Addressing Children's Behavioral Health Workforce Shortages Through Medicaid and the Children's Health Insurance Program

A Resource for State Legislators and Changemakers Working with Children and Families

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Contents

Overview

In light of the worsening behavioral health crisis for children, the Centers for Disease Control and Prevention (CDC) collaborated with ChangeLab Solutions and the George Washington University School of Public Health (GW) to explore state-level Medicaid and the Children's Health Insurance Program (CHIP) policies that have an impact on the workforce for children's behavioral health. While many policies affect a broad range of providers, this review focuses on master's-level providers: licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), and licensed professional counselors (LPCs). The review highlights relevant Medicaid laws and policies in all states and the District of Columbia.

Through this exploration, researchers identified three areas of state-level policies with potential to influence the number of qualified behavioral health providers, including master's-level providers:

Network adequacy requirements, including provider-to-enrollee ratios and wait time, distance, telehealth, and culturally competent care standards

Credentialing process requirements, including processing time for credentialing and recredentialing providers and fees for provider participation

Incentives to expand or improve the workforce, including quality improvement plans, external quality review processes, and provider incentives such as student loan repayment programs

This paper provides a brief introduction to the behavioral health provider workforce, highlights state policies and initiatives to strengthen this workforce, and offers policy considerations to increase children's access to qualified behavioral health providers.

A list of abbreviations is provided in the **Appendix**.

Background

The United States is facing a shortage of behavioral health providers, particularly for children and adolescents.[1] In 2021, the US surgeon general called the children's behavioral health crisis an urgent public health issue, citing increasing rates of anxiety, depression, and suicide, in part due to social isolation and rising rates of loneliness.[2] Approximately one in five children ages 3 to 17 have a mental, emotional, or behavioral health disorder, such as attention-deficit hyperactivity disorder, Tourette syndrome, obsessive-compulsive disorder, posttraumatic stress disorder, anxiety, or depression.[3] Children of color experience higher rates of behavioral health challenges, including suicide, and steeper barriers to accessing behavioral health care than white children do. These disparities were exacerbated by the COVID-19 pandemic.[4,5]

A shortage of behavioral health providers contributes to children's inability to receive behavioral health care. Using data from the Health Resources and Services Administration's Health Workforce Shortage Area tool,[6] a Commonwealth Fund editorial[7] estimated that 160 million Americans lived in areas with behavioral health professional shortages in March 2023, potentially requiring over 8,000 more behavioral health professionals to ensure an adequate supply. For every 100,000 children, it is estimated that there are only fourteen trained child psychiatrists to provide care, a third of what is believed to be necessary to meet demand. Moreover, there are shortages of other pediatric behavioral health providers, including LCSWs, LMFTs, and LPCs, especially in medically underserved communities.[8]

A Commonwealth Fund editorial estimated that 160 million Americans lived in areas with behavioral health professional shortages in March 2023.

Over 42 million children are currently enrolled in Medicaid or the Children's Health Insurance Program (CHIP),[9] providing these programs significant opportunities to improve or hinder access to care. One key area to consider—both within and beyond Medicaid—is how master's-level behavioral health providers could help fill the gap for children's mental health. Such providers include LCSWs, LMFTs, and LPCs.

The Role of Master's-Level Providers in Medicaid and CHIP

Master's-level providers, including LCSWs, LMFTs, and LPCs, offer a variety of behavioral health services. They may diagnose mental disorders and provide psychosocial treatment for individuals, families, and groups[10] and can be effective at behavioral health management, cognitive behavioral therapy, and behavioral health screenings.[11] Given that these occupations are master's-level professions that do not require a doctoral or medical degree, this workforce group has the potential to grow more rapidly than that of psychiatrists or psychologists, who require an MD or PhD.[12] These providers are also among the largest groups of behavioral health providers.[13,14] According to the US Government Accountability Office, as of 2020, LMFTs comprise 11% of the behavioral health specialist workforce, LPCs comprise 28%, and LCSWs

comprise 36%.[15] As noted in prior research (see the companion paper, "**Addressing Children's Behavioral Health Workforce Shortages Through State Licensure Systems: A Resource for State Legislators, Licensing Board Members, and Changemakers Working with Children and Families**"), these provider types may vary in name (e.g., licensed mental health professionals) and qualifications by state, despite some similarities in training.[16]

