American Mental Health Counselors Association
Emerging Clinical Practice Brief

How to Become a Medicaid Mental Health Provider

Who Provides Medicaid Services?

Medicaid services are provided by a range of public and private health care professionals and organizations, the list of which varies from state to state. States have latitude in defining the types and qualifications of providers that may receive Medicaid reimbursement for delivering services. The federal government is deferential to state professional practice acts, which are state statutes and regulations that contain specific licensing requirements, professional standards, scope of practice and prohibited acts, etc. for health care providers.

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Fundamentally, Medicaid is a partnership between the federal and state governments, which includes sharing the cost of the program. The percentage of the cost attributable to the parties varies by state and, in certain instances, varies with the activity for which payment is sought.

Before addressing issues unique to providers of behavioral health services, it is useful to understand some principles relative to Medicaid providers, in general.

Having an understanding of several important foundational Medicaid principles will help inform how and why states approach the design of their provider networks and establish their provider requirements.

Reasonable Promptness and "Statewideness"

The ability to ensure that Medicaid consumers can access needed services in a reasonably timely manner depends on having a sufficient number and type of providers in a given area. Although there may be sufficient numbers and types of providers available in the community, network requirements imposed by the state and the level of reimbursement for services (among other considerations) will impact providers' willingness to participate in the Medicaid program.

States are given flexibility within the confines of federal statute and regulation to determine provider qualifications and reimbursement rates.

Freedom of Choice Among Qualified Providers

An eligible individual may obtain Medicaid services from any provider that is qualified and willing to furnish the services. The ability to waive this requirement is one of the principal reasons that states employ waivers.

Many Americans want to be able to choose their provider. Affording a Medicaid consumer the choice among all providers determined by the state to be qualified is considered an important component of quality and safety—the ability to, proverbially, "vote with one's feet." States are given flexibility within the confines of federal statute and regulation to determine provider qualifications and reimbursement rates.

Single State Agency

The role of the single state agency in directing the state's Medicaid policy includes the responsibility to establish and apply consistent requirements for becoming an eligible Medicaid provider. These requirements typically are codified in state law or rule. The behavioral health and Medicaid departments may jointly file rules—or the behavioral health department may maintain administrative rules with greater policy detail—while the Medicaid department maintains a rule that "authorizes" the other department's requirements. When the Medicaid and behavioral health authorities are in the same department, any concerns about the ultimate authority for Medicaid purposes is lessened significantly.

Efficiency, Economy, and Quality of Care While Assuring Access

Although access to needed services is a primary consideration, it is not the only factor related to provider networks. States must maintain a balance between assuring access and providing quality services in an economical and efficient manner.

Is It a Service or a Provider?

When states consider the design of their provider networks, it is helpful to understand at the outset whether the network is comprised of services or providers. The list of mandatory and optional *services* is actually a combination of services and *types of providers.* Prescription drugs, dentures, family planning, and respiratory care, for example, are services.

State-Specific Professional Practice Acts

Professional practice acts are state laws and regulations that define the scope of practice for a particular provider type. They identify what constitutes the independent practice of a certain professional and what activities the professional can or cannot undertake. These requirements apply to providers regardless of the payer source. In other words, state professional practice acts establish practice requirements for providers regardless of whether they receive reimbursement from Medicaid or private insurance.

The Medicaid provider is the provider agency or independent practitioner who has a direct relationship with the state. It has a signed Medicaid agreement with and is reimbursed directly by the state.

Medicaid regulations give considerable deference to state professional practice acts. In many areas of health care, it is clear what type of provider can perform certain services (e.g., surgery, prescribing medications).

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The rendering provider is a clinician, therapist, program staff, or paraprofessional who provides hands-on care to the Medicaid consumer. The rendering provider may also be the Medicaid provider, as in the case of an independent therapist who is self-employed. Depending on the type of Medicaid service and whether a professional practice act applies, a state may have very specific Medicaid requirements associated with who is eligible to provide hands-on care.

A provider can determine if he or she can participate in its state Medicaid program as a provider of behavioral health services by assessing the services for which the state's Medicaid program provides reimbursement, to which populations, and by what types of providers.

