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CHCF Issue Brief

Addressing Medi-Cal Behavioral Health Workforce Shortages Through Non-Financial Incentives

The behavioral health workforce shortage is well documented: California lacks the number of mental health and substance use disorder providers needed to meet the rising demand for their services.

This shortage is especially acute in Medi-Cal, California's state Medicaid program, with providers often citing reimbursement policies as their primary reason for not participating in Medi-Cal. However, they also state that easier, more streamlined enrollment and payment systems would encourage greater uptake.[1]

Therefore, as Medi-Cal policymakers and managed care plans explore solutions to increase behavioral health provider participation, it is important to examine administrative processes that impact provider participation in the nation's largest Medicaid program. This brief summarizes California's provider onboarding and credentialing requirements and compares them to those of other states, demonstrating steps California may consider taking to make expanded access to Medi-Cal behavioral health services a reality.

Background

Prior to receiving payment, federal Medicaid rules require all licensed behavioral health providers to both enroll in Medi-Cal and be credentialed by any managed care plans (MCPs) in which their patients are enrolled.[2]

In California, nearly all Medi-Cal behavioral health services are organized and paid for by one of three types of managed care plans: county-organized specialty Mental Health Plans (MHPs), county-organized Drug Medi-Cal Organized Delivery System (DMC-ODS) plans, and Medi-Cal MCPs. To receive reimbursement for services provided to eligible Medi-Cal enrollees, licensed health care providers must join the provider network of one of these payers and complete both of the following distinct processes, each of which has numerous steps:

- Enroll with the California Department of Health Care Services (DHCS) as a Medi-Cal Provider.
- Become credentialed with a Medi-Cal MCP, DMC-ODS plan, and/or specialty MHP.

These processes can mean lengthy waiting periods. If Medi-Cal enrollment and credentialing take the maximum time allowed for completion (180 days and 60 days, respectively), eight months could pass before a licensed provider is eligible to see Medi-Cal patients and receive payment for services rendered.

Provider Enrollment

Medi-Cal provider enrollment — the federally required approval process that screens health care providers for sanctions and verifies their licenses and certifications — is designed to reduce fraud and prevent providers who do not meet the Centers for Medicare & Medicaid Services (CMS) enrollment requirements from receiving Medicaid payments.[3] Since 2019, DHCS has required all fee-for-service and managed care providers to complete enrollment in compliance with the 21st Century Cures Act (the Cures Act). While enrollment requirements and processes vary for different provider types, most are done through the DHCS online system: Provider Application and Validation for Enrollment (PAVE).[4]

California's timelines are among the longest in the country, according to feedback from behavioral health providers across numerous states as well as a review of other state Medicaid program requirements (see Table 1).

While California regulations require DHCS to complete initial application reviews within 90 days for physicians or 180 days for non-physicians, those timelines in other states range from 30 to 90 days.[5] Indeed, California is the only state with a maximum timeline of 180 days for non-physician reviewed provider enrollment. And yet, the vast majority of behavioral health providers in the state are not physicians. Thus, California's longer processing timeline disproportionally affects behavioral health providers.

Transparency into actual processing times is limited. While DHCS reports completing the process within the time limit, it does not routinely publish turnaround times. Medi-Cal MCPs have an option to directly enroll providers that participate exclusively in managed care (and not in the fee-for-service program) within 120 days without using the PAVE system.[6] However, there is no consolidated data on either the number of plans that choose this pathway or their average processing times.

Table 1. Maximum Allowable Timeframes for Medicaid Enrollment

STATE	REQUIRED COMPLETION TIME
Washington	30 days
Minnesota	30 days
New Jersey	35 calendar days
Texas	60 days
Florida	60 days for providers that require a site review and 14 days for all other providers
Arizona	60 days
Kentucky	90 days
New York	90 days
California	90 days for physicians; 180 days for non-physicians

Sources: "Enroll as a billing provider," Washington State Health Care Authority, accessed Dec. 15, 2023; "Enrollment with Minnesota Health Care Programs (MHCP)," Minnesota Department of Human Services, last revised Dec. 22, 2023; New Jersey Administrative Code § 10.49 (PDF); "Section 1: Provider Enrollment and Responsibilities," (PDF), in *Texas Medicaid Provider Procedures Manual: Vol. 1*, Texas Health and Human Services, June 2023; *Report No. 13-12: MCM Provider Enrollment Process Audit* (PDF), Florida Agency for Health Care Administration, Office of the Inspector General, Bureau of Medicaid Contract Management Provider Enrollment Unit, March 2014; "AHCCCS Provider Enrollment Applications and Revalidations," Arizona Health Care Cost Containment System, accessed Dec. 15, 2023; "Provider Application Information," Kentucky Cabinet for Health and Family Services, accessed [date]; *Information for All Providers: General Policy* (PDF), New York State Medicaid Program, Dec. 30, 2022; California Welfare and Institutions Code (WIC) § 14043.26.