In 2020, approximately 82% of Medicaid-enrolled children were enrolled in managed care plans.[17] These plans have a list of in-network providers from which enrollees may select and can include LCSWs, LMFTs, and LPCs. In this paper, we describe three state-level policy areas that could be leveraged to increase the qualified behavioral health workforce in a state or facilitate and incentivize participation in Medicaid and CHIP, particularly among master's-level providers:

Network adequacy requirements, including provider-to-enrollee ratios and appointment wait times, travel time and distance between enrollees and providers, telehealth, and culturally competent care standards

Provider credentialing processes, including processing time for credentialing and recredentialing of providers and fees for provider participation

Incentives to expand or improve the workforce, including quality improvement plans, external quality review processes, and provider incentives such as student loan repayment programs

Methodology

Between September 2022 and April 2023, researchers reviewed current managed care organization (MCO) model contracts, state Medicaid/CHIP plans and amendments, Medicaid Section 1115 waivers, Medicaid/CHIP websites, fee-for-service (FFS fee schedules), and FFS and MCO member and provider handbooks and manuals for all states and the District of Columbia (DC). Throughout this paper, MCOs, prepaid inpatient health plans, prepaid ambulatory health plans (PAHP), and Behavioral Health Organizations (BHOs) are uniformly referred to as MCOs. Researchers obtained plan names and enrollment data from Kaiser Family Foundation's 2022 analysis of CMS's Medicaid Managed Care Enrollment Reports.[18] They reviewed both the largest and smallest MCOs by total enrollment (inclusive of adults) in each state to understand plan differences and similarities. The smallest MCOs in some states were responsible only for specific populations, such as children in foster care; in these cases, researchers reviewed the next largest plan that included general coverage for children. In some states, researchers reviewed plans of other specialized entities that enroll people with serious mental illness or have additional behavioral health service needs. Finally, in states where there was a CHIP program separate from Medicaid, researchers reviewed CHIP coverage and plans for mental health–specific information.

This review examined policies related to Medicaid coverage and reimbursement of children's behavioral health services, with a specific focus on LCSW, LMFT, and LPC providers whenever possible. Researchers also reviewed provider contracting and credentialing requirements and managed care network adequacy standards as they relate to children's behavioral health in these documents and others. Finally, they reviewed Centers for Medicare and Medicaid Services (CMS) CHIP annual reports and a selected sample of state managed care external quality reports that contained information on children's behavioral health performance improvement projects or measures as indicated by CMS. These reports provided additional insight into state Medicaid/CHIP programs and their efforts to improve the quality of care for children with behavioral health needs.

Medicaid Section 1115 waivers allow HHS to waive certain provisions of the Social Security Act to allow states to establish innovative demonstration projects that promote the objectives of the Medicaid program.

Network Adequacy Requirements in Medicaid: Federal, State, and MCO Roles

Federal regulations require states to ensure sufficient access to care for adult and children's behavioral health, mental health, and substance use disorder care.[19] Under these requirements, states must ensure that MCOs maintain and monitor a network of providers that offers timely access to all covered services in a culturally competent manner.[20] Federal policies are silent about the types of providers that must be included in a plan's network.[21] States have the responsibility for defining which providers can deliver services and which specific network adequacy requirements apply to behavioral health care in their Medicaid programs.[22] Few states explicitly define eligible behavioral health providers as including LCSWs, LMFTs, and LPCs. Similarly, federal regulations do not include specific definitions of timely access or cultural competence; states set their own definitions and minimum requirements.[23]

States are also ultimately responsible for ensuring MCO compliance with network adequacy requirements and have multiple tools to do so. Each state Medicaid agency that contracts with MCOs is required to have an external quality review organization (EQRO) perform this review to ensure that Medicaid MCOs meet the state-set network adequacy requirements.[24] EQROs or states may require plans to submit annual network development plans to show how MCOs are monitoring and maintaining an appropriate provider network; they may also collect consumer complaints related to inaccurate provider directories, inadequate care, or inaccessible providers.[25] EQROs or plans themselves may also employ "secret shopper" surveys to test the accuracy of plan directories and compliance with network adequacy requirements.[26]

Network Adequacy Requirements in Medicaid: State and MCO Findings

Researchers identified specific components of network adequacy for behavioral health providers in state and MCO policies related to provider-to-enrollee ratios, maximum wait times for appointments, maximum geographic distance from or travel time to a provider, telehealth options to increase access, and requirements related to ensuring culturally competent care.