Providers of Behavioral Health Services

Many types of providers serve individuals with behavioral health needs. Behavioral health services are often delivered by a clinical mental health counselor, social worker, physician, psychologist, or community support paraprofessional in an office, outpatient clinic, or community setting. State Medicaid programs frequently cover other provider types that give behavioral health care, such as primary care physicians, clinics, federally qualified health centers (FQHCs), psychiatric residential treatment facilities (PRTFs), and special institutions of mental diseases, as described below. States' administrative rules and/or statutes typically specify the provider types—including required licensure or certification—that are permitted to provide behavioral health services. A provider can determine if he or she can participate in its state Medicaid program as a provider of behavioral health services by assessing the services for which the state's Medicaid program provides reimbursement, to which populations, and by what types of providers.

Community Mental Health Centers

The Mental Retardation Facilities and Community Mental Health Centers Construction Act was signed into law in October of 1963 only nine months after President John F. Kennedy proposed in a major public address a national mental health program. The Act provided an alternative to institutionalization for those with serious mental illness (SMI). It drastically altered the delivery of mental health services and inspired a new era of optimism in mental health care. This law led to the establishment of more than 750 comprehensive community mental health centers (CMHCs) throughout the country.

Although there is no standard definition of what constitutes CMHCs, what made them unique was the comprehensive scope of their services, their provision of services for individuals who were indigent and to individuals with SMIs or children with SEDs, and their distinctive involvement in their community and neighborhood.

Federally Qualified Health Centers

FQHCs are community-based and consumer-governed organizations that serve populations with limited access to health care. Health Center grantees are grant-supported FQHCs that are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Program (respectively, Sections 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

Psychiatric Residential Treatment Facilities

The Social Security Act was amended in 1972 to allow states the option of covering inpatient psychiatric hospital services for individuals younger than age 21 (the *psych under 21 benefit*). Originally, the statute required that inpatient psychiatric hospital services for individuals younger than age 21 be provided exclusively by psychiatric hospitals that were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Get organized. Medicaid agencies are going to want lots of information including copies of your licenses, proof of malpractice insurance, resumes, and other supporting documentation.

The major benefit of a PRTF is that an individual can receive inpatient psychiatric care in a nonhospital setting and reimbursement rates can include room, board, and expenses. PRTFs are secured facilities that provide a structured, therapeutic environment for individuals under 21 years who need intensive services to effectively treat severe behavioral and/or developmental disturbances.

How to Become a Medicaid Preferred Provider

Step 1 – **Get organized.** Medicaid agencies are going to want lots of information including copies of your licenses, proof of malpractice insurance, resumes, and other supporting documentation.

Step 2 – Make a list of questions. Medicaid agencies vary considerably in the amounts they will pay providers. They also vary in how quickly they will reimburse you, how "provider-friendly" they are, and how many hoops you will be required to jump through to obtain reimbursement.

Step 3 – Contact provider relations. Call each agency and ask to speak with Provider Relations. Every Medicaid Program has someone in this position that can speak frankly with you about their application process. Request an application. They will most likely re-direct you online but this is a good

opportunity to start building a human connection. And, while you are at it, ask them what their unique clinical needs are.

Step 4 – Use your personal contacts. If you've already been networking in the field, it's likely that you have already met – individuals who work in managed care or indirectly with managed care. If you haven't met those individuals already, now is the time to put that on your networking to-meet list. Employee assistance programs (EAPs) and those employed in provider relations can provide you with shortcuts and tips for getting your application accepted. Pick their brains!

Step 5 – Complete the CAQH. The application process can be lengthy and arduous. Plan on 20-30 page applications for most Medicaid Programs. The strenuous nature of the application process is alleviated in knowing that annual updates are fairly quick and simple.

Step 6 – Copy everything you include in your application. It is not unheard of for applications and supporting documentation to be lost, misplaced, or actually shredded after it leaves your hands and long before the application process is completed. Make sure you copy *everything* and keep *detailed notes* about when, how, and who you talk to in Provider Relations and w*ho said what*. It is likely that you will need these notes later on so that your concerns are experienced as sound competent, clear-headed, and informed.

