMS's 2017 network adequacy toolkit (Lipson et al. 2017) for more information.

States use a variety of approaches for reporting and oversight of network adequacy. Most states mandate that managed care plans regularly monitor the number and types of providers in their networks and submit, at least annually, network adequacy compliance reports. For example, **Florida** requires its Medicaid managed care plans to "submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees" (Florida Agency for Health Care Administration 2020, p. 84). **North Carolina's** current (as of May 2020) LME/MCO contract details that the plans are expected to monitor network adequacy and access to care by requiring that network analyses "take into consideration the characteristics of the population in the entire catchment area and shall include input from individuals receiving services and their family members" (North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services 2019, p. 40).

C. Monitoring compliance with network standards and access to behavioral health care

In addition to reviewing and verifying plan-reported provider network data, states may also engage in other activities to monitor compliance with behavioral health network adequacy standards. Examples include the following:

- **Grievance and appeals monitoring.** States can monitor access to services through grievance and appeals files, which states require managed care plans to submit regularly. Through this process, the state may be able to identify gaps in services or problems in specific plans, regions, or types of providers.
- **Secret shoppers** attempt to make appointments as if they were enrollees to assess whether providers are accepting new clients and complying with appointment wait times. For example, **Missouri** has used this strategy to identify gaps in access to psychiatrists and the accuracy of the provider directories. If the distance standards are met for every enrollee in every county, secret shoppers can help the state understand how quickly an enrollee with an immediate need can get an appointment and, if a psychiatrist is not available, whether another professional is available. See the text box "Secret Shoppers" for considerations when conducting secret shopper calls.
- **State report cards** that include access measures compare plans' performance in assuring access to care, and may provide consumers with information that allows them to select plans in which current enrollees report higher levels of access. Such report cards frequently rely on CAHPS (Consumer Assessment of Healthcare Providers and Systems) and HEDIS (Healthcare Effectiveness and Data and Information Set) measures, which reflect enrollee access to health care.

D. Collaboration with managed care plans to encourage innovation and performance improvement

States and MCOs need to communicate regularly about challenges to maintaining an adequate provider network, and work together to identify solutions. States have taken a variety of approaches to plan partnerships, including these:

- In **Missouri**, the state allows managed care plans to request exceptions if they cannot find a provider to meet the distance standards. The state checks its list of licensed providers and

shares with the managed care plan any known providers with whom the plan can contract. In addition, the state has communicated to managed care plans that network adequacy for inpatient mental health services is a priority. A plan is required to notify the state if it intends to terminate its relationship with a hospital that offers inpatient mental health services. If this occurs, the state would monitor whether this change would create a gap in access and mediate any disputes between the plan and the hospital to preserve the contract.

- In **Nebraska,** the state's managed care plan team, which oversees the managed care plans, contracting, and network adequacy requirements, includes staff with a clinical background, such as a nurse and a licensed mental health professional. Having a clinical background helps the team speak the language of providers and translate between clinical information and managed care policies. Nebraska also emphasizes the importance of maintaining open, direct dialogue with providers so that the state can understand providers' needs and hear about emerging issues the providers are seeing. State staff relayed that provider engagement is particularly important in Nebraska, where the same providers are in the Medicaid managed care and non-Medicaid networks.
- In **North Carolina**, the state recently shortened the timeline for granting network adequacy exceptions for LME/MCOs. In the past, if a managed care plan was unable to meet a network standard, it was given one year to address the issue. Shortening the timeline to six months or less enables the plan and state to address access gaps quickly, and it also increases the incentive for the parties to work together to solve the gaps. For example, the state may consider allowing managed care plans to substitute alternative providers or services, or modes of delivery, if a specific service is not available in a geographic area.

Secret shoppers: Considerations for survey design

Secret shopper surveys are one method that states use to verify managed care plans' compliance with provider network standards and to validate the accuracy of provider directories. State Medicaid agencies can use existing staff, External Quality Review Organizations (EQROs), or other vendors to complete these surveys. (When EQROs conduct secret shopper surveys as part of a quality review, states are eligible for an increased federal Medicaid matching rate for the services.)

In 2019, CMS asked Mathematica to conduct secret shopper calls to psychiatrists in select Medicaid managed care plans in six states. Overall, the results indicated that it was difficult for secret shoppers to schedule appointments with participating psychiatrists, suggesting that Medicaid enrollees may have limited access and that provider directories contain outdated information. In addition, to produce useful results, it is important to plan and design the survey carefully. States conducting similar surveys should consider the following lessons learned:

Select the sample frame. States must survey enough of the right kinds of providers, and the sample should be broadly representative of the providers of interest.

- **Which plans?** Although some state Medicaid agencies may be able to survey all managed care plans, those with a large number of plans may need to select a subset. For example, states can consider targeting plans that represent the largest enrollment or the plans that have the greatest network adequacy concerns.
- **Which providers?** States interested in understanding availability among all behavioral health providers should include a representative sample of each type of provider, such as adult and child psychiatrists and those who specialize in mental health and SUD treatment. States with shortages of particular providers may want to oversample providers with known shortages or those for whom Medicaid access may be limited.
- **Which regions?** States can aim for a representative sample statewide or focus on specific regions where access problems are more likely, such as rural areas or those with a high number of access-related grievances.
- **How many calls were attempted and completed?** Consider the time available to complete the calls. If resources are constrained, focus on calling provider types of interest, such as psychiatrists, in areas with known shortages.

Prioritize the key areas of interest.

- **Is the provider directory up to date?** Many provider directories are out-of-date and include providers who no longer contract with the managed care plan. To gauge whether provider directors are up to date, the survey could assess whether the providers listed in plan directories have current, active contracts with the plans. Secret shoppers could ask providers, "Do you currently accept my insurance? I have [plan name]."
- **Does the provider accept new clients?** Even providers who have active contracts with managed care plans may not be accepting new clients. Some provider directories indicate whether providers are accepting new clients, but this information may not be updated regularly. To ascertain how many providers within the network accept new clients, secret shoppers can ask, "Are you accepting new clients?"
- **What is the wait time for an appointment?** Many managed care enrollees experience long wait times for behavioral health appointments even though network adequacy standards specify timely access standards. To understand whether wait times fit within the parameters of timely access standards, secret shoppers can ask, "What is the soonest available appointment for a new client?"
- **Design the survey to portray the enrollees' actual experience.** To help survey staff sound similar to actual enrollees, prepare a script with instructions on what to do when the provider (1) asks the caller to leave a message, (2) refers the caller to a central number for multiple providers, (3) no longer works in the office or practice, or (4) requires a referral. Results should be recorded for these scenarios and described in the findings.

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