Credentialing

For the small minority of Medi-Cal enrollees still in the Medi-Cal fee for service program, eligible providers are able to bill DHCS directly. However, in most cases, providers must first join a managed care network to receive payment for behavioral health services delivered to Medi-Cal members. Doing so requires licensed providers to complete the credentialing verification process — in which their qualifications and credentials are assessed to ensure they meet certain professional and technical standards and requirements — separately for each Medi-Cal managed care network they want to join. This must be done in addition to the general Medi-Cal screening and enrollment requirements.

This process can be onerous and redundant. For one thing, CMS mandates that state Medicaid programs require MCPs to not only credential all providers prior to contracting, but also to re-credential them every 36 months.[7] Each MCP creates its own credentialing policies and procedures and has its own designated governing body (or credentialing committee) that reviews and approves policies, procedures, and provider applications. Few, if any, states have as many Medi-Cal MCPs as California, which is home to more than 20. Those exist on top of its 56 county-operated MHPs and their separate substance use programs.

Starting in 2023, California health plans regulated by the Department of Managed Health Care (DMHC) must process complete behavioral health provider

credentialing applications within 60 days.[8] However, because California does not require all Medi-Cal MCPs (including county MHPs and DMC-ODS plans, as well as some types of MCPs known as county-organized health systems) to have DMHC licenses (commonly known as Knox-Keene licenses), they are not subject to DMHC oversight. For these plans, DHCS neither mandates nor tracks credentialing turnaround times.

This differs from the practices of several other states that mandate MCPs to complete credentialing within specific timeframes or face potential service level penalties (see Table 2).

Table 2. Maximum Allowable Timeframes for Managed Care Credentialing

STATE	REQUIRED TURNAROUND TIMES
Minnesota	45 days
Kentucky	45 days
California	60 days (only for Knox-Keene plans)
Washington	60 calendar days
Florida	60 days
Arizona[9]	60 days
Colorado	90 days
New Jersey[10]	90 days
Texas	90 days

Sources: Minnesota Statute § 62Q; Kentucky Revised Statute § 304. 17A-576-7; "Medi-Cal Managed Care Boilerplate Contracts," DHCS, accessed Dec. 15, 2023; Jenny Phillips (deputy director, Office of Plan Licensing, California Department of Managed Health Care) to all health care service plans, "Newly Enacted Statutes Impacting Health Plans (2022 Legislative Session)" (PDF), All Plan Letter 22-031, Dec. 22, 2022; "Washington Apple Health Integrated Managed Care Contract," (PDF), Washington State Health Care Authority, Jan. 1, 2024; *Attachment II: Scope of Service - Core Provisions* (PDF), Florida Agency for Health Care Administration, last updated October 1, 2022; *Contract Amendment #14*, Colorado Department of Health Care Policy and Financing, accessed Dec. 15, 2023; *Uniform Managed Care Terms & Conditions* (PDF), Texas Health and Human Services Commission, last revised Sept. 1, 2023.

Example Scenario

A provider in Los Angeles that offers specialty and non-specialty mental health services as well as substance use disorder services to all Los Angeles County Medi-Cal enrollees would have to be credentialed and contracted by the county Department of Mental Health, county Department of Public Health, and up to six Medi-Cal MCPs. The provider would have to submit the same documents and track the progress of eight different organizations after enrolling its licensed clinicians with DHCS to be Medi-Cal providers. Providers that work across multiple counties would also need to be credentialed with the MCPs and county MHPs that operate in those other counties.

Centralizing Credentialing to Minimize Provider Administrative Burden

To minimize administrative burden for providers, several states — including Minnesota, Ohio, North Carolina, and Georgia — have centralized the credentialing process within a single statewide organization.[11] For the same reason, Mississippi and Nevada are also moving to centralized Medicaid credentialing processes.[12]

In these examples, the state contracts with a credentialing verification organization that is accredited by the National Committee on Quality Assurance (NCQA) and that completes the process on behalf of all participating MCPs. As a result, a provider can join multiple MCP networks without needing to complete the same credentialing process multiple times.

In 2023, the California Mental Health Services Authority (CalMHSA) undertook a step to help streamline the credentialing process for counties.[13] CalMHSA procured a NCQA-certified credentialing verification organization to offer counties a centralized credentialing solution for mental health and SUD providers. The service aims to "help ease the costly, time consuming,

and cumbersome credentialing process," and county participation is optional.[14]

Aligning Specialty and Non-Specialty Systems

DHCS imposes the same credentialing requirements on Medi-Cal MCPs as it does county MHPs, as shown in Table 3.[15] Despite this, providers that want to deliver behavioral health services across the continuum must credential separately with each MCP and their county's MHP or ODS plan.

Today, there is minimal overlap in providers that participate in the specialty and non-specialty networks. When asked why they do not contract for non-specialty services, specialty mental health providers point to reimbursement rate disparities, staffing challenges, and the difficulty of building a separate operational model for a smaller business line.