BEHAVIORAL HEALTH PROVIDER-TO-ENROLLEE RATIOS

States define behavioral health provider-to-enrollee ratios in a variety of ways. For example, Colorado's health maintenance organization contract required a ratio of one pediatric mental health provider per 1,800 children enrolled in the plan and

a ratio of one behavioral health provider for every 1,000 enrollees.[27] California required its county mental health plans, which are specific, limited-benefit plans offering specialty mental health services including psychiatric inpatient hospital services and targeted case management, to maintain a ratio of one provider to 43 enrollees for pediatric outpatient specialty mental health services.[28] Louisiana appeared to be the only state that specified provider-to-enrollee ratios for master's-level behavioral health providers at a ratio of five clinicians per 1,000 members. Researchers found other behavioral health providers included in MCO provider-to-enrollee ratios. For example, Florida required board-certified or board-eligible child psychiatrists at a ratio of at least 1 provider to 7,100 enrollees.[29]

TIME, DISTANCE, OR TRAVEL SPECIFICATIONS

In addition to or instead of establishing provider-to-enrollee ratios to ensure timely access, states may use other requirements and metrics based on time, distance, or travel. Some states specified maximum wait times, such as Colorado's state regulation, which required a maximum seven-day behavioral health wait time,[30] New Hampshire's Medicaid program that required behavioral health wait time of ten days,[31] and New Mexico's program that required a maximum nonurgent fourteen-day behavioral health wait time.[32]

In addition to or instead of establishing provider-to-enrollee ratios to ensure timely access, states may use other requirements and metrics based on time, distance, or travel.

Other states applied geographic distance or travel time standards, or both, for receipt of behavioral health services. Georgia required at least 90% of members in each county to have access to one behavioral health provider within 30 minutes or 30 miles of an urban area and 45 minutes or 45 miles of a rural area.[33] California required plans to enroll a sufficient number of behavioral health and substance use disorders providers to ensure that enrollees can access providers within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. The state further required that networks consider the pattern and frequency that behavioral health therapies are provided and ensure the network offers services available closer than the 30 minutes or 15 miles requirement if needed for a client to receive this care.[34] Kansas set maximum pediatric behavioral health time and distance standards for MCOs and was the only state that specified master's-level providers among the specialties to whom the standards apply.[35] North Carolina provides a notably different approach: it requires plans to have a provider network sufficient to ensure that enrollees have access to at least one mental health assessment and one substance use assessment per calendar year.[36] Beyond the Kansas example, the materials reviewed in this analysis did not specify master's-level provider types; however, additional research, including through interviews, may uncover whether master's-level behavioral health providers are specifically included under behavioral health provider designations that are applicable to the time, distance, and travel standards.

VARIATION IN NETWORK ADEQUACY BETWEEN MCOS AND THE STATE

While all states set minimum network adequacy requirements for their MCOs, individual MCOs may set more stringent network adequacy requirements than the state requires to better meet population needs. Several examples of these varying requirements include these:

- Although Iowa state legislation did not specify travel time requirements, an MCO in the state specified transportation time requirements for behavioral health

appointments, including a 15-minute leeway before and after pickup time for scheduled, nonemergency appointments and 60-minute leeway before and after pickup time for nonscheduled, nonemergency appointments.[37]

- Kansas set a requirement related to travel distance (30 miles for urban counties, 45 miles for dense rural counties, and 60 miles for frontier counties[38]) but not appointment wait times. Both Kansas MCOs also reviewed specified maximum wait times of 14 days for nonurgent requests for behavioral health appointments, among other metrics.[39,40,41]
- One MCO in Washington State set maximum wait times separately for initial and follow-up routine care by number of calendar days and maximum in-office wait times not to exceed 30 minutes.[42] Another Washington State MCO set a maximum wait time for initial routine care visits and a geographic requirement (e.g., 80% of members in urban areas must have access to at least one provider within 25 miles of their residence).[43]

Because this review included only a subset of MCOs, additional research could identify other MCO policies and elucidate the relationship between varying network adequacy standards and the participation rates of provider types, including master's-level behavioral health providers.

VARIATION IN NETWORK ADEQUACY STANDARDS BY POPULATION DENSITY

Some states have established network adequacy standards separately by population density distinctions such as urban, rural, and frontier. Specifications may be stated in terms of number of miles to the nearest provider or number of minutes to travel to the nearest provider, or a combination of both. At least one state, Louisiana, specifically included a master's-level provider type in their population density–based network adequacy standard; however, most states' standards appear to be applicable to master's-level providers broadly.

Population density definitions and requirements also varied from state to state—for example:

- New Mexico and Colorado both used three designations (urban, rural, and frontier), with New Mexico setting requirements based on miles traveled (e.g., 90% of rural members shall travel no farther than 60 miles[44]), and Colorado setting requirements based on minutes traveled (e.g., plans must have behavioral health providers serving children within 60 minutes of enrollees in rural counties and 90 minutes in frontier counties[45]).
- North Carolina and Kansas set requirements in terms of miles and minutes (e.g., 95% of members in rural counties in North Carolina must have access to two behavioral health providers within 45 minutes or 45 miles);[46] though with somewhat different population density designations.[47,48] North Carolina provided different standards for urban versus rural counties. Kansas time and distance standards were stated as 30 miles or 60 minutes for pediatric behavioral health providers in urban and semiurban counties and 60 miles or 90 minutes in rural and frontier counties.[49]

There is not a consistent definition of rural, urban, and frontier across all states (a finding in itself). For KS, a frontier county is less than 6 people per square mile, densely-settled rural is 20-39.9 people per square mile, and urban is 150 or more people per square mile.

— Institute for Policy & Social Research, The University of Kansas. *Population Density Classifications in Kansas by County, 2022*. **ipsr.unit.ku.edu/ksdata/ksah/population/popden2.pdf.**

- Louisiana explicitly included LCSWs in their pediatric behavioral health specialty network adequacy requirements, mandating that MCOs demonstrate that 90% of enrolled children have access to an LCSW within 30 miles for rural parishes (the Louisiana equivalent of counties) or 15 miles for urban parishes.[50]

MEDICAID MCO NETWORK ADEQUACY AND TELEHEALTH

Providing behavioral health services via telehealth can be effective for some children and adolescents and some behavioral health conditions.[51] Telehealth can thus help address gaps in access, especially for families in underserved areas or families who are less able to take time off work to travel to a provider or who do not have reliable means of transportation.[52] Some states' network adequacy policies permitted telehealth to formally make up for a lack of provider access. For example, Nebraska required that if rural or frontier geographic access standards cannot be met because of a lack of behavioral health providers in those counties, MCOs must use telehealth options to provide behavioral health services to enrollees.[53] Similarly, North Carolina required that when enrollees need a service that is not available within the state's reasonable driving distances, they can either use an out-of-network provider or access the service through telehealth. Enrollees had a choice between these two options.[54] While researchers did find documentation supporting the ability of master's-level behavioral health providers to provide telemental health in Medicaid, researchers were unable to assess the extent to which MCOs may construct alternatively adequate networks using telehealth and master's-level providers. One example of this information, which may be analyzed further in future research, is in Florida, which notes that pediatric specialists, who currently are not required to be listed in the state's network time, distance, or ratio standards, and which may include LCSWs, LMFTs, and LPCs, can be used to ensure access via telemedicine consultations.[55]

Telehealth can help address gaps in access, especially for families in underserved areas or families who are less able to take time off work to travel to a provider or who do not have reliable means of transportation.

CULTURALLY COMPETENT CARE

States can implement network adequacy requirements that either mention accessibility or specify ways to account for providing culturally competent care. For example, North Carolina's approach to ensuring cultural competency of services is an example with a high degree of specificity. The state required that plans ensure that services are available in a culturally and linguistically sensitive manner to all members, including those with limited English proficiency and literacy, those of diverse cultural and ethnic backgrounds, and those with disabilities. Services must be made available regardless of gender, sexual orientation, or gender identity. Additionally, plans must ensure that providers are able to give reasonable accommodations and accessible equipment for those with physical or cognitive disabilities to ensure access to care.[56] Beyond stating the standards for the provision of culturally competent care, North Carolina also required Medicaid MCO plans to report selected measures, including age, race, ethnicity, sex, language, geography, and disability status of enrollees, to allow plans to understand disparities in care. Plans were required to develop an annual health equity report that identified trends and variations in health services usage and outcomes and were required to develop interventions to promote health equity.[57] Regarding culturally competent care requirements, researchers did not note any instance in which master's-level providers were specifically mentioned, although it is presumed that these requirements apply to all Medicaid eligible and enrolled providers equally.

Policy Options Related to Network Adequacy

Given the flexibility of states to establish specific network adequacy standards to meet federal requirements, state policymakers could consider the following possibilities:

- Using established standards for provider-to-enrollee ratios, wait-time limits, and distance and travel time limits, such as those recommended by the National Association of Insurance Commissioners.[58]
- Analyzing current appointment wait times and distances from enrollee residence to provider to understand access needs, including disaggregating the data to determine the availability of culturally and linguistically appropriate services.[59]
- Monitoring consumer complaints[60] or conducting "secret shopper" and other similar surveys of Medicaid MCOs to identify gaps in coverage and access.[61]
- Optimizing telehealth access and provider participation to promote access while ensuring that individuals who benefit from in-person care and those who benefit from telehealth visits receive equal access to providers.[62,63,64]
- Collaborating with the US Department of Labor and CMS to enforce requirements for updated and accurate provider directories to better ensure that network adequacy requirements are met and for patients to find and contact behavioral health providers more easily.[65]
- Explicitly including master's-level providers in network adequacy requirements to increase enrollment of LCSWs, LMFTs, and LPCs in MCOs.[66]

Credentialing in Medicaid/CHIP: Federal, State, and MCO Roles

Licensing and credentialing in the Medicaid and CHIP programs ensure that providers participating in Medicaid and CHIP in both fee-for-service and managed care have met educational and training requirements.

Licensure is the process by which states determine that a provider is qualified to practice in the jurisdiction. State boards determine licensing requirements for behavioral health professionals, and state laws and regulations establish providers' scopes of practice.[67,68] LCSWs, LMFTs, and LPCs, like all other providers, must follow state licensing laws and regulations that define the scope of practice for their profession. ChangeLab Solutions' companion piece, "**Addressing Children's Behavioral Health Workforce Shortages Through State Licensure Systems: A Resource for State Legislators, Licensing Board Members, and Changemakers Working with Children and Families**," offers more information about state laws regarding postgraduate training requirements, state licensing boards, and license portability across jurisdictions.

Credentialing is the process by which the Medicaid agency or MCO determines that a provider is qualified to offer services to their enrollees. Federal regulations require that states have uniform credentialing and recredentialing policies for behavioral health providers and require that MCOs follow these policies, though states have flexibility to implement different credentialing policies within federal parameters.[69]

Credentialing in Medicaid/CHIP: State and MCO Findings

Materials related to state Medicaid programs and MCOs indicated a range of requirements or expectations about processing times for credentialing and recredentialing providers. Few policies explicitly named LCSWs, LMFTs, and LPCs, but instead provided broad requirements for all providers, which would appear to include these provider types. Some states and MCOs had requirements to ensure expediency in credentialing—for example:

- Tennessee required that credentialing applications must be processed by MCOs within thirty calendar days of the application receipt.[70]
- Delaware's First Health MCO required a maximum forty-five-day turnaround time for all initial provider credentialing applications.[71]
- Other states' MCOs, such as ones in North Carolina[72] and Virginia,[73] provided transparency of their processes to the public and potential providers by publishing average wait times.