Step 7 – Create and keep paper trails. Communicating in writing can be your saving grace down the road. You should communicate by phone or face to face to nurture the relationships that you are developing. However, ***always* follow up important conversations via email so that you will have a paper trail to confirm your understanding of contractual details and expectations.** *Honor along with the spoken word is not enough.*

Step 8 – Submit your application and supporting documentation in a timely manner. You will likely be rejected as a provider if you fail to submit a complete application and respond to any additional requests in a timely manner. Those employed in Provider Relations refer to failures of this nature as "timing out." In order to avoid having your application rejected solely because it has timed out, you will need to stay organized and efficient and respond to their requests for additional information quickly.

Step 9 – Follow up. Once your application and supporting documentation has been submitted, your job is not done. You should again contact Provider Relations and ask them about the timetable for processing your application. Consider contacting Provider Relations at least monthly until you have a final disposition of your application.

Medicaid Agencies receive hundreds of applications from licensed mental health professionals every year who want to become preferred providers. That's why it's important to make your application stand out in a positive way to the professionals in Provider Relations that will be evaluating your credentials and experience.

Tip #1 – Focus on your own efficiency and your ability to save on costs. The primary goal of Medicaid Programs is to reduce health care costs. *The care of clients comes second*. Make sure that your application speaks to Medicaid's concerns and not just your own.

Tip #2 – Location makes a difference. If you can provide services in an under-served area, you are more likely to be admitted to a preferred provider list. If you currently provide services in a therapist-saturated market, you may want to consider adding a second site to your practice. By indicating that you are available to provide services in an under-served area for just a few hours each week, you make yourself much more desirable.

Tip #3 – Highlight second languages that you are fluent in. Your unique expertise is what will get you on the list so don't forget to highlight an ability to speak a foreign language every chance you get.

Tip #4 – Special hours can set your practice apart. Many therapists work 8 a.m.– 5 p.m. If you can offer late or early hours or are willing to work on weekends, mention them on your application. Those "special" hours can be a way to expedite your entrance into the world of preferred providers.

Tip #5 – Special populations require special knowledge. Don't indicate that you "work with everybody." That's not what they are looking for. Instead, if you have advanced training and experience working with a special population or two, emphasize this. Populations such as geriatrics, children, GLBT, deaf clients, etc. can open doors for you with Medicaid officials.

Tip #6 – Advanced training and credentials count. Although experience definitely counts, proof of skills via advanced training and credentialing make you much less of a risk and much more desirable to them, too. Track your professional development and flaunt it in your application.

If your application is denied, you can ask for a "single case agreement" when appropriate. If you are able to justify why a client of yours should be allowed to continue working with you *even though you are out of network*, it is entirely possible for them to grant you a "single case agreement" to be considered "in network" for only that client.

Reasons that might justify such an agreement would be those that address the unique needs of your client and the cost / benefit needs to the agency. Perhaps your client has minimal skills in maintaining relationships. If trust in providers is difficult for the client, your relationship with her may qualify as a positive and extenuating circumstance. Or, if your client is mid- gender reassignment and there are no other professionals appropriately trained to address this client's immediate needs, you may be the only logical choice.

Then, if the Medicaid Program is pleased with your work**,** it is also possible for them to easily transition you to being one of their *preferred providers*. It's a matter of massaging those warm relationships with Provider Relations as you go and proving your worth to them. Remember, it's much less expensive for

the Medicaid program at that point to add you to their provider list than it is to begin the credentialing process all over again with a different therapist whose work is unknown to them.

If your application is denied, a different strategy might be to affiliate with another provider who has already been accepted as a preferred provider. Medicaid prefers to work with groups – even when the individuals in those groups are only loosely affiliated with each other. By affiliating with a group of providers or an individual provider who has been accepted onto a panel, you are increasing the perception of *your* value.

And, finally, it's important to remember that the needs of Medicaid managed care programs change**.** Stay abreast of those changes by monitoring on a regular basis. Give Provider Relations a call. Most of all, keep your name and face in front of them and let them know that you are eager to join and support them!

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The Advancement for Clinical Practice Committee of the American Mental Health Counselors Association (AMHCA) is responsible for developing, coordinating, and producing the white papers, which give a brief orientation to clinical mental health counselors about topics relevant to current practice. Existing AMHCA white papers include technology in counseling, trauma-informed practices, and responding to suicide risk. The Committee has a protocol for interested authors and contributors; please contact the chair of the Committee.

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