Table 3. Credentialing Requirements, Managed Care Plans and Mental Health Plans

CORE REQUIREMENTS
Payers must complete primary source verification of: ✓ The appropriate license and/or board certification or registration document ✓ Evidence of graduation or completion of required education ✓ Proof of completion of relevant medical residency and/or specialty training ✓ Satisfaction of applicable continuing education requirements
Payers must verify or collect the following: ✓ Work history ✓ Hospital and clinic privileges in good standing ✓ History of any suspension or curtailment of hospital and clinic privileges ✓ Current Drug Enforcement Administration identification number ✓ National Provider Identifier number ✓ Current malpractice insurance in an adequate amount, as required for the particular provider type ✓ History of liability claims against the provider ✓ Provider information, if any, entered in the National Practitioner Data Bank, when applicable ✓ History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal* ✓ History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards
Payers must collect signed and dated attestations from providers for: ✓ Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation ✓ A history of loss of license or felony conviction ✓ A history of loss or limitation of privileges or disciplinary activity ✓ A lack of present illegal drug use ✓ The application's accuracy and completeness

* Providers terminated from either Medicare or Medicaid/Medi-Cal or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.

Sources: Michelle Baass (director, DHCS) to all Medi-Cal managed care health plans, "Provider Credentialing/Re-Credentialing and Screening/Enrollment" (PDF), All Plan Letter 22-013, July 19, 2022; and Jennifer Kent (director, DHCS) and Edmund G. Brown Jr. (governor) to county behavioral health directors, county drug & alcohol administrators et al., "Provider Credentialing and Re-Credentialing for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties" (PDF), Mental Health and Substance Use Disorders Services (MHSUDS) Information Notice No. 18-019, April 24, 2018.

Good Contracting Practices

For centralizing credentialing to work well, the credentialing entity must perform services in a timely manner, and the credentialing verification organization and MCPs must collaborate well and share information promptly. Thus, effective contracts between states and credentialing verification organizations should include performance guarantees with financial penalties if the credentialing organizations exceed benchmark processing times. States should also collect performance data from the contracted vendors no less than quarterly and publish key performance indicators online.

They also cite the administrative burden of navigating multiple MCP credentialing and contracting processes. Further, MCPs are not always familiar with the Medi-Cal specialty mental health network and program certification requirements.

Adding to the challenge is the fact that most specialty mental health providers are not structured like typical physician groups, and thus do not fit neatly into the parameters of MCP credentialing. Rather, most are nonprofit community agencies that meet the definition of a "Community Mental Health Center" as it is laid out in the California Welfare and Institutions Code.[16] Within California's specialty mental health system, there are approximately 1,800 of these providers (also known as "Legal Entity Providers") across 4,000 service locations.[17] As well, California does not license community mental health centers, which creates further complexity. Instead, every three years providers undergo a certification process specific to each Medi-Cal specialty mental health program they offer. Medi-Cal MCPs tend to be less familiar with this certification process and may ask community mental health centers for their facility licenses as part of the credentialing process.

Furthermore, Medi-Cal's PAVE provider enrollment system does not have a pathway for nonprofit community mental health centers. These systemic differences and varying interpretations, providers say, lead to confusion, delay, frustration, and often eventual abandonment of the process.

Exploring options to streamline NCQA- and CMS-compliant credentialing across both the specialty and non-specialty systems of care could reduce administrative redundancy and increase provider participation. And more providers offering services across systems would mean a more coordinated system for Medi-Cal enrollees, ensuring they can receive all covered Medi-Cal services from the same trusted provider, regardless of who pays for it.

Conclusion

In recent years, Californians have stated repeatedly that their top health policy priority is ensuring people get the mental health treatment they need.[18] And yet, the behavioral health workforce is facing a chronic shortage, which disproportionally affects access for Californians enrolled in Medi-Cal, the state Medicaid program.[19]

One factor limiting workforce expansion is California's approach to compliance with federal Medicaid requirements for provider enrollment and credentialing. Existing processes are lengthy, opaque, and redundant. What's more, California's timelines for Medi-Cal enrollment exceed those found in other states, and the lack of current, publicly available information on DHCS enrollment processing, MCP credentialing performance, or consequences associated with any delays creates an atmosphere of uncertainty.

Providers say other states make it faster and easier to meet the federal requirements. California can look externally and internally for inspiration to do the same. For instance, CalMHSA's new centralized provider enrollment program, which counties may opt into, could prove to be an efficient solution.

Going forward, California's Medi-Cal program leaders should prioritize exploring non-financial incentives to make program participation easier to more behavioral health providers. Doing so will not only address the increasing demand for services but will also contribute to a more equitable and healthier future for Californians on Medi-Cal.

About the Author

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About the Foundation

The **California Health Care Foundation** (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. Gina Eckart, Madeline Guth, and Heather Saunders, "A look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs," Kaiser Family Foundation, Jan. 10, 2023.
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