- States can set requirements for how often providers must complete the credentialing process over time to continue to be included in the plan. For example, North Dakota's Blue Cross Blue Shield MCO[74] and South Carolina's Humana MCO recredentialed providers every three years.[75] Virginia required providers in all MCOs to be recredentialed every five years.[76]

In addition to setting timelines for credentialing and recredentialing, states and MCOs can have other requirements for potential providers. For example, MCOs can require applicants to pay fees to offset the costs of processing the application. North Carolina's Medicaid program required providers to pay $100 to be recredentialed for Medicaid.[77] South Carolina required institutional providers to pay $688 to register with South Carolina Medicaid, though individual physicians, nonphysician practitioners, and nonphysician organizations are exempt from the application fee.[78]

Medicaid health plans may also have credentialing requirements specific to behavioral health providers. For example, some MCOs require that master's-level practitioners hold a degree from an accredited program, are independently licensed in the state where they practice, have professional liability insurance, and detail their work experience in their résumé.[79,80] These requirements were in addition to state credentialing requirements.

Policy Options for Credentialing

Although the credentialing process is designed to ensure that only qualified providers are deemed eligible to practice, unnecessary administrative delays could have negative impacts on children's access to care. To address concerns about credentialing, policymakers could consider whether their state's credentialing process optimizes or incentivizes provider participation and access in these ways:

- Analyzing if the state has a licensing backlog, and direct staffing and support to remove delays in credentialing to address temporary licensing application surges.[81,82]
- Setting state requirements for maximum turnaround times for and individual's credentialing decision.[83]
- Using the Council for Affordable Quality Healthcare's Universal Credentialling Application, which is designed to streamline provider applications, reduce administrative delays, and reduce burdens on credentialing organizations.[84]
- Reducing barriers for recredentialing providers by exempting providers from paying recredentialing fees[85] and lengthening the required time for recredentialing.[86]

Incentives to Support the Behavioral Health Workforce: Federal, State, and MCO Roles

Student loan repayment programs are one method that the federal government has used to draw new professionals into behavioral health professions. The 2023 Pediatric Specialty Loan Repayment Program[87] offered up to $100,000 in student loan repayments for providers who have worked full time for three years in pediatric specialties, including LCSWs, LMFTs, and LPCs working in child and adolescent mental and behavioral health care. Either as part of a quality improvement project (QIP) or EQRO-directed remediation or as a separate initiative, states may also offer incentives such as fee waivers and loan repayments to expand the number of qualified behavioral health care providers. Other incentives can be offered to encourage Medicaid and CHIP MCOs to expand the number of providers participating in health plans, potentially including master's-level behavioral health providers.

Incentives vary regarding how to increase behavioral health provider enrollment in plans. Federal regulations require MCOs to complete annual QIPs, for which states determine the nature, scope, and focus of improvement.[88] States can issue penalties to MCOs for not completing a QIP by implementing capitation payment withholds. External quality reviews can also help states identify deficiencies and can recommend that MCOs or states develop initiatives to improve access to and timeliness of care for adults and children enrolled in Medicaid.[89] States may issue monetary or nonmonetary penalties to MCOs for noncompliance, including suspending enrollment of new individuals and mandating that plans cover out-of-network providers.[90]

Incentives to Support the Behavioral Health Workforce: State and MCO Findings

The Centers for Medicare and Medicaid Services reported that in FY 2021—2022, twenty-two states reported at least one behavioral health-focused performance/quality improvement project in their Medicaid/CHIP MCOs to meet a variety of quality-of-care standards.[91] For example, Rhode Island's Tufts MCO selected improving access to behavioral health telehealth services by reducing known barriers as one of their required QIPs.[92] Through this QIP, the plan disseminated information about behavioral telehealth services to providers and actively recruited additional providers who offered telehealth. Delaware's performance improvement plan focused on increasing follow-up care for children prescribed ADHD medications through provider education,[93] and New Jersey required all MCOs to implement performance improvement plans to increase adolescent risk behavior and depression screenings.[94] Although researchers were unable to find examples

of QIPs focused on master's-level behavioral health providers, states could consider QIPs that explore whether increased participation of these providers improves access to or quality of services.

Although EQROs are charged with identifying deficiencies, their reports and recommendations are not always fault finding. Virginia's EQRO noted that all the MCOs struggled during the 2021 plan year to ensure access and timeliness to behavioral health care.[95] To address these shortcomings, the EQRO recommended that the state Medicaid require MCOs to use behavioral health performance measurement data to identify and address health care disparity.

