Submitted via email: HealthWorkforceComments@help.senate.gov

March 20, 2023

The Honorable Bernard Sanders
Chair of the Senate HELP Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Ranking Member of the Senate HELP Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Bipartisan Request for Information (RFI) on Health Care Workforce Shortages

Dear Senators Sanders and Cassidy:

Medicaid Health Plans of America (MHPA) appreciates the opportunity to respond to your Request for Information (RFI) to support efforts to address the health care workforce shortage. We applaud this important initiative to identify legislative solutions to this problem and look forward to collaborating with you as you craft policy to best serve the millions of Americans who rely on Medicaid for coverage and care.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

MHPA applauds the Senate HELP Committee for taking steps to address the provider workforce shortage including the development of strategies to increase and diversify the pool of providers for Medicaid and CHIP. The severity of the health care workforce shortage varies by state and discipline, although the impact is strongly felt with high need specialties such as primary care and behavioral health, as well as in rural areas and tribal communities. In addition, a recent Kaiser Family Foundation study found that nearly every state reported a home and community-based workforce shortage in one or more HCBS settings for 2022.[1] The COVID-19 pandemic exacerbated these issues by introducing additional strain into the health care system.

We welcome the opportunity to work with your committee to identify solutions to the workforce shortage. Below are our recommendations on ways to address this important issue.

[1] Watts, et. al., KFF: Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey, November 2022. Available at: https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/

Recommendations

Cross-State Licensure. Throughout the COVID-19 pandemic, most states authorized immediate or expedited licensure reciprocity for health care professionals to bolster workforce capacity and sustain access to care for patients. Notably, licensure reciprocity played a critical role in the delivery of virtual care services for patients, particularly those with chronic illnesses, living in rural areas, or geographic regions where there is a dearth of specialty providers. Congress can encourage CMS to promote cross-state licensure by releasing guidance and best practices.

Multi-State Licensure Compacts. Moving beyond the pandemic, MHPA believes that multi-state licensure compacts for providers that harmonize state licensure requirements can be an important boost for telehealth care delivery, as well as for providers that operate near state borders. Such compacts can help facilitate access to care and are particularly important for areas, both geographic and by type of practice, that are experiencing provider shortages. Ensuring that requirements for multi-state licenses take into account existing experience for nurses would also streamline the licensure process, avoiding overly burdensome requirements for already licensed medical professionals to provide services in other states and removing further delays in access to care and services for beneficiaries.

Non-Clinical Workers. Many states are looking for ways to expand the Medicaid provider workforce to include non-clinical health care workers such as community health workers (CHWs), doulas, and peer support specialists. MCOs often cover the costs of these workers through administrative dollars unless a state explicitly allows reimbursement of non-clinical health care workers to be counted as a medical expense. This can be challenging for MCOs that are required to reach a specific medical loss ratio (MLR). By creating a provider enrollment type that covers non-clinical workers, state Medicaid programs would help alleviate this issue by allowing encounters to be reported and captured in the rate setting process. We recommend that Congress work with states to create simple and uniform credentialing processes for non-clinical health care workers that would create efficiencies for requirements related to education and training, certification, and scope of practice.

Out-of-State Provider Billing. Health care providers that live in bordering states can help increase the pool of available providers to serve Medicaid beneficiaries in a state, especially when a larger town or city is located right across a state border. An individual case agreement is a means of contracting with an out-of-state provider; however, we believe a streamlined process for out-of-state providers that live close to a state border to participate in the bordering state's Medicaid program would be administratively efficient and increase the availability of providers, enhancing access to care. To support this approach, we recommend Congress consider how to incentivize states to recognize licenses from bordering states and to not require providers to be physically located in the state where they are billing. Medicaid MCOs could more easily contract with bordering state providers if states adopted these policies and doing so would increase access to providers for Medicaid enrollees. We recommend Congress work with states to ease access for out-of-state providers to bill for Medicaid, particularly those that live near state borders.