While some MCOs failed to meet certain benchmarks, EQROs generally noted which MCOs exceeded certain standards—for example, Healthcare Effectiveness Data and Information Set (HEDIS) measures monitored by the National Committee for Quality Assurance (NCQA). External quality reviews generally include plan rankings nationally to assess plan strengths and weaknesses. In California, for example, the EQRO assessed plans according to whether they were higher or lower than the 50th percentile among MCO plans nationally in HEDIS measurements. As it relates to childhood measures, for instance, during the 2020 measurement year, Kaiser SoCal in California scored well above the national 50th percentile in the following measures:[96]

- **Adult and child populations**
  - Rating of health plan
  - Rating of all health care
- **Child population**
  - Rating of personal doctor
  - Getting needed care

Most external quality reports reviewed for this paper noted specific strengths for each MCO, including how the MCO had followed up on prior year recommendations made by the EQRO and whether the MCO had taken the initiative to improve performance and quality ratings. For example, seeing that their patients were experiencing a decline in access to behavioral health as a result of the COVID-19 pandemic, the CalOptima health plan in California for the 2021—2022 performance measurement year raised awareness about the importance of behavioral health screening, treatment adherence, and follow-up care through social media and member newsletters in an effort to improve access and plan performance.[97]

In another example, Georgia's EQRO noted in the 2023 EQR that the average performance measurement for two of the three MCOs and PeachCare for Kids met or exceeded the 50th percentile for Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase, and the average performance measurement for one MCO and PeachCare for Kids met or exceeded the 90th percentile nationally.[98] Based on some of these successes, the EQR identified self-reported best practices. For instance, Amerigroup offered several QIPs to providers who focus on improving quality measures while reducing medically unnecessary utilization and costs, including one program specifically targeted to behavioral health care. An initiative

offered by Peach State Health Plan encourages providers and members across the state to use telehealth services and facilitate donations of technology for telehealth to reach those without connectivity.[99]

States used a variety of initiatives and loan repayment programs beyond just the Medicaid/CHIP program to aid recruiting and retaining qualified providers in their behavioral health workforce. The Oregon Behavioral Health Workforce Initiative, created through state legislation, sought to expand the state's behavioral health workforce by investing $60 million in scholarships, loan repayment programs, retention, and peer workforce development opportunities. In 2022, the state also waived licensure testing and application fees for social workers and behavioral health and addiction counselors.[100]

States used a variety of initiatives and loan repayment programs beyond just the Medicaid/CHIP program to aid recruiting and retaining qualified providers in their behavioral health workforce.

Statewide initiatives may also be implemented to recruit and train behavioral health providers. For example, in 2021, Massachusetts created the Children's Behavioral Health Initiative to expand access to behavioral health services for children and youth under age 21 to incorporate home- and community-based services, including in-home therapy and mobile crisis intervention. As part of the initiative, the state offered up to $1,500 to licensed behavioral health providers to reimburse them for the cost of licensing fees, examination preparation materials, and study courses.[101] Eligible providers notably included master's-level behavioral health practitioners.[102]

Another example of an initiative to support the behavioral health workforce is Michigan's loan repayment program structured to recruit and retain clinical social workers and behavioral health counselors. Through this initiative, a behavioral health provider could receive up to $300,000 over ten years, incentivizing long-term service in the state.[103] The University of Iowa developed a four-year, nearly $2 million grant program in 2021 to expand practicum sites in rural areas. This initiative established a practice subspecialty in integrated behavioral health that focuses on rural child and adolescent mental health. This grant supplemented and complemented current training efforts and provided new clinical training opportunities for master's in social work students focused on mental and behavioral health care for children and adolescents living in rural, medically underserved areas across Iowa.[104]

Policy Considerations to Support the Behavioral Health Workforce

A variety of options exist for states to require or incentivize efforts to expand the master's-level behavioral health workforce—for example:

- Expanding scholarships and loan repayment programs for master's-level providers, including LCSWs, LMFTs, and LPCs, to stimulate behavioral workforce growth and encourage providers to participate as Medicaid providers.[105,106]
- Increasing Medicaid reimbursement rates for behavioral health services in both primary and behavioral health settings.[107]
- Establishing a working group that includes representatives from state agencies, advocacy organizations, and health care providers to create recommendations on how to further expand or support the behavioral health workforce.[108]
- Directing or incentivizing their Medicaid and CHIP programs to perform QIPs specific to improving behavioral health coverage, quality, and access for children. This includes conducting surveys and monitoring to ensure adequate access to behavioral health care for children and increasing LCSW, LMFT, and LPC participation rates to ensure adequate access.[109]
- Implementing penalties and monitoring policies to identify and hold MCOs accountable if they fail to meet quality improvement goals regarding behavioral health access and care standards.[110] Alternatively, Medicaid and CHIP offices could provide incentives such as alternative payment models, capitation rates, or other monetary incentives for MCOs to increase the participation of behavioral health providers, including LCSWs, LMFTs, and LPCs in Medicaid and CHIP.[111]
- Efforts to support licensure portability across jurisdictions may be supportive of the behavioral health workforce. This area of policy is further explored in ChangeLab Solutions' companion piece titled "**Addressing Children's Behavioral Health Workforce Shortages Through State Licensure Systems: A Resource for State Legislators, Licensing Board Members, and Changemakers Working with Children and Families**."

Limitations

Findings in this paper are limited by our reliance on publicly available information. For example, publicly available documents do not often clearly note which program credentialing requirements, network adequacy standards, or quality and performance improvement initiatives are applicable to LCSW, LMFT, or LPC providers (though many policies appear applicable). Mental Health Parity Reports were beyond the scope of this analysis. Those reports, which are required to be prepared by the Department of Labor for Congress every two years, detail compliance of group health plans with the Mental Health Parity and Addiction Equity Act of 2008 and could provide insight into compliance with parity issues facing the behavioral health workforce.[112] In addition, although researchers reviewed Medicaid and CHIP documents in an effort to identify network adequacy requirements and standards for both programs, because of the interconnectedness of the programs in many states, it was often unclear whether published information applied to CHIP MCOs or just Medicaid MCOs. Some states had entirely separate MCOs for both programs, and some used the same MCOs and plans. Finally, the findings represent the reviewed MCOs (two per jurisdiction) at a single point in time. States change relevant Medicaid policies periodically, and MCOs can change or shift their own policies. Online sources may also have been updated since this paper was written.

Conclusion

The behavioral health crisis facing children is taking place against the backdrop of overall behavioral health care workforce shortages. Master's-level behavioral health providers, including LMFTs, LCSWs, and LPCs, are well suited to addressing state-level shortages.

The following policy options could be considered to increase the size of the qualified workforce and thus provide behavioral health care to children and families who need it, particularly among LMFTs, LCSWs, and LPC, in Medicaid and CHIP:

- **Network adequacy requirements**, which are the federal, state, or MCO requirements that ensure that the population served has sufficient timely access to behavioral health care;
- **Provider credentialing processes** for states or MCOs, which determine whether a provider is qualified to offer services to their health care enrollees; and
- **Incentives to expand or improve the workforce** (at the levels of federal, state, or MCOs) that can draw new providers into behavioral health professions or to encourage Medicaid and CHIP MCOs to expand the number of providers participating in health plans.

To learn more about additional policy levers that may expand the behavioral health workforce, see the following companion materials:

- **Policy graphic**: Expanding the Behavioral Health Workforce: Policy Levers to Expand the Behavioral Health Workforce & Provider Participation Rates in Medicaid & the Children's Health Insurance Program (CHIP)
- **White paper**: Addressing Children's Behavioral Health Workforce Shortages Through State Licensure Systems: A Resource for State Legislators, Licensing Board Members, and Changemakers Working with Children and Families

Appendix: Abbreviations

BHO	Behavioral Health Organization
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-For-Service (Medicaid)
GW	The George Washington University Milken Institute School of Public Health
HEDIS	Healthcare Effectiveness Data and Information Set
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
MCO	Managed Care Organization
MD	Doctor of Medicine
NCQA	National Committee for Quality Assurance
PhD	Doctor of Philosophy
QIP	Quality Improvement Project
SUD	Substance Use Disorder

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