Facilitating Access to Services. Data from 2020 showed that approximately 39 percent of Medicaid beneficiaries were living with a mental health or substance use disorder[2] with access to services and treatments often hampered by limited availability of appointments with clinicians in the behavioral health field. Allowing Medicaid to be billed for services provided by a wider range of providers could help address workforce shortage issues and help minimize long waits for care and services. For example, Federally Qualified Health Centers (FQHCs) could be allowed to bill Medicaid for visits beneficiaries have with a marriage and family therapist, licensed professional counselor, or a licensed addiction counselor. Another consideration to better facilitate access to care and to improve the beneficiary experience could allow for a medical visit to be billed the same day as a behavioral health and/or oral health visit. We would also support increased funding to address workforce availability and retention (e.g., financing for behavioral health degreed programs) and refer to the National Council for Mental Wellbeing/Health Management Associates study available here for more information on capacity issues related to the behavioral workforce and potential state policy actions.

Education and Awareness. Education and community awareness of behavioral health issues and treatment is an essential step to addressing the issue of diversity in the behavioral health care workforce. Behavioral health literacy is the basis for prevention, stigma reduction, and increased awareness to both behavioral health issues and available treatment options. Understanding and placing an emphasis on addressing cultural norms is essential to increasing diversity in the behavioral health care workforce. Improving behavioral health literacy should be a focus of policymakers in order to educate, engage, and encourage community awareness of the importance of behavioral health and well-being.

Telehealth and Behavioral Health: The COVID-19 pandemic exacerbated the pre-existing behavioral health workforce shortage, one that is especially severe in rural and underserved areas. Rural and underserved areas face unique challenges in recruiting and retaining health professionals. TeleBehavioral Health (TeleBH) allows members to continue behavioral health treatment safely and in the comfort of their own homes, which is particularly important in rural, and other underserved areas. Virtual appointments also provide greater access to care for those who are homebound or have a disability. TeleBH connects members with providers who can meet their unique cultural needs and improve access to specialists, giving all members an equal opportunity to obtain specialized care. Additionally, TeleBH removes barriers that can be present with in-person care including Social Determinants of Health (SDoH) (for example, access to reliable transportation), stigma, and time away from work. We recommend that Congress continue to encourage states to embrace telehealth and promote mutual recognition compacts. Moreover, we recommend that Congress continue to emphasize to states the flexibility they have in determining how telehealth services are delivered.

Technology Support. We encourage Congress to provide grants to increase access to broadband internet services and smart-enabled devices. We support building off this to remove barriers to

[2] https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

broadband and provide Medicaid beneficiaries with smart-enabled devices. Improving access to broadband services can help address the digital divide and increase health equity.

Medical Education and Training. Expanding funding and access to the Health Resources and Services Administration's National Health Service Corps could help to alleviate workforce shortages in the long-term care community. Currently, home and community-based services agencies, nursing facilities, and adult day centers are considered ineligible for the program. Therefore, doctors, licensed clinical social workers, nurse practitioners, and other eligible medical professionals cannot be placed in these types of settings, limiting the exposure of new professionals to long-term care service and limiting the ability of these provider types to attract talent.

Congress can also take steps to support education and attract medical professionals to the workforce by pursuing visa relief and expeditions for highly trained foreign health care workers, providing scholarships and loan forgiveness for practitioners, and boosting financial support for nursing schools and faculty.

Scope of Practice in Behavioral Health. In addition to technological solutions and workforce investments, the relaxation of supervision requirements for licensed professional counselors, licensed marriage and family therapists, and other mental health professionals who provide services incident to a physician as part of the primary care team could support access to behavioral health services via strengthened primary care management of behavioral health conditions. We believe the provision of services by an expanded team of licensed behavioral health professionals can support timely access to care.

Again, thank you for the opportunity to contribute to this important work. Addressing workforce issues is one of the keys to unlocking more robust access for the millions of Americans who rely on the Medicaid program – a goal shared by MHPA and its member plans. Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy